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Historical Trends and Recent Patterns

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A brief account of the history of family planning in Costa Rica[1]

María Carranza[2]

Costa Rica has been a focus of demographic attention for at least two reasons: its startling rate of natural population growth, which peaked at 3.8% during 1955 and 1960 and which was considered one of the highest in the world[3]; and the astounding decline in the total fertility rate, from 7.3 to 3.7 children, that took place between 1960 and 1975, and which has rarely been recorded elsewhere (Gómez, 1968: 3; Reynolds, 1973: 312; Rosero-Bixby, 1979: 4). This sharp reduction in the fertility rate, which occurred in all strata of the population, albeit with varying intensity and chronology[4], has been attributed in large measure to the use of modern contraceptive methods (Rosero-Bixby, 1979:13; 1986: 70-71). Their provision by state health institutions played a fundamental role in accelerating the phenomenon and spreading it from urban and educated women (among whom it started) to rural and less educated women (Rosero-Bixby, 1986: 70-71).

Before the 1960s, provision of contraceptive advice and methods in the country appears to have been very much restricted to private physicians and their well-off clientele, mostly in the capital city (Gómez, Raabe & Bermúdez, 1971: 2). Dr. Arturo Cabezas, of protestant affiliation, seems to have been the first to introduce hormonal contraception amongst his private clientele. He recalled a visit, in 1957, by a manufacturer's representative from a Mexican company promoting pills made out of estrogen. At his request, the manufacturer's representative supplied him with a flask containing several thousand pills, which Dr. Cabezas put in little envelopes and offered to his clients (Carranza, 2003).

[1] I want to thank Rita Maxera and Luis Rosero-Bixby for their valuable comments.

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[3] This high rate of population growth was the product of a relatively low death rate and a high birth rate.

[4] Urban middle and upper class women were the ones who started the fertility decline and the ones who account for most of the decline in the fertility rate recorded up to the mid 1960s. From the mid 1960s onwards, rural and poor urban women became the main protagonists of the downward trend in the fertility rate (Rosero-Bixby, 1986:67).

Efforts designed to reach women outside private medical practices unfolded in almost parallel form in two different settings: the capital city and Turrialba, a small rural town 53 km from San José. Starting in 1962, the Evangelical Costa Rican Alliance (Alianza Evangélica Costarricense) organized the Good Will Caravans (Caravanas de Buena Voluntad) and started offering contraceptive advice and vasectomies, among other medical services, to distant rural areas (La Nación, 1964)[5]. A year later, in Turrialba, at the headquarters of the Inter-American Institute of Agricultural Sciences (Instituto Interamericano de Ciencias Agrícolas, hereafter referred to as the IICA), Henry Tschinkel, a forestry engineer and professor at the IICA, concerned about the negative effects of population growth on the environment, started a family planning movement which would have an impact, not just locally but also at a national level. Tschinkel introduced Turrialban doctors and women to the Zipper ring and also supplied the recently launched contraceptive pill (Anovlar). Doctors working for the Ministry of Health and social security health system at Turrialba became involved with the family planning movement and contraceptive advice and methods started to be provided at the local health dispensary and hospital (Carranza, forthcoming a). In 1966, the engineer Alberto González, an IICA student and one of the main activists in the family planning movement in Turrialba, together with medical doctors who had been offering contraception in the capital city, founded the Costa Rican Demographic Association (ADC). The ADC started to provide contraceptive services on a national scale. During the first year of operation, most contraceptives were provided through the private practices of doctors and nurses. However, some of the services were located in public health facilities, with the "acquiescence" of the government (Asociación Demográfica Costarricense, 1967:14). The ADC was responsible for transforming population growth and family planning into subjects that could be addressed publicly, creating the necessary conditions that would legitimize the legal provision of contraceptives in state institutions.

Although Costa Rica has never had a formal population policy, there was, from the late sixties onwards, a concerted effort on the part of government and private institutions aimed at providing the population with access to contraception and reducing population growth[6]. In 1967, the Office of Population was created at the Ministry of Health[7] and in 1968, the same year in which Pope Paul VI released the encyclical Humanae Vitae, and under the presidential mandate of José Joaquín Trejos Fernández, a conservative and catholic president, contraceptives started to be formally offered at the institution's health dispensaries. By 1970, practically all

[5] Also interviews conducted with Dr. Francisco Chavarría and Dr. Arturo Cabezas, 2009.
[6] Efforts to provide contraceptive advice and current methods to men have been sporadic.
[7] This office was created by Executive Decree No. 3 on April 7, 1967.

such dispensaries had incorporated the provision of contraceptives among their services (Carvajal, 1977: 123). In 1968, the Center for Social and Population Studies – CESPO (Centro de Estudios Sociales y de Población) was created at the University of Costa Rica with the aim of training health personnel in the provision of family planning. The Caja Costarricense de Seguro Social (CCSS), a socialized system of medicine created in the late forties and rapidly expanding its coverage at the time, incorporated family planning in its consultations in 1970[8]. Also in 1970, the Ministry of Education incorporated family planning as a component of Sex Education in the student curricula. There were also private organizations working on the subject: The Center for Family Orientation (Centro de Orientación Familiar), belonging to the Episcopal Church, and the Center for Family Integration (Centro de Integración Familiar), part of the Family Christian Movement. All these institutions participated in what would become known as the National Family Planning and Sex Education Program and were also members of the National Committee on Population (Comité Nacional de Población-CONAPO), an ad hoc committee created in 1968 with the aim of coordinating all family planning efforts (Carvajal, 1977: 117; Odio et al, 1973: 3). Contraceptives offered by the Ministry of Health and the CCSS were initially provided by the ADC, and were mostly donated by the International Planned Parenthood Federation (Reynolds & Herrera, 1972: 17-18). The United States Agency for International Development and the United Nations Fund for Population Activities were also important sources of financial assistance to the family planning activities (Rosero-Bixby, 1981; Colin, 1976:33-35). Nonetheless, at present, the CCSS finances family planning activities, including contraceptives, from its own budget.

The provision of contraceptives by the state was a primary factor in the propagation of contraceptive use. The percentage of the population served by state health institutions increased significantly in Costa Rica during the seventies and so did contraceptive use (Miranda, 1994: 124, table 6; Carvajal, 1977: 123, table 2). The first reproductive survey conducted in the metropolitan area in 1964 indicated that 50.5% of women aged 20-50, in a relationship, were practicing contraception. The methods most widely used included condoms, withdrawal and rhythm (Gómez, 1968: 70, 76, tables 63, 68). The first reproductive survey in rural areas was conducted in 1969. Although it showed that overall contraceptive prevalence was lower than that of the capital city five years earlier (22.1%), the proportion of users of modern contraceptives (mostly the pill) was higher than it had been in urban San José in 1964 (Gómez, Raabe and Bermúdez, 1971). By 1978, "modern" contraceptive use was predominant and evenly spread among women living in rural and urban areas, as

[8] CCSS, Directive Board, session 3999, August 8, 1969.

well as among those with diverse grades of formal schooling (Rosero-Bixby, 1979: 24, table 7).

In 1999, the year of the last reproductive survey, 92% of women between 15 and 49 years old (married or cohabiting) in Costa Rica reported having made use of modern contraceptive methods at some point in their lives, and 80% were, at the time of the survey, actively using them. The most widely used contraceptive methods were the contraceptive pill (26%), female sterilization (21%) and the condom (11%). Around 72% of modern contraceptive methods, especially among rural and less well-educated women, were provided by the state (Chen Mok et al, 2001: 45, 55, 60, tables 6, and 12). With regard to female sterilization, it is important to point out that 95% of these surgeries had been performed at state institutions, this in spite of the fact that until 1999, when Presidential Decree 27913-S finally authorized the practice of this surgery for contraceptive purposes, the use of sterilization was permitted only for "therapeutic" use. Only those women whose health could be put at risk by pregnancy or childbirth were supposed to have access to this surgery (Carranza, 2004).

As evidenced by the aforementioned indicators, access to contraceptives is widespread in Costa Rica. This has had an impact on the average size of the Costa Rican family, which nowadays comprises just two children; this is the second lowest fertility rate in Latin America (INEC & CCP, 2008; Population Reference Bureau, 2007)[9]. Nonetheless, there are serious concerns regarding the quality of contraceptive advice and the range of contraceptives offered. The last reproductive survey (1999) indicated that unplanned and mistimed pregnancies in the country stood at 41.4% (Chen Mok et al, 2001: 74, table 1). Although this is a complex issue attributable to diverse causes, the quality of contraceptive advice available to women has been frequently shown to be one of the contributing factors. Family planning consultations at the CCSS, nowadays the sole provider of public health services in the country, last only a few minutes and women are not assigned to a single doctor but get to consult with the doctor on duty. Doctors do not have time to properly advise their patients and there is no room for women to air their doubts; there is little familiarity between patient and doctor. In most cases, it is impossible for the woman to revisit the doctor if problems arise with the prescribed contraceptive (Carranza, 2003). There is also a significant difference between the variety of contraceptives available at drugstores and those offered by the state. By way of example, fourth generation pills are not available at the CCSS, nor is emergency contraception with levonorgestrel, whose provision is being debated at the Legislative Assembly (Carranza, forthcoming b).

[9] Data for 2008.

The female condom has only recently been made available, and only to workers in the sex industry.

There are also important concerns regarding access to contraception by specific groups of people, including adolescents. Although it is declining, pregnancy among adolescents is still considerably high in Costa Rica; the fertility rate among women 15-19 years old was 71 per thousand in 2008 (INEC & CCP, 2008). In spite of this, the CCSS does not have a clear policy for the provision of contraceptive services to them, the understanding being that contraceptive advice and methods should be restricted to adolescents aged 15 years and older. This is based on the provisions of the Family Law and the Penal Code according to which people older than 15 have full capacity to consent in sexual matters[10]. In practice, provision of contraceptives to adolescents is limited and varies significantly between health centers, often depending on the individual attitude of the professional in charge of providing the services.

Finally, it is interesting to point out the effects that a law, intended to grant children their right to a legal father, appears to have had on the fertility rate. The Responsible Paternity Law (Ley de Paternidad Responsable, # 8101), proclaimed in April 2001 and which ascribes legal paternity to the newborn on the basis of the information provided by its mother[11], has not just substantially diminished the number of children born without a declared father (from 31% in 2000 to just 8% in 2002), but also appears to have contributed to an unexpected reduction of about 10% in the number of births in 2002, in comparison with 2000 (INEC & CCP 2009). Ongoing studies appear to indicate that this huge fall in the number of births can only be explained by the aforementioned law. The certainty of acquiring legal responsibility and having to provide for engendered offspring has probably prompted many men to take contraceptive measures to avoid getting women pregnant[12].

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[10] Information provided by Dr. Marco Diaz, Coordinator of the Adolescents Program at the CCSS. The Costa Rican Family Code declares 15 years the minimum age for marriage (article 14). The Costa Rican Penal Code considers sexual relations with a person younger than 15 a crime, if taking advantage of age (article 159).

[11] The burden of proof remains with the declared father. It is up to him to prove with a DNA test (offered for free by the government) that the child is not his, instead of the woman having to prove it is.

[12] Information obtained from personal communication provided by Luis Rosero-Bixby.

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