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**FAMILY PLANNING AND  
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## PUERTO RICO

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## INTRODUCTION

Long before the modern world suddenly awakened to the so-called population explosion, many Puerto Ricans were aware of their country's population problem. Mortality rates were undergoing a remarkably rapid decline but because of the much slower decline in natality, the rate of population increase became a source of serious concern. The problem has attracted many brilliant minds, with approaches as varied as the interests and backgrounds they represent. As a health worker, I have viewed the population problem as a community health problem that arises out of our family care unit.

From this point of view, motivation looms as a most important element in a population control program. As Bernard Berelson of the Population Council said in March, 1965, at the seminar on demography at the School of Public Health of Puerto Rico, "People of high motivation can make any method work successfully." Nevertheless, it must be recognized that motivations are based on the cultural and religious convictions of the people involved, so that in establishing programs it is necessary to motivate through the institutions of the community.

At the same time, recognition by national leaders of the impact of population growth on the socioeconomic development of the nation, is a basic step toward solution of the population problem. The impetus for solution must come from national leaders, not from outside sources, and must be based on the prevailing culture, religion, resources, and psychology of the nation. The role of international agencies is to guide in the assessment of the problem and its proposed solutions, and when

the time is ripe and propitious, to help with funds, equipment, and technical advice. Administratively, a population control or family planning program should be an integral part of the health program of a nation, specifically an activity of a maternal and child health program. Design of the program should be consistent with the elements of human rights and dignity; and procedures should ensure for all individuals the access to and free selection of alternative methods for family limitation and spacing.

### THE SETTING

Only two decades ago Puerto Rico was among the most undeveloped countries of the world. Not only was it a land of hunger, indolence, and misery but, in the minds of many, a hopeless land. The scarcity of natural resources combined with an enormous population density was thought to be an irremediable malady. Several fortunate events, however, saved the island from disaster. We list the following as most important:

1. The New Deal Era, which affected favorably both the socioeconomic and the political aspects.
2. Improved education for all people.
3. Changes in the political structure, resulting from the above, which culminated in an honest and able public administration machinery.
4. Industrialization and economic development.
5. Health improvements.
6. Mass emigration of Puerto Ricans to the United States.

Thus, from a seemingly hopeless situation, a new Puerto Rico emerged. The socioeconomic progress has been amazing, not only for the achievements per se, but for the speed with which they occurred. During the last twenty years, per capita income and gross national product have increased more than 400%. Wages and salaries rose from \$125 million in 1940 to \$867 million in 1960. Industrialization received considerable impetus between 1940 and 1960; employment in manufacturing increased from 26,000 to 93,000; and income derived from this source increased almost 1,000%. Investment in Puerto Rico, which was \$29 million in 1939-40, was \$392 million in 1959-60 (a 1,252% increase).

Education, too, received unusual attention. The number of employed teachers rose from 6,000 in 1949 to 14,000 in 1958. School enrollment increased from 304,000 pupils to 679,000 during the same period. The relative increment has been greater at college level. Enrollment at the University of Puerto Rico, for example, increased

236% during this twenty-year period. As a result of these developments illiteracy declined from 32% in 1940 to 17% in 1960.

In the realm of public health, the utilization of modern health practices, including insecticides and antibiotics, together with economic improvement and other factors, has produced in the island one of the lowest mortality rates in the world. Malaria was completely eradicated in 1955, and tuberculosis, although still high compared with the United States, has been reduced by 90% since 1940. Similar declines have been observed in other infectious diseases, for example, in pneumonia, diarrhea, and enteritis. Infant and maternal mortality rates have been reduced by more than 60% during the past decades. Mortality among children 1-4 years of age in 1960 was only one-tenth of the figure recorded in 1940. Life expectancy at birth, which increased from 30 to 46 years during the first forty years of the present century, was almost 70 years in 1960.

Meanwhile, the crude birth rate declined from 40 in 1950 to 32 in 1960, which represents a marked deviation from the slowly declining trend observed during the first half of the century. The rate of population growth recorded during the decade 1950-60 was only 0.6% per year, as compared with almost 2% observed during the two preceding decades. The 0.6% population increase observed during the last decade constitutes a record (the lowest) for all the censal history of Puerto Rico (1765-1960) and was one of the lowest among all the countries of the world.

This succinctly describes Puerto Rico, an island whose only natural resources are its climate and a population with a true desire of improving their life conditions.<sup>1</sup>

#### HISTORICAL BACKGROUND OF FAMILY PLANNING

The problem of population growth was brought into the open in 1925 when Dr. Lanauze, a physician, organized the Birth Control League in Ponce. This institution soon disappeared as a result of the controversy aroused and nothing else was heard concerning the problem until 1932, when another birth control league appeared in San Juan. After a couple of years the clinic under its sponsorship ceased to exist because of the scarcity of its clientele. Zalduondo states, "The pressure of the church and the apathy of the people put a quick ending to the efforts of the league."<sup>2</sup>

<sup>1</sup> José Nine Curt, *Health in Puerto Rico* (3d ed., 1964); Antonio Samuel Medina, *Maternal and Child Health Care in Puerto Rico* (1964).

<sup>2</sup> Celestina Zalduondo, Presentation, Second Seminar on Family Planning at New York, 1963.

The great economic depression in the United States in the mid-thirties gave rise to several relief programs. In 1934-35 the Puerto Rico Emergency Relief Administration (PRERA), one of the federal relief agencies, decided to establish a series of maternal health clinics as part of a program of medical services. These were extended throughout the island after a successful trial with a pilot clinic at the hospital of the School of Tropical Medicine. Social workers referred individuals to the clinics from among the hundreds of thousands of individuals who applied to the relief stations, and community workers scouted people in their areas who might be interested in the services.

In 1963 these programs were discontinued in the United States on the grounds of a boost in the American economy. However, since our economy remained practically at the same low level, the United States Congress passed special legislation establishing an agency to care for the island's rehabilitation (Puerto Rico Reconstruction Administration). Efforts by this new agency to re-establish the clinics of its predecessor did not materialize, but in this same year (1936) the maternal health clinics under the direction of Dr. Belaval were reactivated under private sponsorship.

In 1937 Puerto Rico passed a law legalizing sterilization for socioeconomic as well as medical reasons and directed the Health Department to offer family planning services. At that time available methods were not generally acceptable; so sterilization was preferred. "It was widely used among the high-parity women, which had very little effect on the birth rate—but it was also abused extensively among very young women waiting in the outpatient dispensaries. Especially in the young women of low parity this resulted in much frustration and the development of guilt complexes with frequent psychosomatic disorders."<sup>8</sup> The Health Department continued to offer family planning services at the maternal health clinics but no major effort was made to launch an educational campaign. As a consequence the clientele of these health clinics dropped considerably.

In 1946 the Association of Population Studies was started as a voluntary agency. It evolved from a study and research unit into "an agency which offered direct contraceptive services to the families," changing its name to the Family Planning Association of Puerto Rico in the late fifties. Its main activities were (1) education about family planning and population growth; (2) direct services to families, including distribution of contraceptives, aid for sterilization (financial), and fertility services; and (3) research. The Association received initial

<sup>8</sup> Adaline P. Satterthwaite, "The Role of Ante-partum and Post-partum Education in Maternal Health," 1964.

financial support from the Planned Parenthood Association of America, because funds could not be obtained in the island. Since then, support has been through private sources in the United States.

In 1959 the voluntary Family Planning Association of Puerto Rico (formerly the Association of Population Studies) started a unique campaign utilizing lay voluntary leaders to distribute a vaginal contraceptive cream on an island-wide basis. Because of lack of financial support the agency was recently forced to reduce their services. In 1962, Mrs. Zalduondo, the executive director of the Family Planning Unit, gave the following as some of the greatest handicaps to their program: (1) indifferent attitude of the government; (2) hostile attitude of the church; (3) the Catholic indoctrination of physicians and other personnel against contraceptive services; (4) indifferent attitude of the press; (5) hypocrisy of civic leaders who themselves use contraceptive services but deny them to the poor; (6) ignorance of the public; and (7) lack of financial support.<sup>4</sup>

#### THE PRESENT APPROACH

The general framework of the family planning program rests on the proposition that in a pluralistic democracy with different groups of different beliefs and religious convictions, it is up to individuals to decide what they want for themselves and their families. Therefore all methods and procedures are to be offered and health workers must not impose their personal bias. We place strong emphasis on human dignity and individual rights in dealing with people.<sup>5</sup>

We see four major components in our approach to the problem. The first component is professional education within the program. We expect to teach Puerto Ricans and others the nature of the population problem, going into some detail about demography and population theories, and the social and economic factors affecting population dynamics. This formal education may vary from short one-day or one-week seminars to short courses of approximately one month to detailed formal instruction involving one or two semesters. Classroom teaching of a medical nature is provided by various departments within the medical school. Public health implications are discussed in the course on maternal and child health at the School of Public Health.

The second component of this program is the clinical service. These services are provided by the Department of Health supported by regular funds from the Maternal and Child Health Program. In the Northeast Region these clinics are an integral part of the regular post-partum

<sup>4</sup> *Ibid.*

<sup>5</sup> Nine Curt, *op. cit.*

clinic. Cases are drawn from existing prenatal and postnatal clinics. We offer a "full selection service" including the rhythm method, chemicals, the IUD or coil, and other available contraceptive agents. Conscientious efforts are being made to provide adequate instruction in the use of the rhythm method if the patient desires to use it. Each patient is given a list of methods for her own free choice. In this way we avoid meddling in religious convictions.

The third component of this program concerns education of the public, a responsibility we feel is a proper function of the different society groups. For example, the Family Planning Association should dedicate its effort to educate and orient people to request services, according to our social and cultural patterns. Education should proceed at the same pace as the development of clinical services, lest we fall into an imbalance between services and demand. Also, we have to consider the contribution of the Catholic church. We feel that in the confessional and in the pulpit as well as in informal conversations, the priest can offer information pertaining to responsible parenthood and improvement of health and can orient people to avail themselves of services and select methods according to their conscience.

The fourth component concerns research and evaluation. Research activities are varied and include effectiveness of the different methods. Another area of interest is the relationship between program activities and the stillbirth rate. We believe that the research and evaluation aspects of the program require a high level of competence and should be handled by professional personnel. It is the impression of many of my colleagues that much of the work that was done previously was well intentioned but lacked scientific validity. Our program requires constant evaluation so that it can be directed accordingly.

Furthermore, we may want to measure the effectiveness of services on the basis of the clinical trial model; for example, two similar villages having different programs of services or utilizing different educational techniques can be compared in relation to the impact of these variables on their fertility pattern.

#### PRESENT PROGRAM ACTIVITIES

Our program, operated by the School of Public Health, School of Medicine, and the Northeast Region of the Department of Health, covers the Northeast Region of Puerto Rico, an area of over 900,000 persons. Almost all the communities in this area have service activities. We do not give contraceptive information as such, but the Family Planning Association, a voluntary group, offers materials and services outside our program.

To integrate all four aspects of the program we have a co-ordinator who is directly responsible to the director of the School of Public Health. At the present time, we are utilizing physicians and nurses who are trained in our School of Medicine (at the University Hospital and the Nursemidwifery School). At the Nursemidwifery School, the problems and alternate solutions are an integral part of the program. The post-partum clinics are the main target of the program. As far as the rhythm clinics are concerned, these are being developed by Catholic physicians who are well versed in the method. We are also utilizing lay couples trained to use the method, who move from town to town forming groups for the exchange of information and follow-up. The services are free and are offered to all interested persons regardless of creed, race, or socioeconomic status. As already mentioned, we expect that the information will be disseminated through the community by different voluntary agencies or church groups. At the present time we are not using any mass media method to expand our program.

This paper has presented our efforts in Puerto Rico to develop a program to cope with the population problem. We recognize that each nation must decide for itself whether it has such a problem; we also respect the right of the individual to use or not use the services offered, and to have the freedom to choose that method which she finds appropriate.



