

The family planning context in Uruguay

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In the global context, Uruguay finds itself within a group of countries that are pioneering the demographic transition process, being the first to start this process in Latin America. There is evidence of a reduction in mortality as early as the 1880s, which leads us to suppose that its beginnings may have been situated in a somewhat earlier period. And few years later, we can identify the beginnings of the decline in birth rates going back to the end of the 19th century, particularly in Montevideo.

In 1963, the overall fertility rate was around 3 children per woman. This situation demonstrates at least two things: Firstly, that the country was at the margin of concerns generated internationally on account of the demographic explosion in Latin America in the 1960s and 1970s. For its part, the most important aspect of the reduction in fertility was achieved in the private arena, before modern contraceptive methods even existed. It was the families (it is not fair just to say it was the women) that came up with strategies or took direct action to reduce the total numbers of children.

Around 1900, infant mortality in Uruguay was a little lower than 100 per thousand births. Along with Norway and Sweden, it shared the privilege of being one of the countries with the lowest infant mortality in the world (Birn, Cabella, and Pollero 2005). The effect that this had on families was one of higher rates of child survival; in fact, between 1889 and 1908, the proportion of children in the average household size in Montevideo rose by 19% (Pollero 2001). The decline in mortality reduced the number of births needed to satisfy family and society's reproduction requirements, and consequently, limiting responses were generated for reproduction and birth.²

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² Evidence exists that the belated age of getting married and celibacy could have operated as a means to control the population at the beginning of the demographic transition process. The contribution of childless women was also significant: practically 25% of those born at the turn of the 19th century (more than half were married) were born out of wedlock, a proportion that declined with those born in the 1920s (Pellegrino and Pollero 2001).

We might ask ourselves, therefore, who were the first people to realize this fact and denounce it? Primarily those who had a certain first-hand access to the evidence: the Church and obstetric doctors (Barrán 2008). Somehow, through the confessions of the faithful, the Church succeeded in acquiring a privileged window on to the secrets and most intimate world of couples. Indeed, in the confession manuals, very direct questions could be found that allowed them to look for the contraceptive “sin” of coitus interruptus. In 1890, the Bishop of Montevideo already uttered a warning about this.³

Gynecologists for their part discovered the most extreme measure to deal with a conception that was already consummated: The increase in the number of abortions. More precisely, given the illegal nature of this practice, abortions subsequently due to complications needed medical intervention, which also implies its total growth⁴. The extent of this practice suggests that there would have been no ethical questioning by a significant number of women (and men). Surely a multiplicity of factors affected this, amongst which the early secularization of Uruguayan society is prominent.⁵ For their part, the explanatory arguments of the doctors of that period included a general lack of knowledge about embryonic life. Nevertheless, it is also possible to imagine that societies so rooted and accustomed to living with premature death (the death of the tiny angels) took away from them the importance of terminating a pregnancy at an early stage.

In a more indirect manner, from the knowledge about the statistical data that revealed the degree of the decline in birth rates, the ruling political class of the various parties also gave notice of the practice of abortion. The 1908 census had resulted in a bitter pill for Uruguayans: it demonstrated that the growth in the population was lower than expected. This fact implied that during the seething final years of the preceding century and start of the 20th century – the last civil war took place in 1904 – the country had ceased to be (momentarily, at least) an interesting destination for European migration. Added to this was the decline in birth rates that came to be likened to the French phenomenon. From a political standpoint, this was regarded as a weakening of the country when compared with the impressive demographic growth experienced by its giant neighbors, Argentina and Brazil.

In 1912, the Republic’s president, José Batlle and Ordoñez, author of the earlier state of Uruguayan well-being, presenting a political argument defending maternity

³ “(...) pity the men who (...) spill forth far and wide (...) at the whim of passion, the mysterious force whose divine origin is found within them (...) pity the mothers who (...) abandon afar (...) these creatures towards nought” Soler, M. 1890. Marriage under religious, moral and social aspects. Tip. Uruguay by M. Martínez. In: Barrán 2008: 214.

⁴ In 1916, the First National Medical Congress declared the problem of voluntary abortion (“intended criminal abortion”) as a serious social peril and called on the Public Authorities to suppress it (Turenne 1917).

⁵ In Uruguay, the separation of Church and State dates from 1919. The first divorce law was passed in 1907.

for single mothers and illegitimate children, said: "After all, we should obtain an outcome that is favorable to nationality, in other words, to a vegetative increase in the national population, a matter of utmost importance in a country such as ours, that is so deficient in terms of population".⁶ Consequently, having established the existence of a decline in birth rates and weak population growth, a concern materialized in the State over the country's vulnerability. To a certain degree, the concern was similar to that France had over the size of Germany (Barrán, 2008).

Nevertheless, this did not result in the creation of specific birth-related policies. If, on the part of the State, there had been an initial concern over mother-child health, the progress made in the country in terms of the protection of infants and mothers, particularly poor, working-class mothers, translated into a greater social concern, characteristic of the welfare matrix of Batllist thinking.

In the 1930s, the growth in abortion in society, and essentially the unsafe conditions under which they were conducted, continued to be heavily criticized by the medical sectors. From the chair of obstetrics at the Faculty of Medicine, the publication was recommended of contraceptive practices to avoid conceiving and thus prevent the need to resort to termination⁷. This concern for women's health resulted in the decriminalization of abortion in the 1934 Penal Code. The measure was short-lived however. The reaction of the conservatives and the catholic sectors was not expected: four years later, after a tough debate, its criminal nature was re-imposed. The newly implemented prohibition did not eliminate the problem. On the contrary, terminations of pregnancies became more common, to the extent that, around 1942, it was estimated that 50% of pregnancies were ending in abortion (Turenne, 1942).

In parallel, since the end of the 1920s, on the international agenda, commitments which the country had signed up for were advocated to give impetus to the implementation of minimum salaries, a wages board and family subsidies in the social security systems.⁸

In 1934, under the framework of the Pan-American organization, and under the stimulus of successive children's congresses, the Children's Code was passed – the first of its kind in Latin America – in order to watch over their right to health, well-being and legal protection. It also created programs to help mothers and children and established the right of the working mother to receive half-salary when on maternity leave.

⁶ Diary of Senate Sessions, volume 101, session of June 19, 1912: 541. Address by José Espalter. In Barrán (2008: 196).

⁷ In 1929, Augusto Turenne, professor of gynecology and obstetrics, spread the concept of conscious motherhood, although only valid for poor, multiparous women (Turenne 1929).

⁸ Amongst these were ILO Agreement no. 26 (Geneva, 1928), the Panamerican Conference in Lima (1928), the 2nd American Congress on Eugenics (Buenos Aires, 1934), ILO Conference (New York, 1941), Atlantic Charter (1941) and Work Conferences (Cardozo, R. and Foladori, W. 1970. Family Allowance System in Uruguay. In: Varela (2004).

In 1943, after much delay and following several legislative initiatives, the Family Allowance Law was voted in, which addressed various aspects of social security for workers and covered practically all the formal workforce in the country. Besides the family subsidy, a system of mother-child healthcare was included in sanatoriums acquired for this purpose.

The motivations brandished in the Social Legislation Committee for the approval of the law are evidence that there was still concern over the decline in birth rates and the increasingly low vegetative growth: "(...) we will get to a point where children will no longer be born and where the country enters rapidly into a process of disintegration"⁹. These concerns were very different from those of the rest of the Latin American countries during this period. Thereafter, the State languished in lethargy for half a century in terms of population policies. With the passage of time, the family subsidy allowances got smaller and smaller.¹⁰

In the meantime, the appearance of modern contraceptives in the market helped to reduce (though it did not eliminate) the number of abortions. Towards the end of the 1960s, a first family planning related program began to be developed, the Uruguayan Association for Family Planning and Human Reproduction (AUPFIRH, later AUPF), a private organization with an anti-natalist profile (funded by the IPPF). In an agreement with the Ministry of Public Health, it provided advice and contraceptives with a range of tariffs to public and private health users. It would seem that for 30 years, the Uruguayan State determined that, based on the agreement with this institution, the topic of the population's reproductive health was resolved, since the topic was absent from the country's political agenda (Varela, 2004).

Once again it was international commitments that brought fresh action to bear. Indeed, after the Population Conference in Cairo, the country began to implement sexual and reproductive healthcare programs from a gender and rights perspective. Added to this was a new demographic situation, an increase in teen fertility, which rose 21% between 1985 and 1996¹¹. Accordingly, in 1996 two programs were implemented, one within the domain of the Ministry Of Health and the other via the Montevideo Municipal Council, initially funded by the UN Population Fund with the State making a commitment to continue the program and take over the funding. The target public of the Ministry of Public Health's program ("Selective Maternity and Paternity") was women of childbearing age, both in Montevideo

⁹ Cardozo, R. and Foladori, W. 1970:131. In: Varela (2004: 404).

¹⁰ Since 2008, a new Family Allowance law has been in force via which a greater coverage of minors in socioeconomically vulnerable conditions was achieved. In order to benefit from the system, it is required to comply with certain educational and health prerequisites.

¹¹ From 1998, teen fertility has shown a decreasing trend and since 2004 the overall fertility rate has fallen to values below the population replacement level (Varela, Pollero and Fostik 2008).

and the country's interior. In this program, the welfare nature and the provision of contraceptives were put first. This program ended in 2000 and was followed up by the creation of the "Woman - Childhood" area and the Women's Comprehensive Health Program, thereby constituting a policy definition in sexual and reproductive health (Varela, 2004). The target population of the Montevideo Municipal Council program is needy women in Montevideo, from adolescence upwards. Its conceptual axis is not welfarist, but rather it encourages a change in the sexual and reproductive healthcare model, focusing on gender. It consists of three subprograms: "Informed and voluntary motherhood," "Comprehensive care in pregnancy and childbirth," and "Prevention of breast cancer" (Varela, 2004).

During the execution of these programs, the Ministry of Public Health drafted the national Childhood, Adolescence and Reproductive Health Plan (2000-2003). Subsequently in 2002, a third program was added (INFAMILIA "Adolescence, Infancy and Family at risk"), subordinate to the Presidency of the Republic with financial backing from the Interamerican Development Bank. One of its missions is the prevention and comprehensive care of the pregnant teen. Amongst its activities, it has provided, along with the Ministry of Public Health, training in sexual and reproductive health to health professionals (López and Abracinska, 2009).

In parallel, can be added to this the organized women's movements and in particular the female bloc (in all the political parties) of the Legislative Branch, who have established their own agenda with regard to promoting laws and measures that will lead institutions to implement sexual and reproductive health programs for both women and men (Varela, 2004).

One of the most important projects driven by this parliamentary bloc is that of the protection of the right to sexual and reproductive health which, amongst its provisions, stipulates the right of women to voluntary termination of a pregnancy during the first 12 weeks. The project achieved the preliminary approval of parliament in 2002. It was presented once again in 2006 by two female officialism senators and was passed by the Senate in 2008. However, it was vetoed by the President of the Republic, Tabaré Vázquez, a member of the medical profession, on legal, scientific and technical grounds, as well as philosophical identity and ethical principles. The law ultimately proclaimed by the Executive Branch modified the project's propositions, keeping only the first and last chapters, constituting more of a declaration (the duties of the State and the rights of children in respect of sexual and reproductive health). Accordingly, the decriminalization of abortion cannot be presented again until the next Legislature.

To sum up, the fact that Uruguayan demographic history during the twentieth century demonstrates similar behavior to the more advanced countries, has

probably affected the scant attention to the population issue from political players and the State. Recently, as a result of the Cairo Conference, and in view of the wake-up call that is the increase in teen fertility, the Ministry of Public Health has begun to orchestrate and implement, through its services, a variety of sexual and reproductive health benefits.

One hundred years after the first census of the twentieth century which led to the voicing of concerns over the meager demographic growth, Uruguay finds itself with a fertility that is below replacement level, in a situation of emigration and with an ageing population – in keeping with its precocious demographic transition. Just as then, voices of concern are once again being heard from several quarters.

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