

Family planning in Venezuela

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Venezuela entered the second half of the 20th century recording historic levels in the rate of growth, at around 4%, as a consequence of high fertility and moderate, though declining, mortality. By the beginning of the 1960s, fertility was well into the transition process, and Venezuelan women around 40 years old had, on average, 4 fewer children, going by the total fertility rate of 2.6 children per woman estimated at the beginning of the current decade. These changes came about in the midst of an intense urbanization that has led to a situation in which 9 out of every 10 Venezuelans live in urban areas. The precursors of fertility transition are, precisely, the residents of urban areas and those who had reached higher levels of education. Subsequently, somewhat belatedly, rural women and less educated women were brought into the process to the extent that, nowadays, it may be said that all segments of the population have now entered transition (Freitez, 2003).

These changes have been helped by the transformation of the role of Venezuelan women, both inside and outside the home, associated with their increasing access to education, the labor market, social organizations and political activity. In this country, as will be seen shortly, governments have not openly intervened in promoting family planning, nor in imposing limits beyond maintaining the administration of the provision of services.

The forerunners of family planning in Venezuela have, in common with other countries in Latin America, the role played by certain associations or groups of doctors, both in the emergence of the program and in its integration into the national health system. However, they differ in terms of the importance that this subject has had on the agenda of the various governments and in the participation of the private sector in the provision of these services.

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The first family planning initiative by the public sector goes back to 1963, when Dr. R. Domínguez promoted the creation of a service in this area in the “Concepción Palacios” Maternity Hospital, the most important of its kind in the country at the time. Subsequently, in 1965, the Ministry of Health and Social Welfare (MSAS) created a Population Division responsible for steering family planning activities. In 1966, the Venezuelan Family Planning Association (AVPF) was formed with the mission of helping to reinforce and protect families, and with the concept of family planning as the tool to achieve this aim (Bidegain and Díaz, 1988). The family planning program was established, therefore, with the purpose of reducing uncontrolled, involuntary procreation, maternal and infant mortality and induced abortion and this, through the use of contraceptive methods devoted to preventing unwanted pregnancies (Pereira and Freitez, 1994).

At the end of the 1960s and beginning of the 1970s, the activities developed by the AVPF sparked some controversy, especially in some sections of the Venezuelan Medical Federation (FVM), which warned of the risks being run by allowing some of the programs to be freely influenced by foreign agencies indiscriminately offering contraceptive methods. By means of a resolution of the FMV General Assembly, this led to doctors being prohibited from working in family planning clinics as long as these clinics were not controlled by the State (Bidegain and Díaz, 1988).

Up to 1974, “World Population Year”, a large part of family planning activity was undertaken in 132 AVPF affiliated clinics. The Venezuelan government, via presidential decree, then decided to take control of activities in this matter. Hence the creation of the Department of Guidance, Education and Family Planning at the very heart of the Maternal and Infant Division of the MSAS, as well as the Family Planning Program Coordination Workshop, to which the 132 AVPF clinics are attached. By transferring the program from the private sector to the public sector, the AVPF found itself practically devoid of its objectives of direct healthcare and the funds necessary for its operation, until it finally disappeared in 1976.²

The subject of family planning has not figured amongst the main concerns of the various governments, not even at times when high fertility rates were being recorded. During the first mandate of President C. A. Pérez (1974-1978), family planning was introduced into the MSAS prevention programs, mandatorily broadening all the service modules and rural medical centers. With this provision, the intention was not to check population growth; quite the contrary, in President Pérez’s administration,

² Since the AVPF ceased to function in 1976, no other private family planning institution emerged until 1986, when PLAFAM was founded, a government organization created with the financial backing of the International Planned Parenthood Federation (IPPF) (Bidegain, and Díaz 1988).

it was perceived that Venezuela had abundant oil wealth that would allow it to face demographic expansion.

The Christian Democrat government (1979-1983), presided over by L. Herrera-Campins, made no official proclamation on the matter, but under his administration, control over the family planning program moved to the Public Health Department and to the Health Commissioners in the respective States (1980). This measure did not help to broaden its activities since the decisions to support the program depend on the priorities established at the level of each state. On the contrary, the other preventive health programs often benefited from a portion of the funds that were previously assigned to family planning. A new Social Democrat government (1984-1988), presided over by J. Lusinchi, redirected the family planning program, transferring it to the Maternal and Infant Health Department, which seems more appropriate though it must continue to share funding, personnel and budget with other priority health programs, such as: Pre- and post-natal care, breastfeeding and pediatric services (Pereira and Freitez, 1994; Bidegain and Díaz, 1988).

In the course of the 1989-93 presidency, which began with the second mandate of C. A. Pérez and ended with a transition government, no official declaration was pronounced on matters concerning family planning. The program remained assigned to the Maternal and Infant Health Department, but the operational problems became more severe by virtue of the worsening institutional and financial crisis in the health sector³. Throughout the second mandate of Rafael Caldera (1994-1998), the family planning program went ahead without the necessary political backing, so that the problems remained of lack of administrative coordination, poor quality of service, deterioration in facilities and serious deficiencies in the availability of contraceptives, notwithstanding the fact that they were allocated funding to purchase them and distribute them amongst the low-earning population (Venezuela NGOs, 1994). The few references available concerning the coverage of this program show that the proportion of women cared for has fluctuated between 8% and 14% of all women of childbearing age during the period from 1980 to 1995 (UNICEF, 1995).

The limitations that were experienced by the family planning program were noted in the EVA-84 assessment report, in which a summary was provided of the administration carried out between 1974 and 1984, which at the time enabled the identification of errors experienced and the production of a series of recommendations to improve the operation of the program in topics related to: the shortage of human resources, the lack of allocation of materials (contraceptives,

³ This period was characterized by a significant deterioration in the economic situation and profound political and social unrest, which led to the dismissal of President C. A. Pérez.

medical teams, sterilized materials, etc.); the lack of publicity, the latter being basically limited to interviews or chats conducted within the service environment, it was very rare to see work taking place in the communities and the spreading of the message via radio and television providing information on the type of services available was nonexistent; deficiency in record keeping, amongst other aspects.

In Venezuela, the first fertility survey on a national scale took place in 1977, under the framework of the World Fertility Survey project. According to the ENF'77, 60% of women in a relationship used some form of contraception, there still being an appreciable prevalence in the use of traditional methods (14%). More than two decades elapsed before there was another survey similar to that of the ENF'77. In 1998 the National Population and Family Survey (ENPOFAM'98) demonstrated that the percentage of use of contraceptives had risen to 70% helped by the increase in the use of modern methods (from 46% to 62%). The provision of modern methods in Venezuela in the middle of the 1970s was mainly centered on the pill and the IUD. These two methods accounted for almost half the total prevalence recorded at the time of the ENF'77 (29%). At the time of the ENPOFAM'98, the percentage of women in union using the pill rose to 21%, but the most important feature has been the marked growth in female sterilization, whose percentage usage has trebled, moving from 9% to 26% (Freitez, 2001).

The ENPOFAM'98 results concerning the participation of public sector health services as a source of supply for the method being used, namely 17% of women exposed to a risk of conceiving (MSAS, 1984), concurs with the previous reference on the low coverage of the family planning program.

With the Caldera government (1994-1998) coming to an end, a review was undertaken of the Maternal Care and Family Planning Standards in force since 1972 and, welcoming the new approaches on genetic health and reproductive rights, promoted in international conferences such as that of Cairo (1994) and Beijing (1995), a new set of standards was approved based on a comprehensive reproductive healthcare approach. Under this framework, family planning is considered to be one element of reproductive health and is included as a strategy that the services in this area may integrate into those of pre- and post-natal maternal care (MSAS, 1998). The objective assigned to family planning was as follows:

“ to guarantee to the entire population access to information, communication, education and services of high quality (...) within the comprehensive framework of reproductive health...”. The approach of the family planning program is directed towards the country's entire population, no matter what the social status, being able to freely and responsibly decide the number of children they wish to have, the spacing of the births and to have available the information and means to achieve this...” (MSAS, 1998:55).

Subsequent to the adoption of this comprehensive reproductive healthcare approach came the administration of President Chávez, who ordained the merger of the Ministry of Health and the Ministry for Family in order to create the Ministry of Health and Social Development. Moreover, in 1999, a new constitutional text was passed that enshrined the right of couples to freely and responsibly decide the number of sons and daughters they wished to conceive, and to have access to information and to the means that assure this right may be exercised. In this sense, the State's responsibility was established as guaranteeing comprehensive care and protection for mothers and the supply of family planning services (Bolivarian Republic of Venezuela (RBV), 2000).

In the light of this context of standardization, new, updated documents were drafted for the Official Standards for Comprehensive Sexual and Reproductive Healthcare (Ministry of Health and Social Development, 2003). These transformations in the legal and institutional map pointed to the recognition of the full exercise of sexual and reproductive rights as human rights and their entailment with quality of life and health as well as with human and social development.

In the framework of the current health policy, the National Sexual and Reproductive Health Program (PNSSR) was developed at the national, state and municipal level, under the responsibility of the Ministry of Labor for Health and Social Protection. This Program is the tool that institutionalizes the National Sexual and Reproductive Health Policy, mainstreaming the approaches to gender and sexual and reproductive rights in the management of health services (Ministry of Health and Social Development 2003). With the implementation of the PNSSR, advances have been made in the mapping of norms and the training of health teams in the management of the approved norms in order to improve comprehensive sexual and reproductive healthcare. Efforts have also been made with community training in reproductive rights.

An important measure which reflects the advances made with the mapping of standards has been the inclusion of emergency contraception in the Official Standard for Comprehensive Sexual and Reproductive Healthcare and in the Strategic Guidelines for Comprehensive Prevention in Sexual and Reproductive Health in Emergency Situations, being recommended for cases of rape, unprotected sexual intercourse and interrupted oral cycles.

In Venezuela, demographic surveys are not conducted with sufficient frequency to be able to track the operation of the various programs included in the PNSSR, whose statistical data are also not sufficiently widely known for the purposes of periodically establishing achievements. A fresh assessment of the SSR services and in particular the logistics of contraceptive supply was carried out by the MSDS with

the support of the UNFPA in 2002. This work revealed, amongst other aspects, that there continues to be a low recording of family planning information, that services are concentrated on women, that the choice of method is made by health staff and that the needs of the users are rarely recognized, and the supply of contraceptives bears little relationship to MSDS demand (2003). It has been attempted to deal with these problems via the design and implementation of a Contraceptive Inputs Logistics System (SILOGIA).

Social acceptance of contraception in Venezuela has been quite broad, to the extent that restrictions on access to methods are basically down to the availability of information and the financial means to obtain them. This means that the problems of accessibility are mainly concentrated on the most disenfranchised population groups, on which the PNSSR should be focusing, seeking to reduce the costs of access, especially at times of decline in household economies.

References

- Bidegain, G. and Diaz, G. (1988) *La planificación familiar en Venezuela*, Caracas: PLAFAM.
- Freitez, A. (2001) Venezuela. *Encuesta Nacional de Población y Familia. (ENPOFAM'98)*. Caracas: Fondo de Población de las Naciones Unidas (FNUAP).
- _____ (2003) "La situación demográfica de Venezuela a inicios del tercer milenio", Caracas: IIES – UCAB, *Temas de Coyuntura*, 47: 45-92.
- Pereira, A. and Freitez, A. (1994) Venezuela: *Informe Nacional sobre Población y Desarrollo 1994*, document prepared for the *Conferencia Internacional sobre Población y Desarrollo 1994*, (unpublished).
- Ministerio de Salud y Desarrollo Social (2003) *Norma Oficial para la Atención Integral en Salud Sexual y Reproductiva*, Caracas: 3 Tomos.
- MSAS (1984) *Evaluación del Programa de Planificación Familiar*, Caracas.
- _____ (1998), *Norma Oficial para la Atención Integral en Salud Reproductiva*, Venezuela.
- ONG's de Venezuela (1994) *Venezuela: País rico con una población pobre*, document prepared for the *Conferencia Internacional de Población y Desarrollo 1994*.
- República Bolivariana de Venezuela (RBV) (2000) *Constitución de la República Bolivariana de Venezuela*, 24 de marzo de 2000, Caracas: Edic. La Piedra.
- UNICEF (1995) *Análisis de situación de la infancia, la juventud y la mujer en Venezuela*, Caracas: Unicef-Venezuela, Oficina para Colombia y Venezuela.

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