EXEMPLARY FAMILY PLANNING LAWS ☐

Our population laws are models to the world

EVEN though legal developments have not kept pace with scientific and technological changes in the field of population and fertility control, interest in revising existing laws or writing new ones is on the increase throughout the world. Countries that are seeking to bring their laws in line with improved policies and practices can look for guidance to examples from other nations. The following selected excerpts from laws related to general population policy, contraceptive methods, voluntary sterilization, abortion, and economic incentives and disincentives are such examples.

POPULATION POLICY.

IN the development of laws concerned with population policy, consideration is usually given to elements such as the establishment of a group or agency to initiate and implement policy recommendations; the makeup, number, purposes, and functions of such a group; and the purposes or reasons for a population policy in relation to the needs and requirements of the country.

Section 86 of Thailand's Constitution focuses on the reasons for developing a population policy. It includes the following provision:

"The State should have a demographic policy appropriate for natural resources, economic and social conditions and technological progress for the purpose of economic and social development and for the security of the state."

In October 1974, the government of El Salvador approved a plan of action for its newly created National Population Commission to oversee. It reads, in part:

". . . the Comprehensive Policy on population should be considered as a series of actions determined and coordinated by the State which have as their objective the full development of the human person as well as the greater participation by each person in the responsibilities and benefits of progress, through the harmonious accommodation of the quality, distribution and size of the population to the country's resources in its economic and social development."

CONTRACEPTIVE METHODS.

THE existing body of laws affecting contraceptive methods is wide-ranging and differs by country due to varying local needs and considerations. In drafting new laws on contraception interested nations might include consideration of one or more of the following areas: contraceptive sales and distribution, regulations governing advertising, taxation of imported raw or finished materials, manufacture of contraceptives, prescription requirements, training of medical and nonmedical personnel involved in a variety of family planning programs and services, and regulations for the establishment of urban and rural clinics. The preceding listing is not all-inclusive, however; each country must consider first its own requirements and develop laws best suited to them. The following are selected excerpts from laws currently in force.

Chile's 1974 law on the use of nonphysicians to distribute oral contraceptives and to insert intrauterine devices reads, in part:

". . . The National Health Service estimates that it must prepare for a growing demand for family planning services from women of child-bearing age. This cannot be accomplished if the administration of contraceptives is limited to surgeons and physicians.

. . . The Public Institution of the National Health System may authorize midwives to prescribe and administer some or all of the reversible contraceptive methods now in use.

. . . The prescription and administration of contraceptives by professional midwives shall be under the control and supervision of the physician responsible for family planning activities in the institution or service concerned."

A Presidential decree in 1973 amended an existing law in the Philippines regarding women in the labor force and making contraceptive services available to them. It reads, in part.

"This Decree (No. 148) amends Republic Act No. 679, notably by prescribing that establishments required by law to maintain a clinic or infirmary must provide free family planning 'services to their employees including (but not limited to) the application or use of contraceptive and/or intrauterine devices" (26).

VOLUNTARY STERILIZATION.

MANY countries have no laws regulating sterilization; therefore, family planning programs are legally free to introduce this method. Other countries have recently provided legislation supporting surgical contraception. These laws deal with such factors as: reasons for allowing sterilization, age requirements, personnel qualified to perform sterilization, provisions for and regulations governing facilities where sterilizations may be performed, and consent required.

The following excerpts are from Sweden's sterilization law, which became effective in January 1976:

Highlights of Singapore's sterilization legislation, approved in 1974 and effective in 1975, include the following:

"Section 2: Treatment of sexual sterilization (means) the surgical sterilization of a male or female that does not involve removal of the reproductive glands or organs unless such removal is necessary for medical or therapeutic reasons . . .

Section 8: No registered medical practitioner shall be liable civilly or criminally for carrying out treatment for sexual sterilization so long as the person undergoing such treatment gives his consent or consent is given on his behalf under this Act and such treatment is not carried out in a negligent manner . . .

Section 9: For avoidance of doubt it is hereby declared that any treatment for sexual sterilization by a registered medical practitioner shall not constitute a 'grievous hurt' under sections 87 and 320 of the Penal Code."

Under the new law in Singapore, any married person over 21 years of age may be sterilized upon request.

ECONOMIC INCENTIVES.

WHEN a country wishes to modify its birth rate, it naturally considers legal means for adjusting incentives and disincentives toward its desired purpose. Some of the areas for possible consideration include: provision of or limitations on maternity benefits; changes in tax laws with respect to dependents claimed as tax deductions; government or public services which can be given or withheld such as housing, school selection, welfare assistance, and insurance; and family allowances. The Singapore government's plan of incentives and disincentives, the first major program of its kind, was introduced in the early 1970s. Other nations have since followed suit—for example, the Philippines and South Korea.

The Singapore plan, launched officially in 1972 and since updated, includes the following provisions:

☐ *Increases in delivery charges at government hospitals for each child after the first;*

☐ *No paid maternity leave to be given for delivery of the third and subsequent children if the woman already has two or more living children;*

☐ *No income tax relief for the fourth and subsequent children born on or after August 1, 1973;*

☐ *No priority to large families in the allocation of Housing and Development Board flats;*

☐ *Lower priority for choice of primary school for children after the third birth (36).*

In 1974, the government of the Philippines amended its Labor Code to read as follows:

"The maternity leave provided in this Article (131,c) shall be paid by the employer only for the first four deliveries by a woman employee after the effectivity of this Code." ☐

LETTER FROM THE REGIONS ☐ Jose Abcede

Harnessing the barrio midwives

CHOCOLATE Hills and midwives seem unlikely ingredients for a story of rural uplift. But in the island of Bohol in the southern Philippines they appear to have mixed well. The mixture has in fact sparked a current that has put fresh life into this pastoral island. Life in its villages has visibly improved.

Since tourism in the Philippines is now in top gear, visitors invariably hear about the Chocolate Hills of Bohol. These are more than 1,000 cone-shaped limestone mounds arranged—as if by design—over an area of several hundred square kilometers in the north-eastern part of Bohol.

This is more mundane, involving ordinary village folks, rather than the legendary giants. It is a human process, not a geological formation, and its object is to seek a better quality of life for the *barrio* people and the improvement of the health of mothers and children.

Why is it special? Why is it an "attraction".

The Bohol Province Family Planning Project is one of four such projects in the world assisted by the New York-based Population Council. The others are in Indonesia, Nigeria and Turkey.

Family planning. Like its counterparts, the Bohol project was started because there were still many unanswered questions about family planning. What is the best approach to reducing fertility? Does a maternal and child health (MCH) service provide the best framework for family planning? How can MCH and family planning be integrated effectively? With what resources? How can community participation be assured?

International organizations interested in these questions teamed up with the Philippine government and other bodies in Bohol to get some answers to these questions. They are the UN Fund for Population Activities (UNFPA), the Population Council and the World Health Organization (WHO). On the Philippine side are the Department of Health, the Population Commission, the UP Population Institute, the Bohol provincial government and the Tagbilaran City health office.

In July 1975, personnel trained in MCH and family planning set to work in the area and a number of project activities were started. Thirteen primary care centres were opened. Project activities, in fact, revolve around these centres which are staffed by newly-trained midwives.

These primary care centres (PCCs) are satellite clinics linked to rural health units and hospitals. They are located in *barrios* not regularly reached by rural health units. Eventually 60 PCCs are to be opened.

The people had a voice in the selection of the sites and in setting up the PCCs. *Barrio* funds were used to buy construction materials and the people themselves built some of the centres. One PCC was built from funds raised at a beauty contest among wives of the *barrio* captains. The *barrio* people also helped to provide housing for the midwives assigned to the centres.

Chocolate Hills: a model family planning project is another attraction.

Dr. A. Zahra, Director of the Division of Family Health at WHO headquarters in Geneva, was a recent visitor to Bohol. He summed up what he saw in these words:

"The Bohol project is a good project because it is realistic. It is a good approach for building up services where these did not exist or where they were not developed. It is good in the sense that the country—or any country for that matter—could afford that kind of service.

"Training is done progressively. It is mostly based on in-service training and is related to the problems of the community. The Bohol project is in the spirit of the WHO/UNICEF alternative approaches for better health services."

Dr. Zahra added that "what needs to be done more is to exploit visits in the home to bring out more community involvement and participation". He suggested that this could lead to increased two-way traffic between homes and the *barrio* primary care centres.

Dr. Zahra was asked why the family planning project should be MCH-based. He replied:

"If you analyze the most important leading causes of ill health, the diseases and complaints, you will find they are related to the mothers and children who form 70 per cent of the population." ☐