Family planning and the law

by Anne-Marie Dourlen-Rollier

My first reflection is that science moves forward more quickly than mankind. The second is that we live in a world which, from a political, ethical and consequently legal point of view, is pluralistic. The nations order the interrelations between state, religion and citizens in different and sometimes opposing ways, so that discrepancies between countries are on the increase.

As regards access to modern contraceptives and their use, voluntary sterilisation and abortion, most countries have formulated laws, some liberal, others still repressive. But artificial reproduction technologies are new, and consequently there is no legislation to regulate the delicate problems they pose. The issue of surrogate motherhood, for instance, has so far only been addressed by 26 states of the United States and by the United Kingdom, where the Surrogacy Arrangement Act was enforced in 1986. The right to family planning and health services has become recognised by all as a social and legal right, but nevertheless the quality of services and access to them vary greatly between countries, as well as between geographic areas in the same country.

In *Europe and North America*, where contraceptives and advice about their use are available to every individual, there is no consensus on whether unmarried minors should have access to the services without parental knowledge or consent. The best family planning services and information in the developing world are available in *East Asia*. This is not the case in *Latin America*, where the only method accepted as a regulator of fertility has traditionally been periodic abstinence, although the use of other methods is becoming increasingly common in some countries.

Africa presents special problems with regard to the acceptability of family planning, but its promotion as a basic human right has become increasingly acceptable during the last decade. Some 26 sub-Saharan countries now provide government family planning services to improve the health of mothers and children. In the *Middle East*, there is a major consensus on not prohibiting contraception but, in the context of Islamic moral views, it should not inhibit the procreative function of marriage.

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Male and female voluntary sterilisation for family planning purposes has increased in importance during the last two decades. At present it is worldwide the most widespread fertility control method, used by 130 million couples. The legality of this procedure – which has to be considered as permanent – is not admitted everywhere.

It is available and included in national family planning programmes in Bangladesh, Korea, Malaysia, but is only allowed on medical grounds in Latin America. This procedure is rarely used in most African countries, and some doctors refuse to discuss the question, even for highly fertile couples. On the other hand, it is very popular in the United Kingdom (21 per cent of all contraceptive use) and in the United States, where it is the leading method (33 per cent). Recently, in Western Europe, many countries have legalised this procedure, (Austria, Federal Republic of Germany, Italy, Portugal, Scandinavia, Spain, Switzerland). In France the situation is still unclear, and physicians are uncomfortable about performing voluntary sterilisation, while many Catholic countries recognise it as legal.

The abortion policies best illustrate the many relationships among laws,

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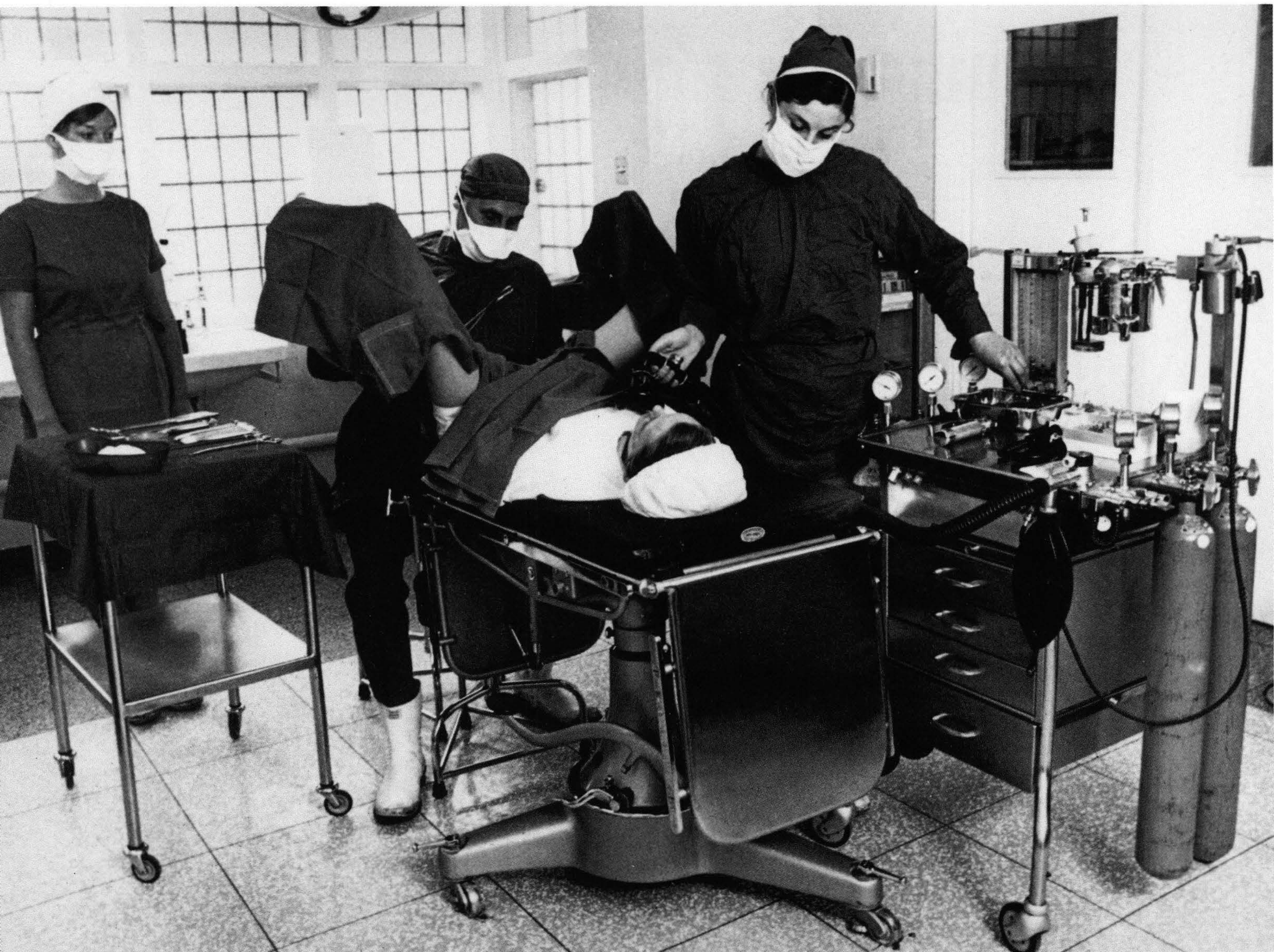
A Colombian father seeks confidential advice on family planning.



religion, social and medical policies. Around 24 per cent of the world population live in countries where abortion is permitted only to save the woman's life, or is utterly prohibited (Muslim countries of Asia, two-thirds of the Latin American nations, half the countries of Africa, Belgium, Ireland and Malta). Nearly 13 per cent live in countries under statutes authorising abortion on medical grounds, including protection of the woman's health and some fetal indications. In 24 per cent social factors are taken into account (India, Japan, most of the states of Eastern Europe, the Federal Republic of Germany, the United Kingdom). But the interpretation of "social factors" varies a lot from one country to another.

And 39 per cent live in countries whose laws permit abortion on request, limited to the first trimester of pregnancy (China, France, Italy, the Netherlands, the Scandinavian countries, the Soviet Union, the United States).

The issue of supporting abortion services remains very controversial, and opposition stems particularly from religious groups, who insist on the right to life of the fetus. The facts show that restrictive laws do not prevent abortion, but lead women to resort to back-street illegal abortions. One-third of the maternal mortality in the world is due to septicaemia and other complications following illegal abortion. The example of Romania is very significant. In order to increase the low birth rate, a restrictive statute was enacted in 1966; the maternal mortality per million women aged 15 to 44 rose from 14.3 in 1965 to 97.5 in 1978.

New techniques

In view of the advances in contraceptive and abortion technologies, laws and regulations need to be reviewed and updated. The boundary between a contraceptive and an abortifacient needs to be precisely drawn, and a new terminology found for defining some new methods.

New technologies have also been developed which enable infertile couples to have a child. Unfortunately, because of the expertise and cost involved, their use is limited to the wealthy developed world. Elsewhere, most countries cannot afford the high cost of specialist centres for infertility diagnosis and treatment.

Because of the complex ethical and legal problems, the developed world is confused about the measures to be taken to enact directives or regulations. Countries have hesitated to legislate on those topics, as shown by the large number of committees appointed by governments to study these extremely delicate matters. Since 1979, at least 85 statements have been issued by

Therapeutic abortion under ideal conditions. Only 39 per cent of the world's population live in countries where laws permit abortion on request.* Facing page: *Elsewhere, the facts show that restrictive laws do* not *prevent abortion, but lead women to resort to illegal and risky back-street abortion.

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committees representing some 25 countries, most of them in North America and Western Europe.

If we examine 15 statements from eight nations, Australia, Canada, Federal Republic of Germany, France, the Netherlands, Spain, the United Kingdom, the United States, we find that they unanimously concluded that *in vitro* fertilisation is in principle acceptable, but some would restrict this to heterosexual married couples with a medical need. Eleven of the 15 committees include couples living together in stable relationships, and only five regard either single women or members of homosexual couples as appropriate candidates for *in vitro* fertilisation in some circumstances.

All the committees accept the potential clinical usefulness of embryo freezing, but they regard the technique as experimental and consider that a time limit should be set for the cryo-preservation of frozen embryos. They disagree on the appropriate length of time.

Of the 15 committees, 12 find ovum donation to be acceptable without qualification. A more cautious approach is taken to embryo donation; they agree that donation should be genuine, but some draw distinctions between reimbursement of donor expenses, payment for time and inconvenience. But there is a fear that this may open the door to commercialisation. The committees also disagree on the question of donor anonymity, and express strong opposition to surrogate motherhood. Eleven committees approved some kinds of research with early embryos remaining from clinical abortion.

The problems posed by the new reproduction technologies cannot be left for ever to health professionals, who, after all, represent only part of society. Nations will have to promulgate laws, but they are right to be cautious, as no legislation can be enacted unless the basic ethical agreement of the population concerned is reached. Up to now no consensus could be obtained on some of the main issues, and each country should be prepared to pass legislation according to its own moral values.

At the same time, there should not be too many disparities between statutes. In view of the increasing interdependence between countries it is essential that an international dialogue be initiated. On such intimate matters, legislation invariably lags behind the evolution of mental attitudes. These attitudes will have to attune themselves to new concepts that overtake traditional ways of thinking. Science moves forward more quickly than mankind evolves; the laws will follow. ■

Medical confidentiality

Insurance companies routinely require a medical examination of prospective clients who seek life insurance, and recently they have started asking doctors whether or not their patient is at risk from AIDS. A general practitioner writing in the *British Medical Journal* commented: "Obviously, if a patient has been tested for HIV (the AIDS virus) and found positive, that information is legitimately of real concern to potential insurers. But we are moving to a ridiculous position in which patients who have been AIDS tested think that they have to conceal this from their physicians, regardless of the result, because doctors may not be safe holders of that information."

The GP and his colleagues decided that insurance companies ought to rely on their clients to answer questions about how they live, and should restrict questions addressed to physicians to matters that are strictly medical. He wrote: "To put our policy into practice we have had a rubber stamp made that reads: *'We are not willing to answer questions about lifestyles'*, and we apply it freely to insurance questionnaires." ■

WHO/E. Schwab

What the doctor hears in the consulting room is intended to be confidential.