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**EXPANDED ROLES FOR NON-PHYSICIANS IN FERTILITY REGULATION:
LEGAL PERSPECTIVES**

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I. INTRODUCTION

Efforts to stimulate interest around the world in fertility regulation are, of course, neither new nor entirely successful. According to a survey conducted by the International Planned Parenthood Federation (IPPF) in 1971, there were approximately 500 million women in the world who were at risk of unwanted pregnancy. Of these only 31 percent were practicing some form of contraception, leaving 350 million unprotected,¹ despite the fact that 94 percent of the fertile women in the world live in countries which have private or government family planning programs. Although these programs have been described as generally "ill-conceived and sociologically unrealistic,"² few would deny the desirability, from the point of view of maternal health, of making family planning services as widely available as possible. Indeed, to receive family planning information and services is an essential correlate of the human right of the individual to make decisions relating to reproduction.³ Thus, much energy and resources have been devoted to developing new strategies to widen the impact of existing family planning programs. Some of these strategies involve expanding the scope of activity of non-physician health personnel.⁴

A rather cohesive body of literature and practice is emerging which suggests that the so-called "paramedical" personnel can contribute greatly to the increased accessibility to fertility regulation services. Numerous pilot studies indicate that properly trained and supervised health and auxiliary personnel can safely and efficiently screen patients for pill distribution, examine patients and insert IUDs, as well as give contraceptive injections. There are even claims that specially qualified non-physicians can perform sterilizations and abortions. Yet to date, this untapped pool of manpower has been given surprisingly little attention.

At present, much of what is done in the way of the actual screening for and provision of fertility regulation services--contraception, sterilization, abortion and menstrual regulation--requires the intervention of a physician.⁵ One reason for this is that such activities are usually defined by law and custom to be part of the practice of medicine. But as Dr. Halfdan Mahler, Director General of the World Health Organization, observes, it is

nonsensical to insist upon using only doctors or other categories of professionally qualified personnel, if you can standardize or simplify your technology to make it safe and applicable through either trained midwives or even people working part-time in health and part-time in other kinds of jobs.⁶

Mahler's comment is all the more insightful when it is brought to mind that in many countries only a fractional minority of the population is able to get medical care from a doctor. Nevertheless, in spite of the simplification and improved safety of family planning technology, medical laws, regulations and practice continue to impede efforts to expand the role of non-physicians in family planning programs.

The record established in pilot programs has reinforced the common-sense notion that an increase in the use of non-physician health and auxiliary personnel will improve the family planning services. Over the past three years we have witnessed a slowly growing trend towards authorizing and training non-physician personnel to perform family planning tasks which usually have been considered, whether as a matter of law or practice, the sole prerogatives of physicians. Witness, for example, the changes that have occurred recently in law and policy in Thailand, the Philippines, South Korea, Chile and Indonesia, and before that in Pakistan and the People's Republic of China. It is important that this momentum continue. As this study indicates at least 24 countries⁷ have family planning programs in which paramedical personnel perform some physician-type function in providing services. It may well be that in numerous other countries similar personnel are undertaking these functions without the formal legal authority to do so because the demand for the services requires it.

The scope of activity of non-physician personnel in fertility regulation has been affected by a number of factors--medical and legal, as well as cultural and political.⁸ Any attempt at expanding the scope will encounter barriers which need to be removed. This paper will focus on the legal barriers.⁹ It will examine the legal regimes governing the activities of non-physician health personnel in providing the "knowledge" and "means" of family planning.¹⁰ As evidence of such regimes will be cited medical laws and regulations pertaining to medical and health care practice generally as well as to the provision of family planning services specifically. These, in turn, will be evaluated in the light of (a) the human right to the knowledge and means of family planning and (b) the pressing need for more extensive use of non-physician personnel in family planning. The experience of countries with relatively few legal restrictions on the use of non-physician personnel will be compared to that of countries with more restrictions, with a view to assessing the impact of the different restrictions on the quality and quantity of family planning services. Based on this comparative analysis, proposals for legal reform will be made.

II. JUSTIFICATION FOR EXPANDED NON-PHYSICIAN ROLES IN FAMILY PLANNING

A. A Brief Historical Perspective

Only relatively recently have physicians come to hold the legal power to exclude others from medical practice. Over the years, as the medical sciences have become more sophisticated and institutionalized, physicians were granted as a matter of practice, and later as a matter of law, authority over the areas in which they exercised expertise. This evolution was a natural one and took into account the fact that physicians were the most highly skilled of those persons dealing with health care. That is not to say that specially defined areas of work were not carved out for other supporting personnel. Yet, among the traditional exclusive powers granted to physicians were the powers to examine, diagnose, prescribe and treat. Hendrick summarizes the history of medical licensure laws in the United States as follows:

Medical licensure laws were first enacted in the United States during the late 19th and early 20th centuries. Their announced purpose was to protect the public against quacks and incompetents, and to foster the growth of scientific practices. To that end, the state legislatures typically defined the practice of medicine in sweeping terms, so as to include within the regulatory provisions practitioners of every degree of form and competence. This legislative purpose was given effect by the courts, which have held every form of diagnosis or treatment to be the practice of medicine The dividing line is 'diagnosis' or 'treatment.' These terms will be broadly interpreted by the courts: 'The practice of medicine is defined broadly enough to apply to witch doctors, voodoo queens, or the pharmacists who suggest aspirin for a headache.' Where the statute fails to define 'the practice of medicine,' the courts have supplied a broad definition, and have rejected the contention that the failure to provide a statutory definition rendered the act void for vagueness.¹¹

Restrictive licensure systems were enacted in other countries as well. Nevertheless, non-physician health personnel have traditionally engaged in what may be broadly defined as the practice of medicine.

One of the precursors of the modern paramedic is the feldsher.¹² Their use in the Tsarist armies dates back to the reign of Peter the Great during the 17th century.¹³ Their continued use as principal providers of medical care over the following two centuries was based on the continuing shortage of physicians. As physicians slowly became more plentiful, the feldsher, once retired from the army, began to provide health care services in rural Russia. At the present time these personnel still assume a key role in providing health care in the USSR and other parts of Eastern Europe. Their training is such that they are allowed to function

independently, with the discretion of referring complicated cases to a doctor.¹⁴

As Western colonial empires developed, it was thought necessary to provide medical care of the type rendered in Europe. In Jamaica, for example, medical practice as such remained undefined well into the 19th century when a College of Physicians and Surgeons was organized. During the previous two centuries, local physicians' assistants were trained by serving a period of apprenticeship with English-trained physicians. Once these personnel had passed a set of examinations, they initially were authorized to sell herbal and traditional remedies. Then, in the face of an inevitable shortage of medical personnel--caused in part by the emancipation of the slaves and the termination of the health services on the great estates--these personnel took over in large measure the practice of medicine in the rural areas.¹⁵

Efforts by the European colonial powers in Africa to establish health services led to divergent strategies regarding the manner in which limited manpower resources were allocated. The British pursued a policy of establishing hospitals, while the French placed greater emphasis on the establishment of dispensaries and anti-epidemic organizations. The French model required personnel with less medical training than would normally be needed to staff a hospital. Prior to World War I, there were some 110 European doctors in French West Africa. Although after 1925 the number was increased to 165 doctors, the number was still sorely insufficient--one doctor for every 72,000 persons!¹⁶ Because of this, a major share of the responsibility for health care fell upon the shoulders of the non-physician personnel who staffed the dispensaries in the rural areas. This in turn required the development of a skilled corps of paramedics. In 1918 a school for the training of these medical auxiliaries was opened in Dakar, Senegal.¹⁷ Over the years, these non-physician personnel have played a vital role in the delivery of basic health services to the population.

The rather widespread use of paramedics has been nowhere more apparent than in Malawi, where historically there has been a near total lack of physicians. There, the establishment of a four-year course in 1936 had the following objective:

[to] train quickly, efficiently and economically someone with knowledge and ability to assist medical practitioners and nurses and, failing the presence of either or both of them, to take such action themselves as their training permits and warrants.¹⁸

Thus, the use of paramedics to provide health care has for many years included a wide-range of skill levels--from assistants to nurses to physicians.¹⁹

The preceding historical overview has illustrated that non-physician health personnel have frequently been used in the face of the shortage

of physicians or nurses.²⁰ The lessons learned can be applied to the field of family planning.

B. General Approach to the Problem

There are two fundamental questions which should be addressed in making arguments for reducing legal restrictions on the use of non-physicians:

(1) Does a need exist for the use of more non-physician personnel to pursue a legally mandated goal in family planning programs, and (2) Can the use of such personnel actually achieve the goal and do so at an acceptable cost in terms of other goals or interests of equal legal stature, such as the goal of protecting the public's health and general welfare? Sections C, D and E below address the first question, while Sections F and G address the second.

The above structuring of the argument is suggested by both logic and judicial decisions in the United States over the last eighty years, which have applied a test of substantive due process or "reasonableness" to medical practice licensing requirements. U.S. courts have held that prohibitions that are "unreasonable" by this test are also unlawful. While the non-M.D. plaintiffs in the American cases have not, in general, been successful in attacking statutory prohibitions of their limited practices, this should not discourage the use of the "reasonableness" test to argue the case for the kind of well-defined and scientific categories of non-physicians that are of interest in this paper. The unsuccessful plaintiffs in the American cases have been cultists,²¹ osteopaths,²² chiropractors,²³ health food sellers,²⁴ and other practitioners who provided an alternative to medicine rather than a limited practice within medicine.

Hendrick has summarized well the arguments under American constitutional law for overturning medical laws and regulations when they are used to block the practice of "legitimate healing arts" which are of limited scope within the practice of general medicine. Such practice includes the non-physician roles in family planning that will be described below. Hendrick's summary is as follows:

Existing case law generally supports the power of the state to require practitioners of unscientific medical cults to obtain the same qualifications required of trained medical doctors. However, this authority should not be extended so as to validate statutory requirements that practitioners of legitimate healing arts master skills unrelated to their form of treatment. A distinction must be drawn between limited practice and quackery. To the extent that they do not make the distinction, present medical practice acts are subject to constitutional attack on two grounds. First, scientific forms of limited medical practice are entitled to legislative recognition. Statutes which require knowledge of unrelated skills are unreasonable. Second, statutory schemes which license unscientific practitioners

(e.g., chiropractors and naturopaths), but deny authorization to qualified limited practitioners, may be guilty of arbitrary and irrational classification.²⁵

In 1915 the "reasonableness" test was severely weakened for American plaintiffs by a holding that the legislative power to set licensing requirements "may be effectuated by requiring even of those who propose to confine their practice to a narrow specialty a much broader knowledge of the subject"²⁶ In 1959 that view was rejected in the decision of England v. Louisiana State Bd. of Medical Examiners. The federal appellate court (5th Circuit) ruled that the plaintiff-chiropractors should be allowed to present evidence of the unreasonableness of Louisiana's law that required that they hold a diploma from an American Medical Association accredited college and also meet some other standards set for M.D.s.²⁷ The decision has been described as "tacit recognition that requiring full M.D. training for a limited practice effectively prevents the exercise of that practice."²⁸ The court had held that "the State cannot outlaw an allegedly useful and lawful profession without a 'reasonable' or 'rational' basis for doing so."²⁹

The burden of proof is another aspect of the "reasonableness" test which should be noted. American cases have applied a strict burden of proof to those who attack the medical practice statutes. One might argue that the political and cultural systems apply a similarly weighty burden of proof to those who argue on non-legal grounds for change in health care systems to allow greater use of non-physician personnel. In any case, the legal burden of proof was defined by the court in the England decision as perhaps "insurmountable" with respect at least to the chiropractor plaintiffs --that plaintiffs "must show that the Act as administered 'has no rational relation' to the regulation of chiropractic and 'therefore is beyond constitutional bounds.'"³⁰

While chiropractors may have had difficulty surmounting a burden of proof, it is suggested that the arguments in the following Sections show that this burden of proof can be convincingly overcome for many categories of non-physician personnel in limited family planning practices.

C. The Human Right to Family Planning Services

In May, 1968, there was official United Nations recognition of the principle that family planning constitutes a basic human right when the United Nations Conference on Human Rights in Teheran proclaimed that "parents have a basic human right to determine freely and responsibly the number and the spacing of their children."³¹ A unanimously adopted resolution added the language "a right to adequate education and information in this respect" for all "couples."³² The Belgian and French delegations assumed that the "right to adequate education and information" included the right to available services or "the means for birth control,"³³ but this assumption was not generally supported by other delegations. However, in 1969 the United Nations Declaration on Social Progress and Development

required Governments to provide families with not only the "knowledge," but also the "means necessary to enable them to exercise their right to determine freely and responsibly the number and spacing of their children."³⁴ Thus, the "knowledge" and "means" for family planning appear to have been clearly established as a human right.

D. Government Obligations to Help Realize Human Rights

From the human right to the knowledge and means for family planning may be inferred a duty by Governments to undertake legal reforms which facilitate the right to family planning,³⁵ at least insofar as those reforms do not diminish the realization of all human rights in the aggregate. This duty to undertake legal reforms flows logically from the fact that human rights are ipso facto legal rights, entailing legal obligations on the part of Governments to undertake the necessary reforms to conform with such rights.³⁶ "Rights" and "duty" are thus two sides of the same coin. There is a duty on the part of all concerned not only to refrain from activities which would impede the exercise of the family planning rights, but also to undertake the necessary measures for the realization of such rights.³⁷ Some of these necessary measures were described in the Plan of Action of the World Population Conference held at Bucharest in 1974. The Plan recommended that nations "make use, wherever needed and appropriate, of adequately trained professional and auxiliary health personnel" in the effort to provide family planning services and advice to those who wish to use them.³⁸ The reasoning behind this particular measure is discussed below.

E. The Scarcity, Maldistribution and Cost of Physicians

Though situations differ from country to country, even officials in the so-called developed world have laid stress on the fact that new and innovative ways of using non-physician personnel in health care services must be sought. It is generally assumed that the basic technology to assure the good health of the population has been developed. What has yet to be resolved is the question of how to make the technology available to a given populace. The need for pragmatic solutions has often been underscored. Obviously, one way to accomplish this is to achieve a more efficient utilization of the available resources, including manpower.

Physicians are too few, too maldistributed and too costly to be used to provide much of the knowledge and many of the means of family planning to the public. One of the most poignant examples of this statement is India. Although India has one of the oldest government-sponsored family planning programs in the world, it has not been successful in stemming its tides of population growth. At least part of the laws governing medical practice authorize only physicians to prescribe oral contraceptives, to insert IUDs and to perform sterilizations and abortions. The laws are reflections of the adoption of the English legal system as a result of colonialism. Yet, circumstances in India differ greatly from those of England, both as to the coverage of medical services and the availability

of doctors. Whereas in India the doctor/patient ratio is 1:6,000, in the United Kingdom it is 1:900. The average ratio for India is, however, somewhat misleading, since most physicians are concentrated in the urban areas, leaving much of rural India without access to physicians. The situation is further aggravated by the fact that as a matter of culturally defined modesty many Indian women will not submit to a physical examination unless the examiner is a woman.

Current tabulations indicate the variation in the doctor per capita ratios in other parts of the world. Of the most populous countries in Africa, Egypt has one physician for every 2,000 persons, Ethiopia one for every 72,000, Nigeria one for every 21,000, South Africa one for every 1,500 and Zaire one for every 34,000. In Asia, Bangladesh has one physician for every 5,000 persons, India one for every 6,000, Indonesia one per 21,000, Pakistan one per 6,000 and the Philippines one per 2,800. In Latin America the figures fluctuate between one per 2,000 in Brazil and one per 13,000 in Haiti. These figures should be contrasted with the ratios in the developed world. There is approximately one physician for every 410 persons in the Soviet Union, one per 760 in the United States and one per 900 in the United Kingdom.

Yet, even the best of these ratios may be misleading for a number of reasons. First, as noted in the example of India, in many of the developing countries physicians are concentrated largely in the urban centers, whereas upwards of 80 percent of the population is spread through the rural areas. The doctor per capita ratio thus often becomes as disproportionate as 1:100,000 in a rural area. Second, not all physicians are trained to provide family planning services. Indeed, in several countries only those who specialize in gynecology are permitted to give family planning advice and services.

To substantially increase the number of doctors for family planning in the developing countries would require far more resources than these countries can allocate to such a purpose. Even now they cannot allocate as much for the family planning program operating budget as is probably necessary, let alone budgeting for more investment in physician training. The United Nations Fund for Population Activities has estimated that between 50 and 65 cents (in U.S. currency) per capita expenditure is needed annually to support an adequate family planning program at the national level--a figure which in some cases will exceed the total health budget of a country! India is presently spending only 7.7 cents per capita on family planning, Pakistan 9.4 cents, South Korea 19.4 cents, and Jamaica 37.0 cents.³⁹

Thus, if Governments are to fulfill their new obligation to provide all persons with the knowledge and means for family planning, it is not conceivable that they can do so without utilizing health personnel who, compared to physicians, are less costly to employ and are either more numerous or can be trained more quickly and at a lower cost (or both). This fact alone, however, is not a sufficient legal argument for reducing legal restrictions on the use of non-physician medical personnel. It must be

shown that such reduction will in fact achieve the intended purpose and do so at an acceptable cost.

F. Ability of Non-Physicians to Perform in Expanded Roles

1. Potential Effectiveness of Non-Physicians

The literature presently available overwhelmingly supports the view that paramedical personnel can be trained to perform safely many family planning functions. Because the types of duties relating to family planning involve the use of relatively simple, repetitive techniques, it has been shown that paramedical personnel can be trained to assume responsibility for their performance. With regard to menstrual regulation, early abortions and male sterilizations there has been little experience outside China with the use of paramedicals, but it is the view of many qualified observers that paramedicals can in principle, as well as in practice, be trained to perform these minor operative procedures at a sufficiently high standard.⁴⁰ While they may not perform as well as a highly trained physician specialist, (i.e., gynecologist or urologist), they may be expected to perform better than general practitioner physicians. The paramedic trained to do vacuum aspiration for early abortion or menstrual regulation can be expected to attain at least a comparable, if not a higher level of skill than most physicians, because the paramedic would specialize in the task. Normally, the physician would be neither willing nor able to restrict his practice so narrowly.⁴¹

2. Proven Effectiveness of Non-Physicians

Despite the legal obstacles, there has been extensive experience with the use of paramedical personnel in many countries. Increasingly, paramedicals are being trained to assume responsibilities which by Western standards have always been thought to be within the bailiwick of physicians. This trend has made itself slowly felt in the area of family planning health care.

In the past ten years there have been many articles written about pilot programs which utilize specially trained non-physician personnel. This literature demonstrates the practicality and effectiveness of using non-physicians in many family planning roles. Thus, by now at least some nurses, midwives and other non-physicians have been successfully trained to perform the following services: (1) distribute condoms; (2) prescribe pills; (3) perform pelvic examinations; (4) recognize and treat pelvic pathology; (5) insert IUDs; (6) identify side effects of both the pill and the IUD; (7) fit diaphragms or cervical caps; (8) give instruction on the rhythm method; (9) perform menstrual regulation; (10) perform uterine aspiration; and (11) perform male and female sterilization operations.⁴²

Faced with an acute shortage of female physicians, who are required for cultural reasons for the insertion of IUDs, Pakistan began in 1966 to train Lady Family Planning Visitors (LFPVs) to do insertions. By 1968

some 465 LFPVs were performing 70 and 80 percent of the more than 500,000 insertions done at the village level.⁴³ In China, the use of the so-called "barefoot doctors" in providing family planning services in the rural areas is one of the most widely cited models for the use of paramedical personnel.⁴⁴ Because of their importance, the Chinese innovations in using non-physicians are the topic of a separate section in this monograph (Part III below).

In performing family planning duties paramedicals have achieved a level of proficiency on a par with, if not better than, physicians. Programs in the United States,⁴⁵ Pakistan⁴⁶ and Korea,⁴⁷ among others, have amply demonstrated that paramedicals at the very least equal the performance of physicians in IUD insertion. The rather detailed comparative study undertaken in Pakistan reached the conclusion that the "IUD performance of paramedical personnel is reasonably comparable to that of medical personnel."⁴⁸

In Bangladesh, non-physician personnel recently have been trained to perform tubectomies on women safely and competently.⁴⁹

As for the pill, the experience in Thailand demonstrates that paramedicals can be trained in one week to screen patients prior to prescription by using a simple check list and that thereafter they can safely prescribe the pill.⁵⁰

Not only can paramedicals prescribe pills safely, but, through their involvement, the number of family planning acceptors increases vastly. Thus, in Thailand during 1970-71 there were only 350 clinics authorized to distribute oral contraceptives under a law which required a physician's prescription. By permitting specially trained auxiliary midwives to distribute the pill, the number of outlets was increased to nearly 4,000, and the number of acceptors increased almost four-fold.⁵¹

Because of their closer social, economic and cultural affinity with contraceptive users, paramedicals are more acceptable to the users. In addition, the fact that most paramedicals are female also argues for their increased role. For example, currently acceptable medical practice requires a pelvic examination prior to the insertion of an IUD, and, in some cases, also prior to issuing the pill. One of the factors which has stifled the success of IUD insertion and pill campaigns and even other types of family planning services is that for cultural reasons women in some areas of the world do not permit male physicians to do either pelvic examinations or IUD insertions.⁵² Since in many of these countries physicians are almost exclusively male, the training of midwives, nurses and other types of female non-physicians to issue contraceptives is essential to making family planning services acceptable to female clients. Moreover, if women prefer to be treated by women, it will be easier to promote family planning if paramedicals, most of whom are women, are used as the delivery agents. Finally, these female paramedicals can more easily than physicians be recruited from among women who have lived in the

community before and are well-known to the community.

Several other comparative studies also lend support to the advisability of employing paramedicals. A comparison between the continuation rates of pill users maintained by physicians and those by midwives in Thailand is instructive. Of those who received the pill from midwives, about 76 percent were still using it after one year, but of those who received the pill from doctors only 67 percent were still on the pill.⁵³ In the United States a comparison of IUD acceptors also showed that after a year a higher continuation rate was achieved among women who had their devices inserted by paramedicals than among those whose insertions were done by physicians.⁵⁴ In another U.S. study patients expressed a preference for specially trained paramedicals, called "family planning specialists."⁵⁵

3. Simplification of Procedures

The preceding subsections have addressed themselves only to the question of whether some non-physicians have the ability to perform fertility control service procedures as effectively as physicians. Another question should now be posed: Can some of these or other procedures be simplified so as to enable non-physicians to perform them well? The answer is often yes. Examples include some new methods for performing IUD insertions, sterilizations, abortions and menstrual regulation. Another example is the simplification of medical screening procedures that are still required in many countries before women are allowed to use oral contraceptives. It appears that a simple checklist or questionnaire that can be administered by non-physicians is as effective a screening procedure as examinations and tests which require a physician's or nurse's involvement.⁵⁶

Thus, simplification of procedures in fertility regulation services is an alternative that must not be overlooked in judging whether non-physicians have the ability, after appropriate training, to undertake new roles in fertility regulation.

G. Elimination of Some Procedures

Still another question should be asked: Can some procedures be eliminated altogether? If so, then in many cases non-physician roles in fertility regulation may be even further expanded. The example of screening women before they are allowed to take oral contraceptives is again appropriate. There is strong support for entirely eliminating such screening procedures. It has been argued that no screening, whether simple or sophisticated, has significant value for reducing the number of pill users who will suffer complications. If true, screening would be unnecessary. This, in turn, would eliminate the need for a prescription requirement for pills and the restriction of their sales in pharmacies only.⁵⁷ Non-physicians could accordingly assume additional roles in pill distribution: e.g., direct sale or free distribution in clinics and

retail stores, or during home visits.

H. Costs of Training, Employing and Supervising Non-Physicians

In comparison to physicians, the costs of training and employing non-physicians are obviously low. The cost difference is so universal and self-evident that no documentation of the difference is necessary here. However, several components of the difference should be distinguished. Some of these are often overlooked. Such oversight leads us to underestimate the cost savings to be gained by the greater use of non-physicians.

1. Training New Personnel

If a comparison is being made in regard to the costs of producing new cadres of health personnel from scratch, one must include not only the cost of professional training but also the cost of the other education which precedes it. For many family planning roles non-physician training can, in comparison to physician training, omit not only several years of professional training but also several years of other education. A further distinction should be made between resource and time costs. Given the urgency which some Governments attach to family planning programs, the time costs may be as important as any other costs. Why should a Government wait eight years for the training of one high school graduate to perform (as a physician) IUD insertions, when after only one year another high school graduate can be trained to do insertions equally well?

2. In-service Training

The costs of in-service family planning training for physicians, midwives, nurses and other non-physicians who already have been trained to provide other health services may also be lower for non-physicians. Somewhat more time may be required to train the non-physician to perform IUD insertions, for example, but savings in other costs (e.g., compensation paid to trainees, opportunity costs, etc.) should offset the time difference.

3. Other Costs

Fees paid to non-physicians for family planning services are usually lower than the fees paid to physicians for the same services.⁵⁸ Salaries, per diems, travel expense scales, fringe benefits and other costs of employment--perhaps even office space--are also lower for non-physicians.

Non-physicians will, of course, often require more supervision than physicians, but the extra cost of such supervision can be more than offset by savings in other costs.

I. Availability of Personnel

Cost is not the only advantage in training and employing non-physicians.

Availability is equally important. There are simply many more persons who can be trained to perform various non-physician roles than there are persons who can be trained to perform as physicians. Many more persons have the educational prerequisites for non-physician training programs than for medical schools. In addition, there is a much greater number of already trained non-physician than physician personnel to whom new or additional roles in family planning can be assigned. The scarcity of physicians was discussed above in Section E. Such scarcity and the lack of legal limits on their activities⁵⁹ makes it unlikely that physicians are underutilized at present. On the other hand, the legal restraints on non-physicians⁶⁰ and their large number cause many of them to be underemployed and therefore available for additional training and expansion of their roles. Data for 36 countries indicate that there is about a 7:1 ratio of non-physicians to physicians among health personnel who are now employed in some family planning activity on a part or full-time basis.⁶¹

J. Other Public Health and Welfare Considerations

Many proposals to expand the health care responsibilities of some non-physicians appear to meet with difficulty because of a fear of an increase in unauthorized medical practice and its possible effect on public health. The fear is that incompetent care might be provided by non-physician personnel who attempt diagnosis and treatment which they have neither been trained for nor authorized to provide. The danger of unauthorized medical practice has apparently encouraged American courts, for example, to give great discretion to legislatures in controlling medical practice.⁶²

The non-physicians who are the topic of this monograph, however, do not pose a significant danger of quackery or other unauthorized medical practice. These non-physicians are not the unscientific, cultist or general-purpose healers whose practices often cause harm directly or indirectly (by causing an ill person to see a physician later than he otherwise would have). Rather, the non-physicians of concern here are part of orthodox medicine, not outside of or in competition with it.⁶³ The expanded roles and training proposed for them are also narrow in scope. Such new training and roles are not likely to encourage unauthorized curative medicine, where the danger from quackery is largely concentrated. Also, these non-physicians will often be closely supervised by physicians.

More generally, it may be argued that potential for harm from expanding the use of non-physicians is not a sufficient reason for prohibiting such expansion, if the resulting benefits more than compensate for it.

III. THE CHINESE EXPERIENCE: A CASE STUDY

Faced with the paucity of modern trained physicians, at a ratio of one for every 26,000 people in 1949 (or a total of 20,000),⁶⁴ what the People's Republic of China has done since it assumed control over mainland China may well be relevant to other countries grappling with similar problems of bringing improved health care to their people. This section is devoted to a brief review of China's policy toward strengthening its health services in family planning.

A three-part health program was launched by the People's Republic of China. It involved: (a) expanding the number of doctors trained in Western medicine (hereinafter referred to as "Western doctors"), (b) integrating traditional Chinese medicine with Western medicine, and (c) increasing the use of paramedicals--"barefoot doctors," "worker doctors" and "Red Guard doctors"⁶⁵--as deliverers of basic health care services. Only the briefest mention need be made of the first two parts. The third part will be the main focus of this case study.

Expansion of the number of Western doctors has been accomplished principally through establishing more Western medical institutions and reducing the length of training from the normal five or six years to three.⁶⁶ The latter was made possible "by eliminating the irrelevant and the redundant, by combining the theoretical with the practical, and by using the 'three-in-one principle of: teachers teach students; students teach teachers; and students teach students."⁶⁷ The sum effect was that by 1965 the number of Western doctors had increased to 150,000 or a ratio of one per 5,000 people.⁶⁸

Integration of traditional Chinese medicine with Western medicine was justified on the ground that most, if not all, Chinese remain convinced of the efficacy of many of the methods of Chinese medicine.⁶⁹ An estimate placed the number of doctors of Chinese medicine in 1965 at 500,000 or a ratio of 1 for every 15,000 people⁷⁰--another important consideration for channeling this vast pool of health personnel to good use. Chairman Mao's directive in the early 1950s that Western medicine be combined as much as possible with Chinese medicine no doubt provided the impetus for the latter's resurgence.⁷¹

Thus, traditional doctors were brought into modern hospitals and clinics, which set up special wards for acupuncture and herbal medicine. Modern doctors were urged to cooperate with and learn from traditional colleagues under the slogan, "Western (modern-style) doctors learn from Chinese doctors." The curricula for reorganized medical schools invariably include acupuncture and herbal remedies among the required courses, and recent reports of model hospitals--usually Army hospitals--stress combined treatment of diseases, using both kinds of medicine. At the same time, traditional practitioners were given some basic modern medical education.⁷² As described in a recent report, the Chinese

believe that the overwhelming majority of ailments can be handled by traditional methods and have created a referral system that moves the more seriously ill individual up the line of competence which ends in the local hospital staffed by the better trained and more experienced personnel.⁷³

Although the results are uneven, there is no question but that such a system of integrating traditional Chinese with Western medicine has raised the levels of health of the majority of the Chinese people. Yet, it is the increased resort to paramedicals to meet China's health needs and, in particular, to perform family planning services, with which this section is primarily concerned.

It may be noted that the Chinese Communists' concern with the state of public health in the face of a shortage of physicians trained in Western medicine predated the establishment of the People's Republic of China in October 1949. In their efforts to improve the health conditions in the areas under their control--predominantly rural--they benefited from the assistance of WHO and UNICEF, even before they joined these two specialized agencies of the United Nations.⁷⁴ Thus, the first UNICEF-sponsored People's Health Workers Training Course was established in a village near Shihchiachuan in November 1948. The course with an enrollment of twenty students was designed to last for three months. Its purpose was "to train in the essential rudiments of sanitation, health and midwifery a large number of people." Promising graduates of each class were to be selected to become instructors in additional training centers to be established. After the Communists assumed control of North China, the training center was relocated in Tungchow, near Peking, and the second course, with an enlarged enrollment of 80 and a longer training period (six months) began in July 1949. This course was blessed with newly arrived UNICEF drugs and medical equipment and additional trained personnel. The latter remained in China until 1950, but the course continued even after their departure. Although the students could only receive some rudimentary training during the six-month period, they were able to combat effectively the high infant mortality rates then prevailing (thirty percent of children died before attaining the age of 5)⁷⁵ For example, many infants in North China had died from tetanus caused by improper procedures used when the umbilical cords were cut after childbirth.⁷⁶ By teaching health workers elementary hygiene and how to give small-pox vaccinations and other inoculations, the program and its graduates did much to improve the rural health in North China.

In the words of one of the UNICEF-supported nurse-midwives who served as an instructor in the training course, the system developed in Tungchow appears to be one "under which all the Barefoot Doctors are functioning in China"

Presently numbered over a million, or about one to every 600 people,⁷⁸ the average barefoot doctor is a graduate of junior high school, is

about 20 years old, has 3 to 6 months of classroom and clinical training in a nearby hospital, and receives additional training of about 1 month each year to upgrade skills and learn new techniques. The numbers of female and male barefoot doctors are about equal. They usually perform preventative work (sanitation, pest control, health education, family planning, immunization, etc.) but also carry out simple curative work, including first aid, distribution of pills and drugs, minor surgery and treatment of some diseases.⁷⁹ The cost of administering the barefoot doctor system is shared among the state, the local unit and clients.⁸⁰

Spurred on by Mao's directive of May 26, 1965 ("... [I]n a medical and health work ... put the stress on the rural areas.")⁸¹ The barefoot doctor system has developed a number of unique features particularly suited to the promotion of family planning, of which the following should be mentioned:⁸²

(a) The selection of those who should receive barefoot doctor training is usually done by the local community which the prospective "doctors" will serve. Such selection helps ensure good rapport. A community is more likely to feel confidence and trust in such "doctors" than in ones selected by outsiders.

(b) Since the average barefoot doctor is engaged in health work only on a part-time basis, he or she continues to work also in agriculture and receives basically the same income as that of full-time agricultural workers. Thus, the "doctors" avoid developing elitist attitudes, while remaining accessible to the community at all times.

(c) through an elaborate referral system--from the village clinics to the county and larger urban hospitals and from the barefoot doctors to the more professionally trained physicians and specialists--each level of health personnel and facilities is utilized at its fullest capability. The barefoot doctors serve essentially as a bridge between the local community and the health specialists. At the same time, a rotation system--sending physicians and specialists from urban hospitals to rural areas to work with barefoot doctors--has served to improve the quality of work of barefoot doctors as well as to take care of more complicated cases.

In addition to distributing contraceptives (including pills), inserting IUDs and even performing abortions and vasectomies (though usually these are done by better trained personnel),⁸³ the barefoot doctors engage in motivational and educational campaigns for family planning--stressing the advisability of late marriage, the desirability of having daughters instead of aiming for sons, the need to plan the number and spacing of children, etc.

If we take abortion--the most difficult of all fertility regulation procedures--as a yardstick for measuring the competence of paramedics in China, the following statements by two Western physicians appear reassuring:

Early abortions are usually performed by nurses and, in the communes, by trained barefoot doctors or midwives ...

The complication rate seems to be very low because of the good aseptic procedures used. Also, it was stated in Canton, Wuhan and Peking, that an abortion performed by nurses is much safer than one by doctors because nurses tend to be more careful ...

Mortality resulting from abortion seems to be non-existent or extremely low. At least no such deaths appeared in the statistics we obtained ...⁸⁴

In view of the foregoing discussion, it is not surprising that the remarkable success of the family planning effort in China has been attributed:

... to a considerable degree, to the fact that the principal local advocate of the program is a person the community knows and trusts, the barefoot doctor. Moreover, the barefoot doctor is constantly present within the community to supply contraceptives, allay misgivings, reinforce positive attitudes, and treat physical side effects⁸⁵ resulting from the practice of birth control.

Whether the Chinese approach is relevant elsewhere in the developing world has been commented upon at length.⁸⁶ Suffice it to say that there is no inherent barrier to the transferability of the Chinese methodology to countries with limited medical personnel and facilities.

IV. LAWS REGULATING MEDICAL PRACTICE AND HEALTH PERSONNEL

A. An Overview

What constitutes, in legal terms the practice of medicine: the answer to such a question is of initial importance for at least four reasons. First, by defining the nature of medical practice the medical practice statutes set out the types of activities which are reserved to physicians. Second, these statutes establish definitions which will help decide which types of personnel are authorized to perform certain functions, i.e., the prescription of orals and injectables, the insertion of IUDs, and the performance of abortions and sterilizations, as discussed later in this paper. Third, the statutes specify the sanctions against the unauthorized practice of medicine. Fourth, the statutes give us some understanding of the legal nature of the practice into which non-physician personnel, arguably, may be encroaching if, as is advocated here, they begin to take on an expanded role in the delivery of family planning services.

The principal sources of regulation of the health professions are the medical practice statutes and rules promulgated pursuant to them. These statutes and rules provide standards for the training and licensing of physicians and some other health personnel. With some exceptions, they define the practice of medicine and limit the right to engage in medical practice to licensed physicians.⁸⁷ The exceptions include authorizing physicians to delegate some of their activities to personnel under their supervision. For non-physician personnel, as well as physicians, the areas in which they may engage may be specified. There may be rules providing for mandatory or optional licensing or for registration.

The preconditions to licensing usually are defined in terms of one or more of the following: (1) the required content of training programs; (2) the accreditation of the training institutions; (3) systems for accreditation of training institutions and programs; (4) examinations outside of these training programs; (5) certification of personnel who obtain training and qualify for practice; (6) accreditation or licensure of institutions to use certain categories of personnel.⁸⁸ Licensing is performed by a government agency. Although licensing may not be required for a particular category of health personnel, certification or registration may be required. Administrative and procedural schemes for licensure, certification, accreditation, and/or registration are prescribed by statutes or by regulations promulgated by a public agency. Defining the scope of practice of medical personnel may also be delegated to a public agency.

Actual accreditation and certification usually are administered by authorized non-governmental agencies, such as associations of medical professionals, pursuant to statutes or regulations, or where not prohibited by them.⁸⁹ It is the task of these associations or public agencies to establish minimum curriculum requirements for the schools, detailing the

subjects to be taught and the practical training that must be experienced. They also formulate the qualifying examinations which each candidate must pass before being certified for practice. Where there are nursing or midwifery councils established, it is usually required that practitioners register with the council.⁹⁰ This may be automatic upon passing the required examinations.

Statutes often give large regulatory discretion to the public agency. For example, the Libyan statute, in reference to several kinds of non-physician health personnel, gives the Ministry of Health the authority to formulate and disseminate rules as to "the activities that such persons may perform."⁹¹ This power is of no small significance, as we shall see later, to efforts to bestow on paramedicals expanded roles in the field of family planning.

B. Physicians

Laws relating to the practice of medicine are universal. The rationales behind their enactment are essentially twofold. On one hand, they provide physicians with a legally protected existence. On the other, they flow from the police power of the state "to act in the interest of protecting the health, safety, welfare and morals of its citizens"⁹² e.g., by protecting the public from quackery and other forms of unqualified medical practice. In addition to setting out what constitutes the practice of medicine, the statutes are normally directed at creating some sort of organizational basis for controlling the practice. This is achieved by granting a number of specific powers to a Board of Medical Examiners (or some other similarly titled body). These most often include the powers to set educational, examination and licensure standards for physicians.

1. Definition of Medicine, Physician and Medical Practitioner⁹³

In order to complete the puzzle of what is meant by the practice of medicine and who can practice, it is sometimes necessary to put fragments of several different laws together. For example, under Philippine law a physician is defined merely as "one who is duly authorized to treat diseases or engage in the practice of medicine"⁹⁴ The practice of medicine is defined elsewhere so as to cover anyone who attempts to "diagnose, treat, operate, or prescribe remedies for any human disease, injury, deformity or physical or mental condition or ... ailment."⁹⁵

Similarly, in Thailand "medicine" is defined in one law as the "examination, prevention and treatment of human disease"⁹⁶ But the Medical Profession Act of 1968 elaborates on that skeletal statement. A person is deemed to be part of the medical profession (i.e., a physician), if he is involved in the

diagnosis, prevention and treatment of human disease,
or midwifery, by means of direct and scientific

performance upon the human body including direct operation by surgery, injections of drugs, injections of other substances into the body for beautification, body building, sterilization, birth control, or the insertion of intrauterine devices or the application of cervical caps for birth control.⁹⁷

The Act goes on to say that no one can practice medicine without being "duly registered and licensed,"⁹⁸ but it does not specify the requirements that one must meet to become "licensed" to practice medicine.

Very few statutes were encountered in the course of this study which specifically defined what is meant by "physician." The law on medical practice in Syria was one of those. According to Section 1 of Legislative Decree No. 12 of January 7, 1970, a physician is one who has received a "diploma in general medicine" from a faculty of medicine in Syria or an "equivalent diploma in medicine" in some foreign country.⁹⁹ The definition of "medical practitioner" as used in the Ethiopian statute is considerably broader, however, and encompasses not only physicians and surgeons, but also pharmacists, midwives, nurses or anyone else who professes to be able to "examine, diagnose, treat, prescribe for or dispense to patients for gain."¹⁰⁰

The words "examine, diagnose, operate, treat or prescribe" constitute the usual definition of the practice of medicine. Yet, the words themselves are seldom defined with any exactitude. In the course of providing medical care it is not uncommon to find non-physician personnel performing functions which could be construed as being characteristic of one or all of the five. To a large extent, the task of discerning whether non-physician personnel have stepped over the line into the practice of medicine has been left to the courts. Two examples suffice.

In the State v. Kwaku Nkyi¹⁰¹ the High Court at Kumasi in Ghana heard the case against a student nurse who had mistakenly injected a child with arsenic. Rather than conclude that the nurse was guilty of manslaughter, the Court took the tack that he had breached the Medical and Dental Act, 1959. In short he had practiced medicine though unauthorized to do so. Assuredly, he was trained to give injections. But the nurse had crossed the line drawn between the practice of medicine and nursing. Without prior authorization from a physician, he attempted to use his skills to diagnose, prescribe and treat the stricken child.

On the other hand, the practical folly of confining such functions solely to physicians is emphasized by a California court. After weighing the facts of a case against a nurse, the court reached the conclusion that by evaluating the seriousness of a symptom she was making a diagnosis. But the court went on to observe:

She has been trained, but to a lesser degree than a physician, in the recognition of diseases and injuries. She should be able to diagnose ... sufficiently to know whether it ... bears danger signs that should warn her to send the patient to a physician.¹⁰²

Thus, we are faced with the tensions which exist between medical practice as defined by law and the medical practice of the real world.

2. Power to Delegate Duties

One of the pressing questions which arises is whether some of the physician's duties, insofar as they relate to family planning, can be delegated by the physician. There are some medical practice laws which prohibit delegation of duties and others which permit such delegation. The Argentine law is typical of the former. Under a section which sets the limits of the authority of physicians is a paragraph which states that they cannot "delegate powers, functions or duties to their auxiliary personnel, which are inherent or restricted to the medical profession."¹⁰³

If laws prohibiting doctors from delegating their authority are construed narrowly, they will serve to bar paramedicals from performing many duties directly related to family planning, regardless of supervision. Some laws even explicitly reserve key contraceptive services to physicians. Thus, the Peruvian Sanitary Code stipulates that "[e]very contraceptive shall be used under the control of a physician" ¹⁰⁴ In Hungary, a "physician" is required to carry out the "necessary examinations" prior to issuing a prescription for a hormonal contraceptive.¹⁰⁵

An example of laws permitting the delegation of authority by physicians is the law of Chile which permits paramedicals to undertake certain functions normally reserved to physicians. But they are permitted to do so only after having been instructed to do so, and must be supervised by a physician.¹⁰⁶

The Cameroon statute is interesting in that, while it flatly precludes anyone from diagnosing or treating "disease or disorders in any way even though under supervision and even in the presence of the doctor,"¹⁰⁷ an exception is made for midwives or nurses who act as assistants to a doctor or who are delegated the power to supervise the doctor's patients.¹⁰⁸ Apparently, the former provision is intended to prevent totally untrained, unskilled health workers from engaging in medical practice; the latter is a recognition that some non-physician health personnel are capable of assuming responsibility for some of a physician's tasks.

C. Traditional Medical Practitioners

Because of the multi-cultural makeup of their population, some countries permit a multi-tiered system of medical practice to exist.

Beneath the modern Western-oriented medical practice, forms of traditional or indigenous medicine are tolerated or even encouraged. Under such a system, the traditional "physicians" are authorized by law to practice the form of medicine in which they are specialized. For example, the Malaysian Medical Act of 1971 includes provisions which exempt from the sanctions imposed on those caught in the unauthorized practice of medicine those persons who practice "therapeutics" according to purely Malay, Chinese, Indian or other native tradition.¹⁰⁹ The Kenyan statute governing medical practitioners likewise protects the "practice of systems of therapeutics according to African or Asian methods."¹¹⁰ But the practice must be geographically confined to the community to which the practitioner belongs, and "native doctors" are specifically forbidden to give injections.¹¹¹

The traditional ayurvedic physicians in Sri Lanka are controlled by a special registration act¹¹² and come under the authority of the Ayurvedic Medical Council. The scope of their practice is considerably wider than that of other traditional practices mentioned in the preceding paragraph. In addition to being able to register as "general physicians," they may render special treatment in nine categories. One of those is "garbani" and "sootheka roga," which in Sanskrit means "ailments or diseases associated with pregnancy and childbirth."¹¹³

In Pakistan, no one who practices traditional forms of medicine may use the title "doctor" unless he is a registered medical practitioner. If registered, he may administer injections and prescribe any antibiotic or dangerous drug.¹¹⁴

By virtue of the provisions of the Medical and Dental Decree 1972, the practice of indigenous systems of therapeutics in Ghana is subject to the following restrictions: (1) that the practitioner be an indigenous inhabitant of Ghana; (2) that no act be performed that is dangerous to life; and (3) that no restricted drug be prescribed, supplied or administered.¹¹⁵

D. Nurses

The extent of power of a nurse to provide medical care is normally defined by legislation on nursing. That is not to say that legislation alone is the source of knowledge. Again, in many cases it takes the combined reading of legislation, Ministry of Health regulations, nursing rules of ethics and rules of particular hospitals to get a full picture of what a nurse's rights, duties and responsibilities are.¹¹⁶ But legislation is the point of departure. In some countries nursing legislation tends to be rather general, while in others the statutes are more specific--carefully and exclusively listing the duties which a nurse may undertake.

1. Definition and Scope of Practice

The legal definitions of nursing vary. The Argentine law states that the practice of nursing "consists of the regular carrying out . . . of activities concerned with the care and treatment of patients."¹¹⁷

Those activities are by statute to be performed in an "auxiliary capacity to physicians."¹¹⁸ A person practicing nursing in Luxembourg is defined as one who "regularly dispenses care, comprising of basic care and therapeutic care or procedures prescribed by the attending physician."¹¹⁹ Within the specific and exhaustive list of tasks which a nurse may perform there is the giving of injections in the absence of a physician who has left instructions to do so. But nurses are prohibited from giving any form of gynecological "massages."¹²⁰

Nursing is defined broadly in the Philippine Nursing Law as the "whole management of care."¹²¹ The law goes on to list a nurse's duties, among which is the "application and execution of legal orders in writing of physicians concerning treatments and medication including the application of hypodermic and intramuscular injections." The injections must, however, be given under the direction and in the presence of the physician.¹²² The Czechoslovakian regulations are extremely detailed in setting out the duties of nurses.¹²³ As far as is pertinent to family planning, they do permit a nurse to "carry out examinations and medical procedures, including examination by means of special instruments."¹²⁴ Under Ghanaian law, a nurse can administer a drug only if ordered to do so by a registered medical practitioner.¹²⁵ This represents the normal rule.

The principal legal barrier to nurses' involvement in contraceptive distribution, IUD insertion, sterilization, or early abortion is that typical laws appear to forbid nurses to perform such duties on their own initiative. Nurses, if they can do anything at all, must work subject to the command and under the supervision of a doctor.¹²⁶

2. Training

Within the curricula and practical training that a prospective nurse must take are elements which relate to the subject of family planning. For example, the First Nursing Ordinance of Austria¹²⁷ sets out in minute detail the number of hours of training and practice in each subject that are required as part of the educational process. Among the requirements for the third year of training is one 30 hour block on gynecology and obstetrics and another devoted to nursing care for gynecological diseases and lying-in women.¹²⁸ During the third and fourth years of the course in general nursing, the candidates must spend, among other requirements, at least 440 hours in a practice associated with gynecology and obstetrics.¹²⁹

It is difficult to decipher from the broad categories of subjects listed under training whether nurses receive much instruction in family planning per se. It seems obvious that if nurses are to take on added responsibility in the area of family planning, they must first be given specific training in the subject. This must include information on the methods, patient screening procedures before prescribing the pill or injecting hormonal contraceptives, and skills involved in the insertion of IUDs and the performance of sterilization, abortion and menstrual regulation.¹³⁰

E. Midwives

1. Definition and Scope of Practice

Because of the large number of births traditionally attended by midwives, a body of specialized legislation has grown up around the practice of midwifery. Given the nature of the practice and the legislation defining its scope, it is unlikely that family planning presently is counted among its specialties. A Philippine law defines midwifery as "the care of normal child-bearing women from the beginning of pregnancy until the end of puericulture and the care of their normal infants during the neo-natal period."¹³¹ In Chile it is defined as "dispensing care in normal cases of pregnancy, childbirth and puerperium."¹³² The practice of midwifery in Austria is more inclusive: giving advice to pregnant women, assisting at delivery, care of women after childbirth and of the newly born, and collaborating with other maternal/child health care services.¹³³

In many ways midwives have more autonomy than nurses, but their exact powers vary according to the regulations which govern their activities. For example, the Libyan statute, while authorizing midwives to perform the customary duties connected with childbirth, stipulates that they may render other health services as instructed by physicians.¹³⁴ In Australia, however, nurse-midwives are forbidden to supervise a pre-natal patient in the absence of authority from a medical practitioner.¹³⁵ Moreover, the regulations stress that they must work with a practitioner and carry out his instructions.¹³⁶

Typical midwifery legislation and regulations often contain a tinge of the Biblical: long lists of "shalts" and "shalt nots." Among the midwifery laws reviewed, there are few positive grants of authority which could be construed as relating to family planning per se. This may be explained by the fact that, since midwives traditionally have been schooled in rendering medical care to a woman from the time she is found pregnant until shortly after childbirth, the types of services that they usually perform are limited to that time span.

2. Specific Constraints or Authorization Regarding Family Planning Activities

Many laws on midwifery contain provisions that may be regarded as either specific constraints on or possible grants of authority for the giving of family planning services. For example, the Luxembourg law expressly prohibits midwives from using "instruments utilized in gynecological or obstetric practice"¹³⁷ and from performing "artificial dilation of the cervix."¹³⁸ A variation on this theme appears in the Argentine law which forbids midwives to keep any "medical instruments" at their place of work, save those which are "strictly necessary" for the practice of midwifery. Given the statutory definition of midwifery in these two countries, these provisions seem to create an effective bar to the insertion of IUDs by midwives. Granted that such laws were not conceived with that speci-

fically in mind, nevertheless they do forbid such activities on the part of midwives. Even more specific is the law in Brazil which forbids midwives to introduce pessaries into the uterus, whether there is pregnancy or not.¹³⁹ On the other hand, the law in Thailand contains a definition of midwifery authorizing practitioners to insert materials into the body for the purpose of "birth control."¹⁴⁰

Performing some sort of a physical examination is a customary prerequisite to the issuance of a prescription for the pills and the insertion of an IUD. Yet some regulations, in particular those in force in Australia, emphasize that a midwifery nurse may not:

carry out internal examination of, or manipulative procedure with respect to a patient, other than such examination or procedure that is, in the opinion of the nurse, absolutely necessary.¹⁴¹

Accordingly, it is unlikely that these regulations could be properly construed to permit pelvic examination, IUD insertions, menstrual regulation or abortion.

Many regulations governing traditional birth attendants, particularly in the Western hemisphere, state that this type of midwife is "not to introduce fingers or any instruments or objects in the birth canal of the mother with the purpose of performing examinations or any other reasons"¹⁴² Although the original purpose was to safeguard the expectant mother's health, the breadth of the wording would cover also family planning services like pelvic examinations, IUD insertions, menstrual regulation and abortion.

Except in the instances specified in the regulation, it is not uncommon for a midwife to be barred from administering any drugs to a patient unless they are given either under a physician's direct supervision or on his written authority.¹⁴³ In Switzerland midwives are expressly forbidden to administer "medicaments to pregnant women," and they are also precluded from carrying on a trade in medicaments.¹⁴⁴ These are in keeping with the rules of medicine which reserve to the physician the authority to prescribe medicines.

There are a few midwifery laws which speak directly to the issue of family planning and the role of the midwife. The German regulations state flatly that midwives are not to use either "medicaments or procedures" which have as their intended result the practice of birth control.¹⁴⁵ Danish regulations create an anomaly in that, while midwives are given training in family planning,¹⁴⁶ it is the physician who is charged with ensuring that female patients are instructed as to the family planning options available to them.¹⁴⁷ A recent change in the Swedish ordinance on midwifery allows that: "A midwife with appropriate training may provide advice and treatment in connection with contraception."¹⁴⁸

The Western Australian statute contains a rather blanket prohibition against a midwife involving herself in "any treatment of a patient which is not properly within the province of a midwife."¹⁴⁹ As nothing is said in the act which could reasonably be viewed as authorizing a family planning role for the midwife, if she were to do so it would surely be ultra vires. This "province" in terms of time runs from the commencement of a pregnancy to a few days after delivery. A "narrow view" of midwifery, resulting from the language in the laws, may well preclude midwives from providing any useful form of family planning services, as a fortiori they would fall outside of the time span during which midwifery can, legally and practically, be practiced. This notion is actually reinforced by the Brazilian law which forbids midwives from providing any services, whatever their nature, outside the time frame between actual pregnancy and post-natal confinement.¹⁵⁰

3. Training

The training requirements for midwives, as for nurses, are usually set by regulations issued by Ministries of Health. But because of the nature of the midwife's work, the educational process has a narrower focus. Naturally, most of the training relates to the practice of obstetrics. Again, because of the general nature of the requirements, it is difficult to discern whether family planning training is part of the program. Among the traditional midwifery laws surveyed for this study, only the Danish training program explicitly includes a family planning element, and it is merely a token five hours. Of the twenty countries encompassed in the recent WHO study on the training of traditional birth attendants, only five had programs which contained a family planning component: Costa Rica, Guatemala, Iran, Indonesia and Malaysia.¹⁵¹

To specify that midwives should give aid only to pregnant women is to ignore their potential usefulness in providing a wider range of maternal/child health care services. As early as 1966, the WHO Committee on the Midwife in Maternity Care concluded that this traditional definition of the scope of maternity care was too narrow. According to the Committee, among the other natural duties which could be assumed by midwives would be giving guidance both on infertility and family planning.¹⁵²

F. Auxiliary Health Personnel

Auxiliaries are a subordinate, yet essential, category of health personnel. Compared to nurses and midwives, they usually have less formal education, less medical training and are given less authority. This second-level status is mirrored in the laws which control their activities. To this extent, expanding their responsibilities to include family planning activities involves legal problems that are somewhat different from those of the nurses and midwives under whose supervision they must normally work. In other ways, the problems are very similar.

The Nurses and Midwives Decree in Ghana stipulates that auxiliary

nurses may perform "services of an elementary nature,"¹⁵³ as permitted by the Nursing Council, but that they must work under the supervision of a registered nurse or midwife. According to Argentine law, auxiliary nurses "shall act as assistants" to university-trained or certified nurses and are to dispense care "only under the instructions and supervision of such nurses."¹⁵⁴ They are also specifically forbidden to give instructions as to treatment and to make diagnoses or prognoses. In Spain, a recently issued regulation on clinical assistants permits them to work in out-patient health centers, authorizing them in general to engage in those activities "which, without coming within the purview of the health professions, facilitate the tasks of physicians, nurses, and technical health aides."¹⁵⁵

The distinction between auxiliaries and professional paramedicals is analogous to the difference between the midwife--specially trained and registered--and the traditional birth attendant or auxiliary midwife. The latter is a person who, though she provides services similar to the professional, "initially acquired her skills delivering babies by herself or by working with other traditional birth attendants."¹⁵⁶

In most cases the traditional birth attendant has no legal status as such. She is not registered, and in essence practices outside of the law.¹⁵⁷ She is most commonly found practicing in small villages in outlying rural areas of developing countries. In that setting she is permitted to practice without interference from the authorities. Typically, she provides pre- and post-natal care which conforms to the mores of the local culture. According to some sources, part of her work has historically included pregnancy prevention or termination by external manipulation of the uterus, the giving of herb potions, other kinds of traditional medicines or advising prolonged breast feeding.¹⁵⁸

It should be noted that auxiliaries have played an important role in the development of effective contraceptive distribution schemes in several countries. Examples include the use of Lady Family Planning Visitors in Pakistan, auxiliary midwives in Thailand and the "barefoot doctor" in the People's Republic of China.¹⁵⁹

G. Sanctions for Unauthorized Practice

The sanctions which may be applied against persons who engage in the unauthorized practice of medicine are important for nurses, midwives, auxiliaries and others who may undertake family planning roles. If they exceed the scope of traditional professional practice, they place themselves in jeopardy, not only of professional disciplinary action, but also of civil and criminal liability. These would ostensibly apply where a nurse, a midwife or another non-physician participated in family planning activities which they were not authorized to carry out. To do so in Argentina, for example, would expose the offender to sanctions under the medical practice law,¹⁶⁰ and to the threat of prosecution under Article 208 of the Criminal Code (Crimes Against the Public Health). The criminal penalty is imprisonment for a term of 15 days to one year, and in theory

can be imposed on

[a]nybody who is not authorized to practice the profession of curing, or who exceeds the limits of such authorization, regularly announces, prescribes, ministers or supplies medicine ... or any other means intended for treatment of a disease of any person.¹⁶¹

According to Colombian law, it is illegal for a nurse or midwife to "exceed their rights and undertake the practice of medicine."¹⁶² If not licensed to do so, anyone caught giving injections in Ghana potentially exposes himself to a fine of 1,000 bedis and/or up to two years in prison.¹⁶³ And in Venezuela it is illegal for anyone to perform any of the duties reserved to doctors,¹⁶⁴ including acts of diagnosis, treatment or prescription. The same is true for midwives, nurses and auxiliary nurses who treat persons with illnesses in the absence of written instructions from a physician.¹⁶⁵

Beyond the possible penal and civil actions which can attach to unauthorized practice, the Indonesian law governing the activities of health personnel authorizes the ranking medical officer of the province of the Minister of Health to take "administrative measures" in cases where the personnel neglect their duties, perform tasks which are not permitted, or infringe upon the regulations issued under the laws on health personnel.¹⁶⁶

In Kenya anyone caught in the unauthorized practice of medicine is subject to a fine of 3,000 shillings and up to 12 months in prison.¹⁶⁷ Special exceptions are made, however, for any person in the employ of the Medical Department of the Government or any approved health service who is called upon to render medical aid in the course of his duties. This is a hopeful model in terms of the use of paramedicals in family planning.

V. REGULATION OF NON-PHYSICIAN ROLES IN FAMILY PLANNING

The World Population Plan of Action adopted at the 1974 World Population Conference in Bucharest accords "high priority" to the "review and analysis of national and international laws which bear directly or indirectly on population factors."¹⁶⁸ More specifically, the UNFPA/UN Symposium on Law and Population in 1974 recommended that:

Governments review their regulatory provisions relating to the prescription of hormonal contraceptives, insertion of IUDs and other family planning procedures, weighing the risks and benefits under national conditions, with a view to maximizing the role of professional paramedical and auxiliary health personnel¹⁶⁹

It is useful to distinguish among categories of laws and regulations. They are: (1) those restricting both physicians and non-physicians in providing family planning services; and (2) those restricting only non-physicians. This section is concerned only with the second category, leaving the first category to such substantive fields as contraception, sterilization, menstrual regulation and abortion.¹⁷⁰

A. Contraception

1. Prescription Requirement

It should be noted that a close connection exists between this requirement and that concerning the place of sale, to be discussed in the ensuing sub-section. The link is based on the need for controlling dangerous drugs and poisons. However, rigid adherence to these requirements has been criticized. For example, Stepan and Kellogg observed in their study of laws on contraception that:

It is surprising how frequently laws relating to the sale of the pill fail to reflect through some degree of flexibility, either the basic factor of the inaccessibility of physicians or urgent demographic pressures. Thus, the law is virtually the same in West Germany and in Nigeria where in a 61 million population, one physician must take care of 40,000 people.¹⁷¹

It is obvious that access to pharmacies as well as physicians is difficult in developing countries, especially in rural areas.

These restrictions on the availability of contraceptives are in turn restrictions on the use of non-physicians for the following reasons: (1) Physicians can write prescriptions, whereas non-physicians usually cannot. (2) Pharmacies are more likely to be located in cities where physicians can be found, rather than in the rural areas. Thus, even if a

non-physician can prescribe contraceptives in the rural areas, the client is not helped in the absence of a pharmacy from which to purchase contraceptives. (3) A physician is more likely to be permitted by law to distribute (as well as to prescribe) contraceptives than is a non-physician health worker, particularly in the private sector.

As noted earlier, one of the traditional statutorily protected functions of a physician is to "prescribe" medications for the treatment of human diseases and disorders. Not infrequently this power is buttressed by regulations relating to pharmaceuticals. Insofar as the pill and contraceptive injections are concerned, they are normally included in the list of "potentially harmful" drugs which can be distributed only by prescription.¹⁷² In combination these laws effectively undercut the potential role of non-physician family planning personnel.

Space does not permit a detailed survey here of the regulations affecting prescription of the pill and injectable contraceptives. That work has been successfully undertaken by others.¹⁷³ But some useful generalizations can be made. First, the prescription requirement has until recently been nearly universal. While in most developed countries, where the doctor/patient ratios are relatively low, the requirement has a certain inhibiting effect on the availability of contraceptives, it is in the developing countries where the requirement causes the greatest problem. In many of these countries it is not unusual to find that the rural populations (which not infrequently reaches 80% of the total) live out their lives virtually without any exposure to the care of a doctor. Are they to be denied contraceptive protection? Obviously, an alternative viable solution must be found, taking into account the original purpose of such requirement, the reality of the situation and possible consequences of legal change.

A second generalization is that although the prescription requirement is still prevalent, there is ample evidence that it is widely ignored. In a growing number of countries the requirement is honored more in the breach than in observance. According to Stepan and Kellogg, this is true in Brazil, Egypt, Ghana, Indonesia, Ivory Coast, Lebanon, Malaysia, Mexico, Panama, the Philippines, Thailand, Turkey and Venezuela.¹⁷⁴ To these may also be added Bolivia, Colombia, Ecuador, El Salvador, Iran, Morocco and Nigeria.¹⁷⁵ One may properly question whether it is necessary to struggle to have paramedicals bestowed with the authority to prescribe contraceptives. The question is a valid one. Indeed, when family planning officials from many of the countries cited above have been quizzed as to their preference between legal reform or the status quo, they invariably favor the latter course. In essence, they have expressed the opinion that to mount a campaign for legal reform relating to paramedicals in general and family planning in particular would be to stir up the proverbial hornet's nest.¹⁷⁶ It would create controversy where there presently is none, for now they carry forward their programs with the benevolent blessing of the government and suffer no interference. It is argued that attempts to alter the laws and regulations in this area would be unfruitful and in the long run destroy the success of presently functioning non-governmental family planning

programs by forcing the enforcement of heretofore unenforced regulations. While one may appreciate such a sensitivity to local conditions, such a position may be misleading. The legal requirement for the prescription may yet act as a constraint simply because it exists. Many non-physician personnel may not be as effective as motivators, promoters, sellers and servicers in family planning when they are violating the letter of the law as when they have the full symbolic and other support of the law. Also, the fact that pharmacies disregard prescription requirements contributes little towards efforts to get widespread approval for the utilization of non-physician health personnel. The non-physician's position in relation to contraceptive distribution remains essentially the same.¹⁷⁷ See Part VI., section B below for a further discussion of the disadvantages of depending on non-enforcement of laws as a strategy for expanding the use of non-physicians in family planning.

A third generalization relates to the gradual erosion of the near universality of the prescription requirement. Over the past five years the trend toward altering the contraceptive prescription procedure has been gaining momentum. Faced with increasing population pressures, more than a handful of countries have made changes in the law. Either paramedicals have been authorized to prescribe contraceptives or the prescription requirement has been abolished altogether. With regard to the first auxiliary midwives in Thailand were authorized in 1970 to prescribe the pill. The impact on the numbers of contraceptive acceptors was immediate and dramatic. The midwives were instructed to use a checklist¹⁷⁸ for screening candidates, referring to physicians only doubtful cases where the prescription of pills might involve prima facie greater risks. Within the last two years Antigua, Bangladesh, Chile, Fiji, Jamaica and Pakistan have totally eliminated the prescription requirement for oral contraceptives.¹⁷⁹ So also most recently have Iraq and Iran, while Morocco now permits refills of oral contraceptive prescriptions.¹⁸⁰ In Chile the National Family Planning Commission recommended and the Ministry of Public Health approved a nation-wide program in which midwives will be permitted to assume new responsibilities including "the prescription ... of all or some of the reversible contraceptive methods presently in use."¹⁸¹ Most of the law changes, however, have been toward the removal of prescription requirements.

Perhaps there is no better way to summarize the thrust of this discussion on the prescription requirement than to quote from a statement issued by the IPPF Central Medical Committee two years ago:

The limitation of oral contraceptive distribution to doctor's prescription makes the method geographically, economically and sometimes culturally inaccessible to many women. As a consequence, deaths and sickness of women and children, which might otherwise be avoided by the voluntary limitation of fertility, continue. ... The Committee believes that whoever normally meets the health needs of the community, whether doctor, nurse,

traditional midwife, pharmacist or storekeeper, can be an appropriate person to distribute oral contraceptives.¹⁸²

2. Place-of-Sale Restrictions

Any restriction on the place-of-sale of non-clinical contraceptives (e.g., pills, condoms, foams and jellies) may be presumed to have a negative impact on the effectiveness of family planning personnel in promoting contraceptive use. But the impact is not limited to restrictions on sales or distribution by the personnel themselves. Since most users in the developing world are persons of modest means and mobility, they tend to purchase their needs for any commodity (e.g., food or medicine) by frequent, small purchases at shops very near their residences. Thus, any restrictions which reduce the accessibility of contraceptive outlets make much more difficult the task of motivating people to continue the use of contraception. Furthermore, the usual restrictions (e.g., sale-in-pharmacy only) have their greatest negative impact in the non-urban areas, where most reliance must be placed on the use of non-physician personnel for contraceptive distribution.

Because the issuance of oral contraceptives is usually subject to prescription, the point of commercial distribution is usually restricted to pharmacies. Yet, some countries restrict the commercial distribution of non-prescription contraceptives as well. The 1967 French legislation on contraception required that all sales of contraceptives take place "exclusively in pharmacies."¹⁸³ The impact of such restrictions on the use of physicians in family planning is, however, sometimes minimized by medical practice laws discussed earlier which authorize physicians to sell contraceptives.¹⁸⁴ Although the usual procedure is for a physician merely to prescribe the contraceptive and leave it to the patient to purchase it, a few countries specifically authorize doctors, under the aegis of drug regulations or health codes, to sell medicaments in special circumstances. In Costa Rica, for example, Article 1 of Executive Decree No. 14 of September 30, 1972 normally forbids the sale of pills from physicians' supplies. However, Article 28 of the Sanitary Code permits doctors "to make them available out of their medicine chests in areas where there is no pharmacy." The laws of Burundi, Tunisia and Zaire authorize doctors to sell pills where there is no pharmacy within 15 kilometers.¹⁸⁵

There are two very different approaches which may be taken toward reducing the obstacle of the sale-in-pharmacy requirement. The first is the direct approach of making exceptions for other kinds of public or commercial outlets to sell or distribute contraceptives. This approach is most feasible if the prescription requirement can first be eliminated or at least waived for refills, since commercial non-pharmacy outlets are not experienced in administering a prescription requirement. Government or privately operated clinics, however, are often authorized to sell on prescription a variety of medicaments, as part of a government's public health services.¹⁸⁶ In some cases authorization is extended to field health workers, permitting them to sell or distribute contraceptives without

prescription during their visits to clients' homes.

The second approach for reducing the obstacle of the sale-in-pharmacy requirement is indirect. It is to retain the requirement for commercial distribution of a contraceptive but, in effect, to waive the requirement for free distribution and to authorize government, private clinics, and certain non-physician health workers to undertake such distribution.

At times both approaches are used simultaneously. Typical examples are the following: First, in Chile contraceptives may be distributed at any location authorized by the National Health Service.¹⁸⁷ However, even when there are many distribution points, the effect on the use of non-physicians may be negated by the requirement of physician authorization or supervision. In Morocco, for example, although contraceptives can be obtained at health centers, hospitals and family planning organizations, a physician must authorize their issuance.¹⁸⁸ Second, in Chile, the Philippines and Korea certain paramedicals are authorized both to distribute the pill and to do so without a physician's authorization.¹⁸⁹ Third, in several other countries pilot projects are under way which utilize paramedicals to distribute contraceptives.¹⁹⁰ The assistance of the traditional birth attendants (kampung bidans) in Malaysia is being sought to increase pill acceptance. Since 1972 they have acted as motivators among their clients. Once the client agrees to practice family planning, she is directed to a health clinic where a nurse performs a screening examination. If the examination reveals that the woman can safely take the pill, the nurse issues her a one-month cycle of pills and coupons for six months' resupply.¹⁹¹ The resupply is undertaken by the kampung bidans. The legal aspects of change in contraceptive distribution in the Philippines are illustrative of a developing trend. In 1966 a law was passed that permitted the sale, dispensation and distribution of contraceptives, but only from a licensed pharmacy or drug company.¹⁹² (Prescriptions by physicians were required.) The law established a regulatory scheme similar to those existing in most countries to "regulate the indiscriminate dispensation of contraceptives, drugs and devices" which could pose a "serious threat to the health and safety of the individual unless under the close supervision of a qualified medical practitioner."¹⁹³ Then, a series of executive orders in 1969¹⁹⁴ and 1970¹⁹⁵ established the Population Commission to study the Philippine population situation and make recommendations. In 1971 the Congress gave the Commission a statutory basis and more carefully defined its functions.¹⁹⁶ But it was Presidential Decree No. 79 of 1972¹⁹⁷ which signalled the expansion of the roles of paramedical personnel in contraceptive distribution. Section 5 of the Decree empowered the Commission to employ the necessary number of physicians, nurses and midwives to "provide, dispense and administer" the various methods of contraception, with the caveat that paramedicals receive the proper training and licensing. All schools for the training of nurses, midwives and allied health personnel were instructed to "prepare, plan and implement the integration of family planning"¹⁹⁸ into their curricula and make such skills one of the prerequisites to be fulfilled prior to licensing. As a result of the new provisions nurses and midwives are being trained and authorized to distribute pills. The Commission has

just recently established a Paramedic Certifying Board to handle all "accreditation-certification activities" relating to the training of nurses and midwives.¹⁹⁹ Originally, it was unclear whether these personnel could act to fill the prescription requirement. In theory, a prescription still was required and the sale had to be made in a pharmacy.²⁰⁰

Insofar as tension existed between Republic Act No. 4729 and Presidential Decree No. 179 it appears to have been resolved by a Department of Justice ruling in June 1975. Issued in reply to a letter from the Population Center Foundation, Inc., the Department recently ruled that the 1966 "prescription requirement" law had been repealed by the Decree and that the sale of contraceptives could be made through other commercial distribution channels, besides pharmacies and pharmaceutical companies.²⁰¹

The rationale for limiting distribution outlets for any contraceptive is closely related to the presence or absence of a prescription requirement. If the need for such a requirement can be disproved and the requirement eliminated, then there is less justification for controlling the number and nature of the distribution outlets. Curiously, however, some of the countries that have eliminated the prescription requirement have kept the one on pharmacy sales.²⁰² This inconsistency needs to be given attention.

3. Insertion of IUDs

To a degree the insertion of IUDs involves different issues than are involved in the mere prescription or distribution of the pill. IUDs cannot be self-administered. Their insertion involves a medical intervention not required for the distribution of other contraceptives. This entails a different set of skills and a different type of knowledge than need be acquired for prescribing the pill or giving an injection. Surprisingly few laws or regulations exist which are framed specifically to regulate IUD insertions. The typical pattern is to assume that an IUD insertion is a medical procedure which falls solely within the authority of a physician as a matter of traditional medical practice. Thus, no specific regulations are thought to be required. This pattern fails to give attention to the question of where insertions may take place.

The amendments to the Eugenic Protection Law in Japan codify the notion that to insert an IUD is to practice medicine by stating that "the act of inserting a contraceptive device in the cavity of the uterus shall not be performed by any person other than a physician."²⁰³ The recently revised Hungarian regulations restrict the practice of insertion solely to trained gynecologists.²⁰⁴

France is one of the few countries with a detailed law on the subject of IUD insertion. Among the provisions of the 1967 law was the following:

Intra-uterine contraceptives may be inserted by a physician only in a hospital establishment, an approved

treatment center, or in conformity with conditions to be determined by public administrative regulations.²⁰⁵

Initially then, IUD insertions were restricted to public or private hospitals with gynecological or maternity departments or a genetic counselling service. The burden was placed on the institution to demonstrate that it had the necessary equipment. But under later regulations physicians were given authority to perform insertions outside of the hospital setting, in clinics or surgeries, if they received approval to do so from the local medical inspector.²⁰⁶

There is a growing trend, principally in the developing world, though not restricted to it, toward authorizing non-physician personnel to perform IUD insertions. The South Korean Maternal and Child Health Law, No. 2514 of February 8, 1973 states in Section 7 that the

insertion of intra-uterine contraceptives shall be performed only by a physician or those who are designated by presidential decree.²⁰⁷

The Presidential Ordinance No. 6713 of 28 May 1973 indicates that the category of "designated" persons includes:

... licensed midwives or nurses who have been trained in such courses as prescribed by the Minister of Health and Social Affairs for more than two months²⁰⁸

Of course, midwives in Pakistan have been used to insert IUDs for nearly a decade. And IUDs were "the first contraceptive method introduced in China on a large scale."²⁰⁹ Most of the insertions there are done by trained nurses, midwives or "barefoot doctors," as described above in Part III. In addition, Chile, Mexico and the Philippines have recently authorized non-physician personnel to insert IUDs.²¹⁰ In the absence of contrary regulations, both nurses and physicians in Thailand insert IUDs.²¹¹

In Indonesia a full-fledged effort is being made to create a cadre of personnel known as "family health nurses," a type of auxiliary nurse-midwife. As early as 1972 the Ministry of Health in cooperation with the Family Planning Coordinating Board began training these personnel in general health care and family planning. IUD insertion is one of the skills to be taught to the family health nurses, and they will be trained to do insertions both in the patients' homes and in satellite clinics.²¹²

In the United States non-physician health personnel have been used to insert IUDs, despite the relatively high availability of obstetrician-gynecologists, as well as other categories of physicians. For the year 1973 it has been estimated that six percent of all insertions were done by "paramedical personnel."²¹³ These approximately 46,000 insertions were spread among all ten regions of the country, indicating that the

medical practice laws in most states were being interpreted in such a way as to permit non-physicians to perform IUD insertions. No data are available on the types of non-physicians who performed these 46,000 insertions, but it is presumed that the majority were nurses.²¹⁴

A survey of training programs for non-physicians in 1975 found that in no less than 27 countries there are one or more programs to train non-physicians to do IUD insertions.²¹⁵ We may infer that in these 27 countries the medical practice laws have been either interpreted to allow insertions by non-physicians or amended or overridden by other laws, regulations or government decrees that permit such insertions. Five of these 27 countries were mentioned before in this sub-section. There are another three countries (China, Pakistan and Mexico) not included among these 27 where it is known from other sources that non-physicians are permitted to do IUD insertions. Thus, the total is at least 30.

B. Regulation of Other Fertility-Related Services

Sterilization, abortion and menstrual regulation are all important means of fertility regulation whose availability is often directly affected by statute or administrative decree. Direct regulation of these fertility services often takes the form of specifying the types of health personnel who may provide the service and the type of facility where the service may be provided. Any regulation which specifies that only physicians may provide the service has an obvious and immediate impact on the use of non-physicians. Yet, by limiting the number of sites where the service may be obtained or by making it geographically inaccessible to those who would normally seek it, the availability of the service is also restricted.

Aside from the People's Republic of China, we are not aware of a single nation which, as a matter of national policy, has authorized non-physician personnel to perform either abortions or sterilizations.²¹⁶ However, there are the odd pilot projects here and there which have trained health and auxiliary personnel to do these medical procedures, and surely there are vast numbers of these personnel that perform the procedures illegally, particularly abortions.

1. Sterilization

In their 1974 review of the world's laws concerning voluntary sterilization Stepan and Kellogg define two categories of laws: non-restrictive and restrictive. Even the non-restrictive laws usually contain three kinds of limitations relating to: (1) ensuring that consent is full and mature (e.g., age limits and waiting periods); (2) safeguarding the spouse's interest; and (3) ensuring quality of medical treatment.²¹⁷ Stepan and Kellogg conclude that these limitations "do not seriously restrict the right of couples to family planning, provided the age requirement is not too high."²¹⁸ One of these limitations, however, effectively eliminates the possibility of using non-physicians to perform sterilizations. Those limitations whose aim it is to ensure quality of medical treatment usually

specify that a physician must perform the sterilization. In many instances the choice of location for the operation is also restricted. If a country has relatively few physicians who are trained to perform sterilization and/or only a few hospitals and clinics where the sterilization can be done, these limitations pose serious barriers to making this type of family planning service available.

Among the four non-restrictive laws cited by Stepan and Kellogg, three require a physician. The fourth, the English law, simply permits voluntary vasectomy services and authorizes local health authorities, with the approval of the Secretary of State, to "make arrangements ... for treatment of voluntary vasectomy."²¹⁹ Presumably, however, in England and many other countries the laws regulating the health professions would be interpreted by "local health authorities" to require that physicians perform sterilizations. To this extent the existence of such a physician requirement in a law on sterilization is somewhat redundant. It is significant for our purposes, however, that non-physicians are nearly universally precluded from performing sterilizations, male or female.

As with IUD insertions, any limitation on the choice of locations for performing the service has no effect on the use of non-physicians, if some other law prohibits them from performing the service altogether. Yet, one must take such limitations into consideration in designing a strategy for expanded use of non-physicians. There appear to be a handful of countries where non-physicians have been trained and are permitted to do sterilizations. Iran reportedly has "no laws which would affect voluntary sterilization directly or indirectly."²²⁰ There, the Iranian Family Planning Post Partum Programme trains behairs (midwives), who have had three years prior midwifery training, to perform female sterilizations.²²¹ In Malaysia, the Penal Code has been interpreted to allow sterilization only for medical reasons. But the relevant sections of the Code make no reference to the type of personnel who may perform the sterilization.²²² It has been reported that male non-physician health workers in Malaysia are being taught to do vasectomies.²²³ In Indonesia there is no civil or criminal law on sterilization, and "Moslem religious courts do not seem to have jurisdiction over the subject when sterilizations are practiced on therapeutic grounds."²²⁴

Mantri (indigenous medical practitioners) presently are being trained to do vasectomies.²²⁵ Trained female health auxiliary workers have been used in rural Bangladesh on a pilot project basis to perform tubectomies.²²⁶

2. Abortion

Many of the national laws on abortion fail to mention the types of personnel who may perform the service. Of the ones that are specific, the most commonly used language reserves to "doctors," "physicians" or "medical practitioners" the right to perform abortions. For our purposes, even those abortion laws which may be considered liberal take, nevertheless, a highly restrictive approach as to the types of personnel who are authorized to perform abortions and the setting in which the abortions are to take

place. Where no mention is made of the personnel or setting for the abortions, authorities must rely either on the interpretation of the medical practice act or government agency rules to identify personnel who may undertake abortions.²²⁷

a. Personnel Who May Perform Abortions

Five of the six most populous countries in the world now permit legal abortion, at least in early pregnancy, for a wide variety of reasons, *i.e.*, physical, mental, social and economic. The laws of these countries vary, however, in the approach toward the use of non-physicians for the performance of abortions. In China, for example, "early abortions are usually performed by nurses and, in the communes, by trained barefoot doctors or midwives."²²⁸ Yet, in India any abortion must be performed by a "registered medical practitioner."²²⁹ Similarly, in the United States, the states have been permitted by the Supreme Court to "proscribe any abortion by a person who is not a physician"²³⁰ In the U.S.S.R. the Decree of November 23, 1955 grants the Minister of Health the discretion to define the type of personnel who may perform abortions and limits the personnel to "doctors" and other persons with "special qualifications."²³¹ Whether persons with "special qualifications" would include non-physicians is problematic. A WHO study indicates that in practice abortions are being done only by physicians.²³²

The Japanese abortion law extends the privilege of performing legal abortions only to physicians "designated by the Medical Association, which is a body corporate established in the prefectural district"²³³

A 1975 world survey of family planning training programs reported that three countries--Bangladesh, New Zealand and Tunisia--have programs which train non-physicians to perform "uterine aspiration."²³⁴ On the one hand, in Bangladesh²³⁵ and New Zealand²³⁶ laws still prohibit abortion except to save the life or health of the woman. Yet, the laws are not widely enforced.²³⁷ This should cause one to query whether such desuetude facilitates experimentation with non-physician personnel. On the other hand, Tunisia has a liberal abortion law. Although the Tunisian abortion law is very liberal with regard to the grounds for a legal abortion, it expressly requires that abortions be performed "by a qualified physician."²³⁸ Thus, the existence of an abortion training program for non-physicians in Tunisia is somewhat surprising.

Not one of the 22 countries that liberalized their abortion laws between 1972 and 1975 has authorized properly trained non-physicians to do abortions.²³⁹ On the contrary, most did just the opposite. For example, under the 1973 revision of the Danish abortion law, a non-physician who performs an abortion is subject to imprisonment for up to four years.²⁴⁰ The 1973 abortion law for the Northern Territory of Australia limits abortions done on the most liberal grounds to abortions performed by gynecologists or obstetricians. Other legal abortions must be performed by a "medical practitioner."²⁴¹

The 1974 Austrian abortion law requires that a physician perform the abortion, except

where the abortion is performed to save the pregnant woman from an immediate danger to her life, which would not otherwise be averted under circumstances where medical aid was not available in time.²⁴²

The Austrian law also provides heavier penalties for non-physicians than for physicians who have performed illegal abortions. The 1974 amendments to the Bulgarian abortion law limit the performance of an abortion-on-request (permitted before 10 weeks of gestation) to gynecologists and obstetricians.²⁴³

b. Facilities Offering Abortion Services

As examples of the types of regulatory schemes in force, we begin again with a review of laws in the world's most populous countries. In China it has been reported that:

Early abortion is done mainly in the basic health units (that is: in the communes, at the production team health stations; in the cities, at the street and lane health stations; and in the factories, at the health stations). Some early abortions and all late abortions are performed in bigger hospitals.²⁴⁴

India's law limits abortions to government hospitals or "other places" approved by the government.²⁴⁵ New regulations have clarified the process by which such "other places" can be licensed to perform abortions.²⁴⁶ Certification Boards were supposed to have been created to license other facilities, usually private clinics, to do abortions. Yet, in most states these Boards have either not been constituted or have not performed this function.²⁴⁷ Under the new regulations the Chief Medical Officer of each District is authorized to license non-governmental institutions to perform abortions.²⁴⁸

In the United States, the Supreme Court in Doe v. Bolton²⁴⁹ struck down a state law which required that all abortions be done in private accredited hospitals. The Court ruled that a state law that limited the site at which physicians could perform abortions during the first trimester of pregnancy was unconstitutional. For abortions after the first trimester, however, some restrictions as to the type of facility at which the service would be provided would be permissible, insofar as they are reasonably related to protecting maternal health.²⁵⁰ As a result, early abortions are performed on an outpatient basis and in non-hospital facilities in many States.

In the U.S.S.R., "abortions may be performed only in hospitals and other medical institutions, in accordance with instructions issued by the

Ministry of Health," and "the minimum period of hospitalization is three days."²⁵¹ The Eugenic Protection Law of 1948 and amendments to it are the basis of the easy availability of abortion in Japan. Although the law is very detailed with regard to the legal grounds for abortions, collection of statistics relating to abortions and the creation of "Eugenic Protection Offices" to advise persons about abortion and contraception, the law does not limit the places where physicians may perform abortions.²⁵² As a result, a large portion of all abortions are done in doctors' offices.

The approach of many of the 22 countries that recently have liberalized their abortion laws is to give the Ministry of Health or some other regulatory agency broad discretion in defining what facilities may offer abortion-related services. This is done either by stipulating explicitly that the agency will have the authority or by failing to make any specific reference to the matter. In the second instance whether a facility is appropriate for abortion services would be determined in the same manner as the determination is made for other medical procedures--i.e., by a combination of factors including customary practice of the medical profession and existing government regulatory procedures for medical facilities in general.

Where a law specifically notes that abortions may be performed in "hospitals," it is not uncommon to find language which authorizes abortions to be performed in other settings also. Examples of this approach are: Britain: "private day-care abortion centers;"²⁵³ Czechoslovakia: "a maternity home, if the proper conditions are satisfied;"²⁵⁴ Denmark: "a clinic (ambulatorium) attached to the hospital;"²⁵⁵ East Germany: "State clinic;"²⁵⁶ West Germany: "an establishment in which the necessary medical after-care is assured;"²⁵⁷ Hungary: "maternity institutions" and "clinics" that provide in-patient care;²⁵⁸ Singapore: "an approved institution;"²⁵⁹ Sweden: "a clinic approved by the State Directorate for Health and Welfare;"²⁶⁰ Tunisia: (1st trimester) "health establishment or an authorized clinic: and (2nd and 3rd trimester) "in an establishment approved for that purpose;"²⁶¹ United States: (described above in this subsection, p. 39).

The laws of many other countries stipulate that abortions may be performed only in a hospital, a requirement which necessarily restricts the availability of the service. Australia (Northern Territory), Bulgaria and France are frequently cited examples.²⁶²

c. Committee Approval Requirements

In addition to restrictions placed on the types of personnel who may perform abortions and where the service may be performed, abortion laws and regulations sometimes specify that, in addition to the person performing the abortion, one or more physicians or medical specialists must be consulted and must agree that certain grounds for the abortion exist. These may be called "committee approval" requirements. They pose a potential barrier to the expanded role of non-physicians in this area. This requirement inhibits the use of non-physicians in the same manner as

does the requirement that abortions be performed only in hospitals. Both requirements make abortions even more difficult for rural than for urban populations, since rural populations have much less access to physicians and hospitals.

3. Menstrual Regulation

Two of the present writers²⁶³ have examined the legal status of menstrual regulation. There are no laws which specifically regulate the performing of menstrual regulation procedures. Whether menstrual regulation is subject to legal constraints depends on whether it comes within the definition of abortion in a given statute. There is ample evidence that where the burden of proof placed on the prosecutor in an abortion trial includes proof of a pre-existing pregnancy, menstrual regulation is neither within the legal definition of abortion nor likely to be prosecuted, because of the difficulty of acquiring proof of pregnancy at the very early point in a pregnancy (if any) when the procedure is performed.²⁶⁴

Under other statutory schemes, where menstrual regulation is used for the express purpose of interrupting a suspected pregnancy, the person performing the procedure is violating the law. Where it is performed for other reasons, no violation occurs.²⁶⁵ Yet, this legal judgment may not provide a sufficient basis to expand the role of non-physicians in this field. Unfortunately, doubt about the applicability of the abortion laws tends to raise questions about the use of non-physicians.

To the extent that abortion laws and regulations are inapplicable to menstrual regulation in a given country, no specific limitations of that nature exist which would inhibit the use of non-physicians. Other regulations and customary medical practice may also inhibit or prevent the use of non-physicians. The medical practice acts discussed above are examples of the types of strictures which exist. Accordingly, medical experts involved in family planning have called for legislation or regulations which would clarify the authority of non-physicians to do menstrual regulation and establish the types of training they should receive.²⁶⁶ Similar efforts should be made in other areas of family planning services in order to protect the patients as well as the health personnel.

VI. EXPANDED ROLES FOR NON-PHYSICIANS IN FAMILY PLANNING

A. An Overview: Restrictive vs. Innovative Approaches

There is considerable variation among nations in the use of non-physician health personnel in family planning. Some of this variation corresponds to variation in statutory law. When two or more countries have essentially the same relevant statutory law, however, there still may be differences among them in regulations promulgated under the authority granted and guidelines provided by these laws. Moreover, even when the laws and regulations may be essentially the same for several countries, the use of non-physicians may vary because of variation in the regulations promulgated by associations of health professionals and by health institutions or because of variation among physicians and administrators in their personal preferences.

Some analysts suggest that the choice of roles for non-physicians in family planning, as well as general health care, requires a trade-off between quality and quantity of health care. The medical profession has generally appeared to be concerned with quality more than quantity. When it objects to certain proposals for expanding the use of paramedicals, the rationale is a concern that the quality of care provided to some hypothetical patient by the paramedical will be unacceptably lower than that provided by a physician. But the trade-off is not really between quality and quantity if one insists that the unit of analysis should always be the total population and not a hypothetical patient who is assumed to have a choice between being served by a physician and a non-physician. As discussed in previous sections, the majority of the world's population does not have such a choice because of their poverty and scarcity of physicians. Viewed thus, the choice of roles for non-physicians is less a trade-off between quality and quantity of health care than a simple determination of the number of people who should receive the minimally acceptable quantity and quality of care. For a given level of funding of a family planning program, the alternative role definitions may be further described as follows:

1. Liberal Definition of Roles

This approach seeks to provide family planning supplies and services to the largest possible portion of the population at a minimally acceptable standard so that, for the population as a whole, the human right to free and responsible choice of family size is more fully realized.

2. Restrictive Definition of Roles

The second approach seeks to maintain the highest quality of family planning services even at the cost of reaching only a small portion of the population. Thus, the remainder of the population may be denied the right to family planning altogether--this, despite the fact that the quality of

such family planning services as IUD insertion and pill prescription provided by non-physician health personnel has been proven to be equal or superior to the quality provided by physicians, as discussed in Part II above.

Table I shows the range of opinion within the medical profession as to what categories of personnel should be allowed to perform what services. Even the "conservative" opinion appears to allow non-physicians a role in providing some services, such as the distribution of condoms and spermicides. To these may be added such obvious tasks as the dissemination of family planning information.

Table I: Range of Opinion within Medical Profession as to What Personnel Should Provide Certain Family Planning Services²⁶⁷

Service	Opinion About Who Should Provide Service		
	"Conservative"	"Middle of the Road"	"Liberal"
Female sterilization:			
Endoscopy	Gynaecologist	Gynaecologist	Gynaecologist
Laparotomy	Gynaecologist	Surgeon	Non-Specialist
Vasectomy	Urologist	General practitioner	Specially trained non-doctor health personnel
Abortion:			Specially trained non-doctor health personnel
Up to 12 weeks	Gynaecologist	General Practitioner	
Over 12 weeks	Gynaecologist	Gynaecologist	Gynaecologist
Prescription or distribution of oral contraceptives	General practitioner	Nurse or Midwife	Any available channel of distribution
IUD Insertion	Gynaecologist	General Practitioner	Specially trained non-doctor health personnel
Distribution of condoms and spermicides	Explicitly non-doctor	Doctor has a role in distribution	All and every appropriate channel

On the other end, the "liberal" view would permit non-physicians to insert IUDs, distribute pills or even perform vasectomies and early abortions. Some family planning physicians believe that non-physicians should also be trained to do some kinds of female sterilization operations.²⁶⁸

The question remains as to the strategies for achieving the types of liberal approach discussed above. Based on the material in Parts IV and V above, the following strategies may be explored: (1) utilizing non-physicians in the absence of enforcement of existing laws, (2) interpreting the law in a way which favors paramedical use, (3) delegating family planning duties under the supervision of a physician, and (4) granting authorization for non-physicians to provide various family planning services.

B. Utilizing Non-Physicians in the Absence of Enforcement of Restrictive Laws

As we have seen, many laws require that oral contraceptives be prescribed by physicians and sold only in pharmacies or other authorized outlets. Comparative studies have shown, however, large-scale noncompliance with the laws and the absence of enforcement. This situation occurs often during periods of policy change: the laws have not caught up with new government policies. An official in Nicaragua is quoted in a recent study as stating that:

With respect to contraceptives they continue to be a controlled product even though we don't pay much attention to them in view of the family planning program of the Government. It would not be logical for us to be so strict when the Ministry of Public Health is itself promoting family planning.²⁶⁹

The dilemmas arising out of such circumstances are not insubstantial. As the authors of the same study point out:

While the regulations have very little regulatory value, they do put the distributors in an uncomfortable position, in that they are technically breaking the law through following practices which have the de facto approval of the Ministry.²⁷⁰

Such violation of the requirements of the law is not restricted to the developing world. For example, the Family Planning Association in the United Kingdom announced in 1974 that it was permitting at least one third of its trained nurses to examine patients and prescribe the pill (a function reserved by law to the physicians).²⁷¹

It may be argued that continuance of this state of affairs is not unwelcomed since the goal of achieving wider access to the means of family planning is partially, if not suitably, achieved. Indeed, those with experience in Latin America have argued that, given the cultural and religious

milieu, no other course of action is possible. There, many family planning programs function illegally, but the Government tolerates them.

Experience seems to indicate, however, that this approach is not desirable. It has the disadvantage of creating considerable confusion. This can affect attempts to utilize paramedicals more fully in the delivery of family planning services, for there is no certainty that they will escape some sort of punishment. Also, since noncompliance breeds contempt for the law, it is in the Government's self-interest to reform the law. The argument for retaining obsolete laws because they are not observed may also be faulted on the ground that such laws can inhibit Governments from taking active roles in family planning programs. Can a Government afford the criticism that it is violating its own laws? In this regard the De Marchi case²⁷² is instructive. The decision of the Italian Constitutional Court in 1971 declared as unconstitutional a Fascist-originated law prohibiting the dissemination of birth control information. The decision not only enabled the Italian people to practice family planning legally, but also caused the Ministry of Health to instruct all public gynecological clinics to provide family planning services!

At best the non-enforcement-of-law approach is a preliminary step in bringing about a properly structured legal reform. The law may often not be changed without a demonstration that a practice is safe. But if the practice is illegal, a violation of the law may be necessary to demonstrate the safety of such practice. By temporarily ignoring the law, practice precedes law, ultimately forcing some change.

One of the ways to avoid the threat of enforcement, while at the same time creating precedent for legal change, is to develop programs which utilize non-physicians on a pilot project basis with the approval of the Ministry of Health. Experience has proved the usefulness of this approach.

C. Reinterpretation of the Existing Law

This approach is quintessentially a legal exercise. The technique can be used to advantage where there is some confusion as to what the law means, there are two or more provisions which seem to contradict one another or there is an absence of clear law on the subject.

The technique has been used to bring about a change in the law in other areas affecting family planning. For example, closely interpreting the statute on mutilation, the Secretary of Justice in the Philippines ruled that voluntary sterilizations could be made available without violating the law. Prior to that ruling, considerable confusion existed as to whether voluntary sterilizations were legal in the Philippines. The language of the statute indicates why. According to the Penal Code, it was a crime to "intentionally mutilate another by depriving him, either totally or partially, of some essential organ for reproduction."²⁷³ In order to interpret the statute in such a way as to avoid imposing a criminal sanction on the more effective method of family planning, the Secretary of

Justice reached back into Spanish law for a definition of mutilation, which was the lopping or clipping off of some part of the body. Since vasectomy and tubal ligations do not involve the actual removal of organs, he ruled that such surgical interventions did not fall within the prohibition in that statute.²⁷⁴ It is interesting to note that this legal opinion is responsible for making the Philippines today a showcase of success in voluntary sterilization!

The principal barrier to the use of this reinterpretation technique in the paramedical context is that the laws on nursing and midwifery are usually all too clear on what these personnel may or may not do. The listing of duties is clear and exhaustive. There is little room for reinterpretation.

There are, however, two instances where this approach may be feasible. One is where laws on medical practice have not caught up with new technologies, hence ambiguous. The insertion of IUDs provides an excellent example. The ambiguity of regulations concerning IUD insertions, or the total lack thereof, have led to the acceptance of the practice of insertion by non-physicians in a few countries.²⁷⁵ The other instance is derived from the situation created by laws and regulations which require that paramedicals in providing health care act on instruction from and under the supervision of a physician. These types of provisions could be read as authorizing physicians to delegate many family planning tasks.

D. Delegation by Physicians

This approach does not suffer from the same pitfalls associated with straining for the gnats of interpretation or the uncertainty of ignoring the law when its enforcement is lax. The doctrine of "custom and usage" has firmly established delegation as a prerogative of a physician. There are limits though. For example, the physician must maintain some sort of supervision over the personnel to whom he has granted expanded roles. But this is an area in which there is legitimate leeway, as experience in the United States has shown.²⁷⁶

Thus, a physician may be able to delegate to paramedicals, after appropriate training, the duties of screening patients for pill prescription, performing examinations and IUD insertions, and, in the absence of clear prohibitions, even the performing of sterilizations, abortions and menstrual regulation. Delegation in the latter areas should, however, be undertaken with some caution. The vital principle in this whole area of law is that the physician must ensure that those performing family planning tasks under his supervision are suitably trained.

There are some functions which by law physicians may not totally delegate. Examples are the actual prescribing of medicaments. One approach, however, is for a physician to issue signed prescription forms in bulk to paramedicals to give to the consumer after screening or after he has issued standing orders for distribution to certain patients. This approach may be

blocked, however, if regulations: (1) require that injections, for example, be administered in the "presence" of a physician; (2) forbid a physician to delegate any function which is inherent in the full practice of medicine; (3) forbid paramedicals to use instruments associated with the practice of gynecology.

An example relating to IUD insertions will serve to explain another legal obstacle to delegation. In California a number of nurses were trained to insert IUDs. Studies had indicated that they could competently do the insertions after adequate training. Yet, of the cadre that was trained only a few began to do insertions. The others were restrained because, among other reasons, of the unsettled legal questions having to do with their vulnerability to malpractice suits. To the extent that legal questions remain unresolved by use of the delegation approach, an argument may be made for more comprehensive legal reform.

Another limitation of this approach is that it depends on the willingness of a physician. Only a few physicians may wish to use the approach, thus still limiting public access to family planning services. On the other hand, the approach does afford to those physicians who are active in family planning programs a method for increasing the coverage of their services without risking the dangers of trying to promote an outright change in the law (e.g., forcing a Government which does not favor family planning to restrict those services).

All things considered, in the absence of a total overhaul of the law relating to the utilization of paramedicals, the delegation alternative appears both useful and attractive.

E. Outright Granting of Authority

If there is one defect common to all three of the previously mentioned strategies, it is that they, in varying degrees, play charades with the law. They do not directly confront the problem and usually produce only very limited and uneven progress, although as we have pointed out, in some instances there is no other choice. Their attack on the legal constraints is piecemeal, and too much is left uncertain.²⁷⁷ The problem must be addressed more comprehensively. In this regard, one approach is to issue regulations that explicitly empower non-physicians to provide specified family planning services. In framing the regulations, thought must be given to the following considerations: (1) special exemptions from sections of medical practice laws; (2) criteria for selecting candidates for training; (3) the specialized nature of the training programs; (4) licensure and registration requirements; (5) specificity as to which tasks the non-physicians may undertake, keeping in mind the nonspecific alternative of licensing health care organizations (rather than individuals) to train and employ non-physicians as they deem appropriate; (6) grants of authority; and (7) medical back-up or referral system.

It is not essential that all of these components be covered in one

document, although that has its advantages. The usual procedure calls for the issuance of a regulation authorizing the training of paramedicals, leaving the details to further regulation under the aegis of the Ministry of Health. Another approach is to amend the medical practice statutes, but that is more time consuming. Fortunately, in most countries these types of regulatory measures are left to the discretion of the Ministry of Health. Some very specific and restrictive statutes will, however, have to be amended before paramedicals can be given wider authority, *i.e.*, midwifery laws which specifically state what midwives may and may not do in an all-inclusive fashion. Whatever the approach, it is of utmost importance that the new regulations strike down the existing barriers and eliminate the heretofore frustrating ambiguities.

Experience in Chile suggests one desirable approach. In the early 1970s a group of physicians interested in family planning used the concept of non-physician participation in the distribution of family planning services as a way of getting government approval for a pilot project in Concepcion, Chile,²⁷⁸ aimed at training professional midwives to handle all sorts of contraception. Their efforts included persuading the local school of midwifery to train midwives to provide contraceptive services, including the insertion of IUDs. In 1974, after this pilot project was clearly a success, the physicians approached the Ministry of Public Health with well-developed arguments (of the type set out in Part II above) for granting to all Chilean midwives (after training) the authority to provide these services. About that time the National Family Planning Commission also recommended that midwives provide these services. The Commission had considered the following persuasive arguments: (1) Chilean women wished to avoid unwanted pregnancies; (2) 70 percent of Chilean women accepted the concept of family planning; (3) because of the limited number of physicians, the demand for services could not be met; and (4) programs in other countries which utilized non-physician personnel had met with success. In October 1974, the Ministry of Public Health formally authorized midwives to undertake the handling of all types of contraception and established the institutional and training guidelines for such a program.²⁷⁹ The decision of the Ministry effectively repealed the provisions of a 1968 regulation which authorized midwives to give instruction only about the rhythm method. Since the Chilean regulation is one of the more complete legal documents available on the subject, it has been included in Appendix I.

The key issues in legal action to expand the roles of non-physicians in family planning may be recapitulated as follows:

Authorization: The authorization granted to non-physician personnel should be direct and should relate to the specific type of activities the personnel are to undertake. Authorization of those personnel who have already qualified as health workers (midwife, nurse, auxiliary) should be made contingent on two conditions: (1) that a certified course of training be completed and (2) that some sort of qualifying examination be passed. Those who are presently in training will receive the necessary

courses and examinations as part of their training. Other types of non-physician personnel, such as those used in community-based distribution programs, should also be considered as being capable of qualifying for authorization, once appropriate training has been completed.

At a more general level, authorization must include repeal of contrary provisions of the law and/or exemption of personnel from the restrictive features of other related laws.

Training: The training of non-physician personnel to provide family planning services is the most fundamental issue. As in the case of the Chilean regulations, this should include specific types of knowledge and specific experience with procedures. It is necessary to provide them with the skills both to perform procedures independently and to recognize situations in which they must seek the help of others, e.g., by referring cases to physicians. Both physicians and non-physicians who have personal experience in direct provision of family planning services must be involved in formulating the training requirements. The training may vary from a simple one-week course on distribution of the pill to a more lengthy course of several months.

Qualification: This requirement is designed to ensure that the quality of knowledge and performance of the personnel meet acceptable standards. It relates directly to the type of training given to them. Both training and qualification requirements should be given some institutional setting within which to work.

Supervision and Referral: It is advisable that some sort of supervision of non-physician personnel be maintained. The type of supervision may, of course, vary according to circumstances and the methods of family planning undertaken. For example, it is reasonable to assume that supervision given to non-physicians performing abortions or sterilization will be closer and more controlling than that given to non-physicians who distribute pills. A referral or back-up system to handle complications which the non-physician is not trained to deal with is another aspect of supervision. Whereas training and qualification procedures discussed above are necessary to ensure adequate performance by personnel when they first undertake new responsibilities, supervision is equally necessary to ensure that this level of performance is maintained.

VII. CONCLUSIONS

In the past five years a growing number of international symposia and organizations, both public and private, and national governments, have been advocating that laws relating to population growth and movement be analyzed and brought into conformity with the human right to practice family planning. With regard to the role of non-physicians in family planning, governmental obligations imposed by human rights may be classified into three categories:

(a) Those broadening the individual's right of free choice in fertility matters, such as removing prescription and place of sale requirements for oral contraceptives and allowing trained paramedicals to insert IUDs, perform vasectomy, early abortion and menstrual regulation;

(b) Those giving the health professions a rational legal status, i.e., by defining the standards and functions of physicians and different categories of non-physicians in family planning and by setting the licensing procedures and requirements;

(c) Those requiring public resources to enable the individuals to regulate fertility, such as providing free contraceptives and family planning services, developing a comprehensive rural health system like that of the "barefoot doctors," and establishing paramedical training centers.

It may be observed that in terms of the costs involved, the first two types of governmental obligations would be easier to fulfill than the third, which requires reallocation of resources--a particularly difficult task if the resources are scant--as well as the mobilization of mass support.

The relative ease with which the first two types of government obligations can be fulfilled does not suggest, however, either that these are less important than the third or that, because of such ease, they have already been implemented. Only a few governments, for example, have so far removed the prescription or place-of-sale requirement for oral contraceptives, notwithstanding the overwhelming evidence pointing to the need for its removal. The above classification of governmental obligations imposed by human rights may serve the purpose of drawing the attention of Governments to the necessity of setting realistic priorities in their family planning programs in light of their resources as well as to the necessity of taking immediate actions toward the implementation of the family planning right.

A major obstacle to instituting a health reform program lies in the fact that in many countries governmental regulation of the medical profession has been entrusted or forfeited to the profession itself. Human nature being what it is, it would be unrealistic to expect that, barring the most enlightened and public-spirited leadership, the profession would wish to rock the boat which has assured its members monopoly and prosperity.

From their narrow perspective they are naturally inclined to a scale of value that prefers "perfect" safety for one individual to "reasonable" safety for a hundred. But can the public afford such a luxury, even assuming that "perfect" safety is attainable? Is it not time that the helm of the public healthship be restored to the public where it belongs? Is it not reasonable to assume that public health should take into account a "public" interest which may diverge from a strictly "medical" viewpoint? Could not a balanced policy be better formulated through a balanced body made up of physicians as well as non-physician, public-interest representatives? Should not each of the non-physician health professional groups be allowed a voice to determine what its members can and cannot do in the area of fertility regulation under the overall coordination of the Ministry of Public Health, rather than being dictated to by a physician-dominated and oriented medical association?

Lastly, should not the original rationale for health legislation under which physicians were given a near-dictatorial role be re-examined in light of population pressures and recent developments in fertility regulation? Should not the developing countries enact new laws and regulations that respond to their current needs, rather than retain old laws which were imposed by former colonial powers and which laws may not be relevant to the setting in these countries? This monograph seeks to provoke discussion of these questions.

As Dr. Halfdan Mahler, Director-General of WHO, remarks in an interview aptly titled "WHO Must Be the Family Planning Coordinator:"

Our specific task is to set up a health infrastructure which is not a bureaucratic concept but something which dynamically interacts with the most peripheral community Our work should not be hampered by any vested interest of the medical profession which still hangs as a cloud over many of the things we do.²⁸⁰

We may hope, and the record established to date is encouraging in this regard, that by expanding the role of non-physician health personnel a solution will be achieved for a problem which appears otherwise insoluble.

FOOTNOTES

1

Robbins, "Unmet Needs in Family Planning: A World Survey," 5 Family Planning Perspectives 232 (1973).

2

Peel and Potts, "The Sociology of Population Control," 7 Social Science and Medicine 179-84 (1973).

3

At the World Population Conference in Bucharest 135 nations recognized this basic right. The only dissenting view was taken by the Vatican. The human right to family planning services is discussed further in Part II, Section C infra.

4

The term "non-physician health personnel" is used in preference to other nomenclature to emphasize that all types of personnel involved in health care other than physicians are the object of attention in this paper. The commonly used term, "paramedicals," lacks precision in that it has been defined variously to mean "professional nurses and midwives and those with comparable education and professional status," thus excluding many other types of health workers. Hall, Bacon, Horwitz and Smallegan, Family Planning Manpower: Problems and Priorities 144 (CPC Working Paper No. 1) (Chapel Hill: Carolina Population Center, 1974). Other authors have used the term "paramedical" in relation to family planning services when referring to any or all of the following: medical or physician's assistants, auxiliary midwives, nurse-midwives, licensed vocational nurses, lady family planning visitors, barefoot doctors, health auxiliaries, and even individuals with no previous medical experience. "What's in a Name?," World Health, vol. 25, June 1972, at 3; Ostergard, Broen and Marshall, "The Family Planning Specialist," 15 Clinical Obstetrics and Gynecology 370 (1972); Rosenfield, "Auxiliaries and Family Planning," 1974 The Lancet 443 (1974); Reasley, "The Nurse-Midwife as a Mediator of Contraception," 98 American Journal of Obstetrics and Gynecology 201 (1967); Rosenfield, "Family Planning: An Expanded Role for Paramedical Personnel," 110 American Journal of Obstetrics and Gynecology 1030 (1971); Kohl, Majzlin, Burnhill, Jones, Solish, Oshkent and Pendleton, "The Nurse-Midwife as a Family Planner," 62 American Journal of Public Health 1448 (1972); Ostergard and Broen, "The Insertion of Intrauterine Devices by Physicians and Paramedical Personnel," 42 Obstetrics and Gynecology 257 (1973); Jafarey, Harde and Satterthwaite, "Use of Medical-Paramedical Personnel and Traditional Midwives in the Pakistan Family Planning Program," 5 Demography 667-68 (1968); Chen, "China's Population Program at the Grass-Roots Level," 4 Studies in Family Planning 219, 223 (1973); World Health Organization,

Health Aspects of Family Planning, Technical Report Series No. 442, at 27 (1970); N. Fendall, "Family Planning and the Auxiliary," in Auxiliaries in Health Care: Programs in Developing Countries 88 (Baltimore: Johns Hopkins University, 1972); Ostergard, "The Potential for Paramedical Personnel in Family Planning," 64 American Journal of Public Health 27 (1974).

At the UN/UNFPA Symposium on Law and Population held in Tunis in June 1974, several participants expressed concern over the term, "paramedical," because it tends to downgrade the status of some recognized professions, such as nursing and midwifery, the practice of which is often governed by special legislation. See generally "Report of Workshop on Laws Relating to Paramedical Role in Contraception" in Symposium, 1974, note 5 infra at 246. The participants argued that this is due to the fact that the prefix, "para," usually connotes having an ancillary status or function. Ancillary, in turn, is defined as being of a subservient or subordinate status. The Concise Oxford Dictionary 43, 879 (5th ed. 1975). It has been pointed out that the types of medical personnel which fall into the paramedical category are neither subordinate nor subservient, and that they are essential to the success of any health services program. The World Health Organization takes the position that such terms as "assistant," "auxiliary," and "aide" are demeaning and should be avoided. WHO Technical Report Series, No. 212, at 3, 26 (1961). The term "paramedical" is nevertheless used in this paper interchangeably with "non-physician health personnel" for ease of reference. There is a legal basis for using the term. Some statutes governing medical practice explicitly use the word, "paramedical," when referring to some classes of non-physician personnel. Under the Indonesian law both nurses and midwives are deemed "paramedicals." Law No. 6, 1963, art. 2 (VI). See also Ministry of Health Instruction No. 33 of 1 July 1967, Věstník Ministerstva Zdravotnictví, No. 14, 20 September 1967, at 117-20; an English translation of the Instruction may be found in the International Digest of Health Legislation [hereinafter IDHL] 348 (1969) (Czechoslovakia). On the other hand, some laws use the term, "auxiliary" or "allied." Law No. 17132 of 24 January 1967, Boletín Oficial de la República Argentina, No. 21119, 31 January 1967, at 110; 20 IDHL 246 (1969); The Health Law, section 123, Al-Jardiah Al-Rasmiyah, vol. 12, no. 6, 18 February 1974, at 188-24; 26 IDHL 159, 161 (Libyan Arab Republic).

5

Shattock and Fendall, "The Role of the Paramedical in Voluntary Male Sterilization and Menstrual Regulation," in The Symposium on Law and Population, Tunis, 21-24 June 1974 at 149, 151 (New York: United Nations Fund for Population Activities, 1975) [hereinafter cited as Symposium, 1974]. Rosenfield, "Laws Regulating the Manufacture and Distribution of Contraceptives," in Id. at 96-101. J. Stepan and E. Kellogg, The World's Laws on Contraceptives, Law and Population Monograph Series No. 17 (Medford, Mass.: Law and Population Programme, Tufts University, 1973).

6

"Interview: Dr. Halfdan Mahler," People (IPPF Publication) vol. 1, no. 1, Oct. 1973, at 10-12. This is an echo of his predecessor, Dr. Candau, who also noted that "at the present rate of development, a major part of the developing world will not be able, in this century, to supply enough 'conventional' physicians for their barest needs. We need a new approach" Cited by R. Ten Have in Proceedings of the First National Family Planning Seminar 85 (Kuala Lumpur, Malaysia, June 1968).

7

See Appendix II.

8

Indeed, barriers of a cultural, political and medical nature may be the more significant. As Dr. Mahler has noted, one of the constraints on WHO's efforts in family planning is the "vested interests of the medical profession which still hangs as a cloud over many of the things we do." Note 6 supra at 12.

9

"Legal barriers," as used in this study, unless otherwise indicated, encompass restrictions on the use of non-physician personnel by constitutional and statutory law, administrative regulations and judicial decisions. In effect they are barriers created by all types of government rule-making that affect the activities of non-physician health personnel.

10

Resolution XVIII on Human Rights Aspects of Family Planning, U.N. Conference on Human Rights, Teheran, 1968, U.N. Doc. No. A/CONF. 32/41 (1968), para. 16, reprinted in 63 American Journal of International Law 678 (1969). G.A. Res. 2542, art. 22 (b), 24 U.N. GAOR, Supp. 30, at 49, 52, U.N. Doc. No. A/7630 (1969).

11

Hendrick, "Forms of Limited Practice under the Medical Practice Act," 26 University of Miami Law Review 805 (1972).

12

Derived from the German for field barber. We do not wish to overlook the historical role of the midwife but will confine the discussion here to other examples.

13

Fendall, "Forerunners," World Health, vol. 25, June 1972, at 4.

14

The feldsher practice in Poland is governed by special legislation. They may "examine, diagnose and treat" without supervision and also give injections and prescribe drugs as a physician would. Ordinance of February 1953, sections 2(1), 3, 5; Law No. 336 of 20 July 1950; 4 IDHL 574 (1953).

15

Fendall, note 13 supra.

16

R.L. Buell, 2 The Native Problem in Africa 36-37 (London: Frank Cass, 1965).

17

Decree of 14 January 1918, [1918] J.O.A.O.F. 56. From its creation until the school became part of the Institut des Hautes Etudes de Dakar in 1950, 514 medical assistants, 50 pharmacists and 481 midwives were trained. For a useful study of the legal aspects of health policy in Senegal see Snyder, "Health Policy and Law in Senegal," 11 Osgood Hall Law Journal 129-55 (1973).

18

Fendall, note 13 supra at 6.

19

The goal should not be to provide high quality, sophisticated service to a few, but adequate basic services to as many as is possible.

20

Some observers would argue that this is only part of the issue. The other premise is, they would opine, that many of the methods of family planning need not be distributed solely under the umbrella of the clinical setting. This applies to the developed and developing nations equally, whereas the physician shortage rationale is more applicable to just the latter. See generally, Atkinson, Castadot, Quadros and Rosenfield, "Oral Contraceptives: Considerations of Safety in Non-Clinical Distribution," 5 Studies in Family Planning 242 (1974); Speidel, Ravenholt and Perry, "Non-clinical Distribution of Oral Contraceptives," in S. Lewit, ed., Advances in Planned Parenthood 271 (1973).

21

Hendrick, note 11 supra at 821.

22

Collins v. Texas 223 U.S. 288 (1912), as cited in id. at 814.

23

Commonwealth v. Zimmerman 221 Mass. 184, 108 N.E. 893 (1915), as cited in Hendrick, note 11 supra at 815.

24

Pinkus v. MacMahon 129 N.J.L. 367, 29 A.2d 885 (Sup. Ct. 1943), as cited in Hendrick, note 11 supra at 815.

25

Hendrick, note 11 supra at 804-5.

26

Commonwealth v. Zimmerman, note 23 supra at 189, 108 N.E. at 895.

27

259 F. 2d 626 (5th Cir. 1958), rehearing denied, 263 F. 2d 661 (5th Cir.), certiorari denied, 359 U.S. 1012 (1959) [hereinafter cited as England], as cited in Hendrick, note 11 supra.

28

Hendrick, note 11 supra at 816.

29

England, note 27 supra, 263 F. 2d 661, 674 (5th Cir. 1959).

30

Id. (emphasis added).

31

Note 10 supra.

32

Id.

33

U.N. Doc. A/CONF.32/C.2/L.19 (1968) and 2nd Comm., 23 U.N. GAOR, U.N. Doc. A/CONF.32/C.2/SR.12, at 142 and 144 (1968).

34

Note 10 supra.

35

Lee, "Law, Human Rights and Population: A Strategy for Action," 12 Virginia Journal of International Law 309, 319 (1972). This was a background paper for the U.N. Second Asian Population Conference, 1-13 November 1972, in Tokyo.

36

Statement by Vincente Abad Santos, Secretary of Justice of the Philippines to Dean Irene Cortes of the University of the Philippines, College of Law, dated 16 March 1972, in support of the Law and Population Project. Cited in Lee and Paxman, "Pregnancy and Abortion in Adolescence: A Comparative Legal Survey and Proposals for Reform," 6 Columbia Human Rights Law Review 307, 310 (1974-75).

37

Id.

38

Para. 29(e).

39

Note 2 supra.

40

Shattock and Feudall, note 5 supra. See also, Potts, "Overview of Fertility Regulation Activities and Doctors' Responsibility," 5 Tropical Doctor 147-51 (1975).

41

Id.

(We are assuming the usual environment in which physicians are in short supply.)

42

Wortman, "Training Non-physicians in Family Planning Services," Population Reports, Series J, no. 6, September 1975.

On the use of paramedicals to do sterilization, see Chowdhury and Chowdhury, "Tubectomies by Paraprofessional Surgeons in Rural Bangladesh," 1975 Lancet 567-70 (1975).

43

Jafarey, Hardee and Sattenthwaite, note 4 supra at 666-67.

44

See generally, Faundes and Luukkainen, "Health and Family Planning Services in the Chinese People's Republic," 3 Studies in Family Planning, Supplement 166 (1972).

45

Ostergard and Broen, note 4 supra.

46

Kaul, "A Comparison of Field Performance of Medical vs. Paramedical Personnel in the IUD Programme in Mymesingh and Lahore," 3 Pakistan Journal of Family Planning 75 (1969).

47

Bang, Song and Choi, "Improving Access to the IUD: Experiments in Koyang, Korea," Studies in Family Planning, no. 27, March 1968, at 4.

48

Note 47 supra.

49

Chowdhury and Chowdhury, note 42 supra.

50

A copy of the checklist used in Thailand may be found in Rosenfield and Lemcharoen, "Auxiliary Midwife Prescription of Oral Contraceptives," 114 American Journal of Obstetrics and Gynecology 943 (1972). A recent study in a London clinic concerning the screening procedures used for most pill recipients concluded that:

The complex screening procedures still required in many countries for women requesting OCs are probably unnecessary and should certainly be re-evaluated.

Huber and Huber, "Screening Oral Contraceptive Candidates and Inconsequential Pelvic Examinations," 6 Studies in Family Planning 49, 51 (1975). The authors are of the opinion that the procedures can be simplified and carried out by non-physician personnel.

51

Rosenfield and Lemcharoen, note 50 supra at 942-43, 948.

The available literature tends to overlook the fact that in April 1968 the Ministry of Health in Sri Lanka "authorized trained field midwives to prescribe and supply pills outside the clinic, under medical supervision." Wright, "Sri Lanka: The Impact of Allowing Paramedical Prescription and Resupply of Oral Contraceptives," 6 Studies in Family Planning 102 (1975).

52

In Korea, paramedicals were authorized to distribute pills without the acceptor having to be first examined by a physician. Prior to 1972, however, the IUD program suffered because women were reluctant to see a doctor, since the vast majority of doctors were men. Yang, Chang and Worth, "The Republic of Korea's Efforts, Achievements and Problems in Family Planning," ECAFE Doc. No. POP/APC.2/IP/17 (1972), at 14. (This paper was presented at the Second Asian Population Conference, 1-13 November 1972, in Tokyo, Japan.) The following year the government authorized the training of nurses and midwives to do IUD insertions.

53

Rosenfield, note 4 supra at 444.

54

Ostergard and Broen, note 4 supra at 258.

55

Ostergard, note 4 supra at 27-31.

56

Huntingford, Introduction to Smith and Kane, The Pill Off Prescription 2 (London: Birth Control Trust, 1975). See, references in notes 20 and 50 supra.

57

Dr. Huntingford was one of the physicians who signed the letter in the Lancet, advocating that nurses and midwives be allowed to prescribe the pill. He now repents of having done so due to the fact that the proposal was too conservative. Id. See also, references in notes 20 and 50 supra.

58

Nortman, "Population and Family Planning Programs: A Factbook," Reports on Population/Family Planning, no. 2, October 1975, (7th ed.), at 54-56. (This is the seventh annual edition of this "Factbook.") For example, in Bangladesh a physician is paid the U.S. equivalent of 80¢ for each IUD insertion; the paramedicals are paid 40¢. In Korea physicians are paid the equivalent of \$1.05 for each IUD insertion; nurses and midwives get 42¢.

59

See discussion of the legal definition of the practice of medicine in Part IV infra.

60

See discussion of these legal restraints in Part IV infra.

61

Nortman, note 58 supra at 48-53. This "Factbook" compiles data obtained by questionnaires. Many countries, but less than all countries with family planning services, have supplied data for this annual publication. For 36 countries there are data on the number and types of personnel who are "specifically allocated to family planning services," either part-time or full-time. Some conclusions from these data are uncertain, because there is enormous variation among the 36 countries in the names assigned to non-physician personnel. In addition, definitions of these names or designations in terms of training and current duties are not provided. There are, for example, 14 personnel categories that include the word, "nurse," alone or along with one or more modifying words. Seven names include the word, "midwife." There are five other designations which appear to refer to relatively well-trained and clinically-oriented personnel. Eight designations appear to describe personnel who now do only education, motivation and information distribution (as opposed to providing fertility control supplies and services). Another 14 designations describe personnel who might be providing some fertility control supplies or services, but most appear to operate outside of clinic settings or at a lower skill level than the preceding categories. All the above, however, are non-physicians who appear to have direct contact with consumers and who now provide or could provide some family planning supplies and services as at least part of their jobs. Their total number for the 36 countries is about 197,000 or almost seven persons for every one physician listed in the same data (about 30,000 physicians). In addition, there are another about 10,000 personnel whose function is supervisory, administrative or clerical.

62

Hendrick, note 11 supra at 807-09.

63

Hendrick makes a similar distinction between "nonscientific healers" and operators of weight reducing spas, "qualified nutritionists," and "para-medical technicians." Hendrick, note 11 supra at 821-22.

64

Figure given by Ho Ch'eng, Deputy Minister of Health, in "Chung-hsi i t'u'an-chieh yu Chung-i te chin-hsin went'i" (United Chinese and Western-style Doctors and the Question of Improving Chinese-style Medicine), Jen Min Jih Pao (People's Daily), 13 June 1950. See also, Croizier, "Traditional Medicine as a Basis for Chinese Medical Practice," in R. Quinn, ed., Medicine and Public Health in the People's Republic of China 3 (Washington, D.C.: U.S. Department of Health, Education and Welfare, 1972).

65

These health workers are engaged primarily as agricultural workers (the "barefoot doctors"), production workers (the "worker doctors"), or housewives or retired people (the "Red Guard doctors"). They are not paid specifically for their medical work, but simply do not lose their work points (in the case of the "barefoot doctors") or salary (in the case of the "worker doctors") for time spent in health work. The length of their formal training varies from 3 months for "barefoot doctors," to 1 month and 10 days for "worker" and "Red Guard" doctors, respectively. See Sidel, "Medical Personnel and Their Training," in Quinn, note 64 supra at 157, 164-65.

66

Id. at 163.

67

Id. at 164.

68

Id. at 156.

69

Id. at 155.

70

Id. at 165.

71

Id. at 155. For Mao's statement that "Chinese medicine and pharmacology are a great treasure-house; efforts should be made to explore them and raise them to a higher level," see "China Creates Acupunctural Anesthesia," Peking Review, vol. 14, no. 33, 13 August 1971, at 7-11.

72

Croizier, note 64 supra at 9.

73

Congressional Research Service, Library of Congress, China's Experience in Population Control: The Elusive Model, 1974, 93d Congress, 2d Session (Committee Print 1974) (report prepared for the Committee on Foreign Affairs, U.S. House of Representatives), at 9.

74

The material on UNICEF activities in North China is based principally on L.T. Lee, China and International Agreements: A Study of Compliance 106-15 (Leiden: A.W. Sijthoff and Durham, N.C.: Rule of Law Press, 1961); Twenty Years of Nurse-Midwifery, 1933-1953, at 67-68, 70-71; (New York: Maternity Center Association, 1955); and communication from Isabel Hemingway, R.N., C.N.M., to L.T. Lee, dated 14 March 1975.

75

Li, "Politics and Health Care in China: The Barefoot Doctors," 27 Stanford Law Review 827 (1975).

For conditions in China prior to 1949, see J. Horn, Away with All Pests: An English Surgeon in People's China: 1954-1969 (1971); Bowers, "The History of Public Health in China to 1937," in M. Wegman, Tsung-yi Lin and F. Purcell, eds., Public Health in the People's Republic of China 26 (1973); Worth, "Health in Rural China: From Village to Commune," 77 American Journal of Hygiene 228 (1963).

76

Isabel Hemingway, "Demonstration of Tying the Cord," in a picture album entitled UNICEF-Tungchow 1949-50.

77

Hemingway, note 74 supra.

78

Chen, "Lessons from the Chinese Experience: China's Planned Birth Program and Its Transferability," 6 Studies in Family Planning 357 (1975).

79

Li, note 75 supra at 830.

80

Id. at 831.

81

Chen, Mao Papers: An Anthology and Bibliography 100 (London: Oxford University Press, 1970); Rifkin, "Health Care for Rural Areas," in Quinn, note 64 supra at 144.

82

See generally Li, note 75 supra at 836-38.

83

Faundes and Luukkainen, note 44 supra at 170. See also, Hall, Bacon, Horvitz and Smallegan, note 4 supra at 47.

84

Faundes and Luukkainen, note 44 supra at 173.

85

Li, note 75 supra at 837.

86

Chen, note 78 supra at 359-66.

87

This is referred to as "mandatory licensing." "Permissive licensing" statutes also exist. They only forbid unlicensed persons to use the title or abbreviation recognized in the law as the designation for licensed personnel. See Hershey, "The Inhibiting Effect upon Innovation of the Prevailing Licensure System," 166 Annals of the New York Academy of Sciences 951 (1969).

88

See, A.M. Sadler, B.L. Salder and A.A. Bliss, The Physician's Assistant: Today and Tomorrow 83-97 (New Haven: Yale University School of Medicine, 1972).

89

Id. at 83-84.

90

For example, in Dahomey, generally speaking, persons cannot practice midwifery unless they hold a state diploma, are citizens of Dahomey and are registered with the National Association of Midwives. Ordinance No. 73-38 of 21 April 1973, Journal Officiel de la République du Dahomey, no. 11, 1 June 1973, at 495-504; 25 IDHL 92-93 (1974).

91

The Health Law, section 123, Al-Jaridah Al-Rasmiyah, vol. 12, no. 6, 18 February 1974, at 188; 26 IDHL 159, 161 (Libyan Arab Republic).

92

Hershey, note 87 supra at 951.

93

We wish to acknowledge the usefulness of a paper prepared by Mary June for the Population Division of AID, titled "Law and the Paramedical in Family Planning" (22 March 1974, unpublished), in preparing this section.

94

Rules of Board of Medical Examiners, art. 1, section 3 (d), Official Gazette, vol. 64, no. 51, 16 December 1968, at 13167. These rules were promulgated under the authority granted by section 22 of the Medical Act, note 95 infra.

95

Philippines Annotated Laws, Administrative Code, section 770 (1958). Section 10 of the Medical Act adds to the list of duties falling within the purview of medical practice that of "physically examin[ing]" any person. The Lebanese law lists among the types of activities reserved to medical practitioners "any medical or surgical act on a human being" and "prescription or administration of a curative or preventative drug." Law of 26 October 1946, sections 1(2), (3), Bulletin de Législation Libanaise, no. 39, 15 September 1955, at 19-24.

96

Act for the Control of the Practice of the Art of Healing, No. 7, 1966, Royal Thai Government Gazette, vol. 83, 27 December 1966, at 573-75 20 IDHL 152-53 (1969). There is considerable ambiguity in this law. Those who practice midwifery are permitted inter alia to perform surgery, give injections of drugs and insert materials into the body for birth control. Taken at face value it would mean that midwives can insert IUDs. The medical practice law of 1968 contains the same statement, raising a question as to whether only licensed medical practitioners can do these things or whether midwives are also authorized to do so. Given the language of the law defining midwifery it would seem reasonable to interpret it as authorizing IUD insertions by practitioners of midwifery. Whether this includes midwives is problematic. Under this act one may be a "second class practitioner of the modern art of healing," if the applicant has undergone a course of training in obstetrics and has satisfied the requirements of the Commission. That would appear to cover midwives. Yet it has only been recently that they have been trained to do so.

97

Royal Thai Gazette, vol. 85, no. 22, 19 September 1968, at 565-74; 21 IDHL 403-05 (1970).

98

Id., section 21.

99

Recueil des Lois et de la Législation Financière de la République Arabe Syrienne, no. 3, March 1970, at 2-14; 23 IDHL 845 (1972). In order to qualify as a physician in Libya, one must hold a Bachelor's Degree in Medicine and Surgery from a recognized university. Note 19 supra, section 113.

100

Medical Practitioners Registration Proclamation, 1948, No. 100, art. 2.

101

1 Ghana Law Reports 197 (1962).

102

Cooper v. National Motor Bearing Co. 136 Cal. App. 2d 229, 238, 288 2d 581, 587 (1955).

103

Law No. 17132 of 24 January 1967, section 20 (22), Boletín Oficial de la República Argentina, no. 21119, 31 January 1967, at 1-10; 20 IDHL 246 (1969). Of the duties inherently reserved to physicians in Libya which affect family planning are giving medical advice, treating a patient, performing a surgical operation, prescribing medicaments and taking a specimen from the body of a patient. Note 19 supra, section 113. An exemption is granted to midwives to the extent that they must perform any of the above in the course of a pregnancy or delivery. Id., section 125.

104

Sanitary Code, section 24; 21 IDHL 140 (1970).

105

Ministry of Health, Instructions No. 23, Egészségügyi Közlöny, no. 17, 1 September 1973, at 410-11; 25 IDHL 330 (1974),

106

Decree No. 723 of 11 December 1967 (Sanitary Code), section 113, Diario Oficial, no. 26956, 31 January 1968, at 567-74; 20 IDHL, 47, 67 (1969).

107

Law. No. 66LF.7 of 10 June 1966, art. 17 (1); 18 IDHL 554 (1967).

108

Id.

109

Section 34, His Majesty's Government Gazette, no. 20, 20 September 1971, 26 IDHL 170-71 (1975).

110

Medical Practitioners and Dentists Act, Section 26.

111

Id.

112

Notice of 5 October 1970 of the Ayurvedic Medical Council, Ceylon Government Gazette, Part I, section I, 30 October 1970, at 689; 23 IDHL 435 (1972).

113

Id.

114

Ordinance No. 65 of 7 June 1962, The Gazette of Pakistan Extraordinary, 7 June 1962, at 918i-j; 16 IDHL 168 (1965). The provision under discussion here does, however, contain a clause regarding the issuance of prescriptions which would extend the right to prescribe to non-physician personnel "authorized in this behalf by the Government." This leaves open the possibility of granting paramedicals the authority to prescribe contraceptives. The point is largely moot, however, because Pakistan has eliminated the prescription requirement for pills. Ministry of Health Decree of 4 May 1973.

115

Part V, section 41 (b), N.R.C.D. 91 (1972).

116

In addition to those cited in the text, the following laws regulate the practice of nursing and midwifery: Federal Law No. 102 of 22 March 1961 (nursing), 13 IDHL 191 (1962) (Austria); Law 1233 of 1950, art. 4; Law 2343 of 1959 (midwifery and nursing); Executive Decree No. 2 of 27 April 1966 (training) (Costa Rica); Public Health Code, Book IV (midwives, nurses and auxiliaries) (France); Regulation No. 11 of 7 July 1962, 18 IDHL 736 (1967) (Iraq); The Nurses Act, 1950, as revised 1969, His Majesty's Government Gazette, no. 8, 9 April 1970 (nursing), 26 IDHL 163 (1975); The Midwives (Registration) Regulations, 1971, Serial No. P.U. (A) 161, His Majesty's Government Gazette, no. 10, 20 May 1971 (midwives), 26 IDHL 165 (1975) (Malaysia); Law No. 222 of 25 December 1878 and Decree No. 36 of 12 February 1879 (nursing and midwifery) (Netherlands); Nursing Act (Act No. 45 of 1944) as amended and Nursing Act (Act No. 69 of 1957) (nursing and midwifery), 10 IDHL 676 (1959) (South Africa); Law of 25 November 1944, sec. 34 and Order of 26 November 1945 (nursing and midwifery); Decree of 18 January 1957, as amended by Decree No. 446 of 28 February 1963 (midwifery training), 15 IDHL 169 (1964) (Spain); Decree of 12 December 1957, Chapter II (C) (nursing and midwifery) (Yugoslavia). In addition, laws on midwifery practice are known to exist in Colombia, Cyprus, Egypt, Fiji, Finland, Haiti, India, Israel, Italy, Japan, Kenya, Pakistan, Rhodesia, Somalia, Sweden, Syria, Uganda, the United Kingdom and the United States. See "Midwifery: A Survey of Recent Legislation," 5 IDHL 433 (1954). The above listing is not intended to be exhaustive. For a comparative treatment of laws on auxiliaries see "Auxiliary Personnel in Nursing: A Survey of Existing Legislation," 17 IDHL 197 (1966) and "Medical, Dental and Pharmaceutical Auxiliaries: A Survey of Existing Legislation," 19 IDHL 3 (1968).

117

Law No. 17132 of 24 January 1967, section 58, note 103 supra. A model law developed by the American Nurses' Association defines the practice of nursing as the: "observing, care and counsel of the ill, injured or infirm, or the maintenance of health or prevention of illness of others, or the supervision and teaching of other personnel, or the administration of medications in treatments as prescribed by a licensed physician or licensed dentist" 2 Report of the National Advisory Commission on Health Manpower 439 (Nov. 1967).

118

Id.,

119

Regulation of 20 June 1969, issued under sections 1 and 5 of the Law of November 1967, Journal Officiel du Grand-Duché de Luxembourg, Part A, no. 27, 21 June 1968, at 800-06; 20 IDHL 789, 791 (1969).

120

Id.

121

Republic Act No. 877, 19 June 1953, section 17(1).

122

Id., section 17(7).

123

Ministry of Health Instruction No. 33 of 1 July 1967 (rights and duties of paramedical and auxiliary health personnel) section 1(e), Věstník Ministerstva Zdravotnictví, No. 14, 20 September 1967, at 117-20; 20 IDHL 348 (1969).

124

Id., section 1(f), (g).

125

Nurses Regulations, 1971, Regulation 12(2), Fourth Schedule, L.I. 683.

126

In New Zealand an interesting provision in the Nursing Regulations, 1973, departs from the normal rule of having nurses work subordinately to physicians. While Regulation 2A permits a registered community nurse to practice obstetrical nursing, it must be done under the "supervision and control of a registered midwife." Serial No. 1973/245, 8 October 1973; 25 IDHL 404, 409 (1974).

127

Ordinance of 26 October 1973 of the Federal Minister of Health and Environmental Protection (The First Nursing Ordinance), Bundesgesetzblatt für

die Republik Österreich, no. 150, Serial No. 634, 20 December 1973, at 3783-94; 25 IDHL 286-90 (1974).

128

Id., 25 IDHL at 287.

129

Id. at 289

130

See Wortman, note 42 supra.

131

Midwifery Law of 18 June 1960, Republic Act No. 24, section 24. A midwife is defined in Western Australia as a person registered as a "midwifery nurse" under the Nurses Registration Act, section 3, Government Gazette of Western Australia, no. 38, 6 May 1968, at 1286-95; 21 IDHL 42 (1970).

132

Decree No. 725 of 11 December 1967, section 117, note 106 supra; 21 IDHL 47, 68 (1970).

133

Law on Midwives (1963), Notice No. 3 of the Federal Government of 12 November 1963, Bundesgesetzblatt für die Republik Österreich, no. 3, 16 January 1964, at 299-304; 16 IDHL 654 (1965).

134

Note 4 supra, section 125.

135

Nurses Registration Amendment Regulations, 1971, section 35(3), Serial No. 46 of 1971; 24 IDHL, 693 (1973).

136

Id., section 35(1).

137

Note 119 supra, section 13.

138

Id., section 15. The regulations issued under the Argentine law preclude a midwife from either inserting "pessaries" into the uterus or dilating the cervix, note 103 supra, Regulations to section 50, 20 IDHL 285-86 (1969).

139

Decree No. 50.387 of 28 March, 1961, section 16(f), Diário Oficial, no. 73, section I, Part I, 29 March 1961 at 3057-58; 13 IDHL 633 (1962).

140

Note 96 supra.

141

The Nurses' Registration Amendment Regulations, 1971, section 36, note 135 supra.

142

de Lourdes Verderese, Traditional Birth Attendant in Maternal and Child Health and Family Planning, Annex III (Remarks), at 83, WHO Doc. No. HMD/NUR/74.1 (1974).

143

Note 111 supra, section 41 (1). Similarly, a midwife in Luxembourg can give injections when they are prescribed by a physician. Note 96 supra, section 13.

144

Ordinance of 20 February 1964, Bulletin du Service Fédéral de l'Hygiène Publique, Supp. A, No. 2, 17 October 1964, at 33-38; 16 IDHL 781-82 (1965). The 1952 Ordinance relating to midwives forbade the use of any internal means having an effect on pregnancy. Ordinance of 12 June 1952, Bulletin du Service Fédéral de l'Hygiène Publique, section A-2, 23 August 1952, at 50-52; 5 IDHL 400-01 (1954).

145

Order of 25 July 1961, section 7(3), Hamburgisches Gesetzund Verordnungsblatt, Part I, No. 44, 8 August 1961, at 267-75; 14 IDHL 624 (1963). In the Canton of Vaud, however, pharmacists are instructed to dispense medicaments on prescriptions made out by midwives within their competence. It is unlikely that the regulation permits them to prescribe contraceptives. Law of 27 November 1973, Recueil des Lois, Décrets, Arrêtés et Autres Actes du Gouvernement du Canton de Vaud, Vol. 170-1973, at 372-73; 26 IDHL 221 (1975).

146

Decree No. 297 of 27 June 1967 (training of midwives), section 3, no. 31, Lovtidende, Part A, 11 July 1967, at 1007-09; 20 IDHL 757, 762 (1969). They receive 5 hours of family planning in the third year. Admittedly, that is not sufficient to instruct them in the nuances of performing family planning services.

147

Law No. 282 of 7 June 1972, Lovtidende, no. 28, Part A, 11 July 1972, at 547-48; 23 IDHL 700-01 (1972).

148

Ordinance No. 109 of 3 April 1975, section 6.

149

Nurses Registration Act, section 24, note 131 supra.

150

Decree No. 50.387, section 16(a), note 140 supra.

151

de Lourdes Verderese, note 142 supra, Annex III (2), at 82.

152

See generally, World Health Organization, The Midwife in Maternity Care, Technical Report Series No. 331 (1966) and Wortman, note 42 supra.

153

Section 16(5), [1972] N.R.C.D. 117.

154

Law No. 17132 of 24 January 1967, note 84 supra, section 60. For rather complete surveys of laws on auxiliaries see Auxiliary Personnel in Nursing: A Survey of Existing Legislation (Geneva: WHO, 1966) and Medical, Dental and Pharmaceutical Auxiliaries (Geneva: WHO, 1968).

155

Order of 15 February 1973, Boletín Oficial del Estado Gazeta de Madrid, no. 47, 23 February 1973, at 3573-74; 25 IDHL 173 (1974). In Spain a three-tiered structure of non-physician personnel exists: technical health aids (nurses and midwives); auxiliary professions (lab technicians, auxiliary nurses, etc.); and subordinate auxiliary professions (clinical assistants).

156

de Lourdes Verderese, note 142 supra, at 7.

157

Laws relating to midwifery normally forbid any person who has not received the required training, a diploma and registration from practicing midwifery. See, "Midwifery: A Survey of Current Legislation," 5 IDHL 433 (1954).

The WHO document cited in note 156 indicates that of the 64 countries surveyed, 38 (59%) did not have any legislation affecting traditional birth attendants. Id. at 16. In all likelihood those which stated that they have legislation were referring to their midwifery laws.

158

de Lourdes Verderese, note 142 supra at 10; one method used by the Yorubas of Nigeria is for the woman to take very salty water after intercourse. Some of the other methods appear to be abortifacient. For example, during early pregnancy, potash is added to lime juice and taken three times daily for three days. In some cases washing blue or local gin is added to the lime mixture. Suppositories fashioned from the leaves and seeds of certain local trees are also used. Olusanya, "Nigeria: Cultural Barriers to Family Planning among the Yorubas," Studies in Family Planning, no. 37, January 1969, at 13.

159

Wortman, note 42 supra.

160

Law No. 17132 of 24 January 1967, section 4, note 103 supra.

161

Emphasis supplied. Section 269 of the Costa Rican Penal Code also contains a provision pertaining to the illegality of the unauthorized practice of medicine, nursing or other medical or allied professions. Decree No. 4573 of 4 May 1970; 26 IDHL 61-62 (1975).

162

Law No. 14 of 28 April 1962, Diário Oficial, no. 30784, 5 May 1962, at 417-18; 14 IDHL 7-8 (1963). In some states in the United States the pattern has been for the courts to find paramedicals guilty of malpractice in cases where they have been found performing functions which they are capable of doing but for which they are not licensed or where the law governing their profession does not authorize them to do so. See, e.g., Barber v. Reinking, 411 P.2d 861 (1966). (An experienced licensed practical nurse was found guilty of malpractice for administering an injection.)

163

Medical Dental Decree, 1972, section 41(2).

164

Medical Practice Law, art. 13(1).

165

Id., art. 13(3).

166

Law No. 6, 1963 (health personnel).

167

Medical Practitioners and Dentists Act, section 25.

168

Paragraph 78(g) and (h).

169

Symposium on Law and Population: Text of Recommendations, Law and Population Monograph Series, No. 20, at 18 (Medford, Mass.: Law and Population Programme, Tufts University, 1974).

170

See generally, the following studies from the Law and Population Monograph Series (Medford, Mass.: Law and Population Programme, Tufts University): Stepan and Kellogg, The World's Laws on Contraceptives (1974); Stepan and Kellogg, The World's Laws on Voluntary Sterilization for Family Planning Purposes (1973); Lee and Paxman, Legal Aspects of Menstrual Regulation; Lee, Brief Survey of Abortion Laws of Five Largest Countries (1973); Lee, International Status of Abortion Legalization (1973); Lee and Paxman, Pregnancy and Abortion in Adolescence: Legal Aspects (1975).

171

Stepan and Kellogg, note 5 supra at 18.

172

See, for example, Regulation of Pharmaceutical Products, Decree No. 471 of 1971 and Decree No. 269 of 1972, 8 (Chile); Law No. 271/1949, section 5 and Regulation of 13 June 1966, No. 42/1966, section 32 (Czechoslovakia); Law 67-1176, section 3(2), (3) and Law 69-105, sections 1-3 (France); Drugs and Cosmetics Act of 1940, Schedule L (India); Pharmacy and Poisons Ordinance, art. 25 (2) (a) and Part I (Kenya); Medicines Act of 1967, sections 21, 32, 39, 44 and Ministry of Health Regulation, sections 26-27 (Thailand).

173

In addition to the Stepan and Kellogg study, one should also consult Laws Regulating Contraceptive Supply, Demand and Procurement, a recent study covering 140 countries, prepared for the International Contraceptive Study Project of the United Nations Fund for Population Activities by Luke T. Lee with the assistance of Jill Metcalf and Bernard Wolf (hereinafter cited as UNFPA Study). See also, Black, "Oral Contraceptives Prescription Requirements and Commercial Availability in 45 Developing Countries," 5 Studies in Family Planning, 252 (1974).

174

Stepan and Kellogg, note 5 supra at 18.

175

UNFPA Study, note 173 supra, Country Profiles.

176

This was the opinion of a group of IPPF personnel from Latin American countries at the Seminar on Law and Planned Parenthood convened in New York on 25 September 1974.

177

The possibility should not be ignored that where the requirement is not enforced, paramedicals may be distributing contraceptives on a large scale.

178

Rosenfield and Lemcharoen, note 50 supra at 943.

179

Dean and Piotrow, "Eighteen Months of Legal Change," Population Reports, Series E, no. 1, July 1974, at E-4.

180

Vumbaco, "Recent Law and Policy Changes in Fertility Control," Population Reports, Series E, no. 4, March 1976, at E-44.

181

Ministerio de Salud, Encargo de Funciones a la Professional Matrona para el Manejo de Algunos Métodos Anticonceptivos Actualmente en Uso, 2, section 1, 9 August 1974. For a translation of the recommendation and resolution see Appendix I below.

182

A text of the entire statement may be found in Stepan and Kellogg, note 5 supra, Appendix I, at 101.

183

Law No. 67-1176, section 3, paras. 2-3.

184

Poisons Ordinance No. 24/52, section 18 (Malaysia).

185

UNFPA Study, note 173 supra, Country Profiles. The controlling provision for Zaire is found in the Ordinance of 15 March 1933, sections 3, 9 and 10.

186

Ministry of Health and Social Welfare Regulation 34 of 1960.

187

Regulation of Pharmaceutical Products, Decree No. 471 of 1971 and Decree No. 269 of 1972, art. 8.

188

Royal Decree No. 181-66 of 21 July 1967, Bulletin Officiel, no. 2854 of 21 July 1967.

189

Dean and Piotrow, note 179 supra. There are two exceptions to the trend. Argentina has made it more difficult to get the pill: a prescription must be signed by three physicians. Presidential Decree No. 659 of 28 February 1974, reproduced in International Advisory Committee for Population and Law, note 220 infra at 34-35. In Hong Kong there is a move to put the pill on the Poisons List, thus making its sale subject to prescription. South China Morning Post, 30 May 1975, at 1, col. 1.

190

Not the least of these is a recently announced project under which nurses will be trained to prescribe pills and insert IUDs at King's College Hospital, London. The Times, 6 June 1975, at 3, col. 7. The press release accompanying the announcement said that the move should not "necessarily" be regarded as a pattern for the future role of nurses in the family planning clinic. The effect of the disclaimer is not all that impactful, however. It has been recognized that nurses under the supervision of doctors have for some time now been prescribing pills at the clinics, a practice which under law is technically illegal. IPPF Open File, 6 June 1975, at 1. In Australia a committee of the National Health and Medical Research Council has recommended that pharmacists be allowed to sell a wide range of drugs, including oral contraceptives, without a prescription. IPPF Open File, 10 June 1975, at 4.

191

"Midwives Carry Information, Supplies to Rural Malaysia," IEC Newsletter, no. 16, January 1974, at 1 (Honolulu: East-West Communications Institute).

192

This requirement is reinforced by the Pharmacy Law, Republic Act No. 5921 (1969).

193

Letter from Juan Ponce Enrile, Secretary of Justice to the Secretary of Health, dated 28 April 1969. A copy of the letter may be found in Law and Population in the Philippines, Law and Population Book Series No. 9, at 138 (Medford, Mass.: Law and Population Programme, Tufts University, 1974).

194

Order No. 174, 65 O.G. 2296 (1969).

195

Order No. 233, 66 O.G. 5187 (1970).

196

Republic Act No. 6365 (1971).

- 197
68 O.G. 9896 (1972); 24 IDHL 897 (1973).
- 198
Letter of Instruction No. 47, 8 December 1972, 68 O.G. 9885 (1972).
- 199
Note to one of the authors from Dr. Jose Catindig, dated 7 June 1976.
- 200
Stepan and Kellogg, note 5 supra at 62.
- 201
IPPF, "Report on Legal and Policy Aspects of Wider Distribution of Oral Contraceptives" (Draft), July 1975, at 9. It is unclear whether the ruling abolishes the prescription requirement which was part of the 1966 Act. The implication seems to be that it does. But Republic Act No. 5921 would still stand in the way, unless that provision was repealed as it relates to issuance of a prescription for oral contraceptives.
- 202
This appears to be the case in Fiji. 3 Population Dynamics Quarterly 18 (1975).
- 203
Law No. 156 of 13 July 1948, as amended, section 15 (1); 16 IDHL 690, 694 (1965).
- 204
Minister of Health Instruction No. 22, Egészegügyi Közlöny, no. 17, 1 September 1973, at 408-10; 25 IDHL 329 (1974). The same is true for Finland. See Turnpeinen, "Social Aspects of Family Planning in Finland," in Scheveningen Round Table, May 1966, at 16.
- 205
Law No. 67-1176, section 3(2).
- 206
Decree No. 72-180 of 7 March 1972, Journal Officiel, no. 57, 8 March 1972, at 2447 and no. 65, 17 March 1972, at 2805; 23 IDHL 32 (1972).
- 207
An English translation of the entire law may be found in 24 IDHL 98 (1973).
- 208
Id., at 902, section 2.
- 209
Faundes and Luukkainen, note 44 supra at 173.

210

Dean and Piotrow, note 179 supra. It is also known that paramedicals have been used to insert IUDs in Barbados, Nigeria, Senegal and the United States. Cummins and Vaillant, "The Training of the Nurse-Midwife for a National Program in Barbados Combining the IUD and Cervical Cytology," in B. Berelson, ed., Family Planning and Population Programs 451 (Chicago: University of Chicago Press, 1966); Hartfield, "The Role of the Nurse in a Family Planning Programme," 3 Contraception 105-14 (1971); Whest-Allegre, "The Case for Midwives and Paramedics in Africa," in J. Morehead, ed., Paramedical Personnel in Family Planning--A Creative Partnership 15 (Boston: The Pathfinder Fund, 1974); Ostergard, Broen and Marshall, note 4 supra.

211

UNFPA Study, note 173 supra, Country Profiles.

212

Masduki, "Family Planning in Indonesian Villages--An Experiment," IPPF Medical Bulletin, vol. 8, October 1974, at 3-4.

213

Kahn and Tyler, "IUD Insertion Practices in the United States and Puerto Rico, 1973," 7 Perspectives 210-12 (1975).

214

Potts, "Laws Regulating the Manufacture and Distribution of Contraceptives," in Symposium, 1974, note 5 supra at 88, 90.

215

Wortman, note 42 supra at J-94 and J-95.

216

See Part III supra.

217

Stepan and Kellogg, The World's Laws on Voluntary Sterilization for Family Planning Purposes, note 170 supra at 77.

218

Id.

219

Id., at 75.

220

International Advisory Committee on Population and Law, Annual Review of Population Law, 1974, Law and Population Monograph Series No. 30, at 19 (Medford, Mass.: Tufts University, 1975). [hereinafter cited as Annual Review, 1974].

221

Ghorbani, "Iranian Nurse-Midwives Train for Tubal Ligation," International Project of the Association for Voluntary Sterilization Newsletter, Fall, 1974, at 2.

222

Inference from portions of the Code (sections 87, 88 and 320) as quoted in a letter from Professor Ahmad Ibrahim, Acting Vice Chancellor, University of Malaya, Kuala Lumpur, dated 2 November 1972.

223

Wortman, note 42 supra at J-98.

224

Stepan and Kellogg, note 217 supra at 113 (Table 4 and footnote 39).

225

Wortman, note 42 supra at J-98.

226

Note 49 supra.

227

For example, in the United States the Church amendment to the Health Programs Extension Act of 1973 permits non-profit hospitals to refuse to allow both sterilizations and abortions within their facilities, regardless of the wishes of patients or individual physicians. "Private Hospitals May Not Be Compelled to Perform Sterilizations or Abortions Courts Hold," 4 Family Planning/Population Reporter 8 (1975).

228

Faundes and Luukkainen, note 44 supra at 165-76.

229

The Medical Termination of Pregnancy Bill of 1971, section 3(2), as cited in Lee, "Five Largest Countries Allow Legal Abortion on Broad Grounds," Population Reports, Series F, no. 1 (1973) at F-4.

230

Doe v. Bolton 410 U.S. 179; opinion is reproduced in part in Lee, note 229 supra at F-6.

231

World Health Organization, Abortion Laws 57 (Geneva: WHO, 1971).

232

Id.

233

Paragraph (1) of art. 14 of the Eugenic Protection Law of 1948, as amended, as cited in Lee, note 229 supra at F-7.

234

Wortman, note 42 supra at J-94-95.

235

Tietze and Murstein, "Induced Abortions: 1975 Factbook," Reports on Population/Family Planning, no. 14, December 1975, (2nd ed.).

236

World Health Organization, note 231 supra at 68.

237

Id. (New Zealand). Re Bangladesh see, Zimmerman, "Abortion Law and Practice -- A Status Report," Population Reports, Series E, no. 3, March 1976, at E-35.

238

Decree Law No. 73-2 of 26 September 1973 [English translation in 25 IDHL 184 (1974)], ratified by Law No. 73-57 of 19 November 1973. Journal Officiel de la République Tunisienne, 16-27 November 1973, at 1849.

239

See: Dean and Piotrow, note 179 supra; Vumbaco, note 180 supra; Zimmerman, note 237 supra; Annual Review, 1974, note 220 supra and the 1975 edition of same publication (in press).

240

Law No. 350 of 13 June 1973, Chapter 5, Lovtidende for Kongeriget Danmark, Part A, no. 32, 6 July 1973, at 993-95; 24 IDHL 773, 777 (1973) (English translation).

241

Criminal Law Consolidation Ordinance No. 2 (1973) (No. 6 of 1974), section 79A, Australian Legal Monthly Digest, July 1974, section 2763, at 23.

242

Federal law of 23 January 1974, BGB1. No. 60, section 97(1), para. 3; Annual Review, 1974, note 220 supra at 48 (English translation).

243

Amendments and addition to the Instruction No. 0-27 of the Ministry of Public Health, D'rzhaven Vestnik, no. 15, 22 February 1974, at 7-8; law on this point is paraphrased in Annual Review, 1974, note 220 supra at 50 (English translation).

244

Faundes and Luukkainen, note 44 supra at 173.

245

The Medical Termination of Pregnancy Bill of 1971, section 4, as reproduced in part in Lee, note 229 supra.

246

Cook, "Abortion Laws in Commonwealth Countries," IPPF Medical Bulletin, vol. 10, no. 2, April 1976, at 2, col. 2.

247

S. Grewd, "Medical Termination of Pregnancy—Its Status, Achievements, and Lacunae," Paper presented to WHO Workshop on implementation of pregnancy termination at district hospital and block levels, as quoted in Id.

248

Cook, note 246 supra.

249

410 U.S. 179.

250

Roe v. Wade 410 U.S. 113; opinion reproduced in part in Lee, note 229 supra at F-6.

251

World Health Organization, note 231 supra at 57-58.

252

Id., at 33-35.

253

Cook, note 246 supra at 1, col. 1.

254

Order No. 71, para. 12, of 16 May 1973 of the Ministry of Health of the Czech Socialist Republic to implement Law No. 68 of 1957 (Sbírka Zákonů, Československá Socialistická Republika, no. 20, 29 June 1973, at 207-13). 25 IDHL 71, 75 (1974) (English translation).

255

Note 240 supra at Chapter 3, section 10(1).

256

Law of 9 March 1972 (G.B.I., Part I, at 89); 23 IDHL 767 (1972) (English translation).

257

Fünftes Gesetz zur Reform des Strafrechts, 18 June 1974, BGBI I, at 1297; 25 IDHL 779 (1974) (English translation).

258

Instructions No. 33 of the Minister of Health for the Implementation of Ordinance No. 4 of 1 December 1973 of the Minister of Health (Egészségügyi Közlöny, 10 December 1973), Special issue, at 11-15; 25 IDHL 339 (1974) (English translation).

259

Abortion Act 1974 (Act No. 24 of 1974), section 3(2).

260

Statute on Abortion of 9 July 1974, section 5 SFS (Svensk Forfattningssamling) (1974), at 595; Annual Review, 1974, note 220 supra at 69 (English translation).

261

Note 238 supra.

262

Notes 241 (Australia) and 243 (Bulgaria) supra. Law No. 75-17 of 17 January 1975, title I, art. 2, Journal Officiel, 18 January 1975, at 739 (France). An English translation of French law is in Annual Review, 1974, note 220 supra at 58.

263

L. Lee and J. Paxman, Legal Aspects of Menstrual Regulation, Law and Population Monograph Series, No. 19 (Medford, Mass.: Law and Population Programme, Tufts University, 1974).

264

Id.

265

Id.

266

See, Shattock and Fendall, note 5 supra at 158-163.

267

Reproduced with small changes from Potts, "Public Health Legislation and Family Planning," Background paper for UNESCO meeting in Teaching Population in Law Schools, Paris, 18-22 February 1974, SCH/74/CONF 701/1 8 February 1974.

268

Another characteristic of the restrictive approach is to define the roles of non-physicians through a system of authorization (licensing, accreditation and certification) whereby any one non-physician is restricted to a very narrowly and specifically defined role and so that it is difficult to experiment with new roles or combinations of roles. It has been suggested by several experts on health manpower problems that the only effective long-run approach should allow for more flexibility and change in non-physician roles. One such approach would involve giving much greater discretion to medical organizations e.g., health care "teams," hospitals, government health care agencies and family planning programs, large group practices, etc. Licensing and certification of non-physician specialities would be eliminated or changed to give some of these medical organizations more freedom in the recruitment, training and deployment of manpower. The emphasis would shift from authorization of individuals to the authorization of organizations. Such organizations would be licensed or accredited to recruit, train and/or utilize non-physicians in a manner that the institutions find to be efficient and effective. This latter approach may be described as an innovative alternative. See: Hershey, note 87 supra at 954-55; Forgotson, Bradley, Ballenger, and December, "Health Services for the Poor--The Manpower Problem: Innovations and the Law," 3 Wisconsin Law Review 756, 781-83; and Roemer, "Legal Regulation of Health Manpower in the 1970's: Needs, Objectives, Options, Constraints, and their Trade-Offs," in H. Milt, ed., Health Manpower: Adapting in the Seventies 33, 42 (New York: National Health Council, 1971). The goals of this innovative approach may not be achieved, however, if the composition of the body that does the licensing or accrediting is not appropriate. Some authors have suggested the need for non-physician representation on such bodies, i.e., representation from other health personnel, non-physician health care administrators, and consumers. Sadler, Sadler, and Bliss, note 88 supra at 103-04. In turn, the health care organizations should themselves have an appropriate range of interests represented in their governing bodies.

269

de Bernard and Korten, Private and Commercial Distribution of Contraceptives in Nicaragua: A Preliminary Study 15 (Managua: Instituto Centro Americano de Administración de Empresas, 1973).

270

Id. at 16.

271

Allusion is made to the practice in The Times, 6 June 1975, at 3, col. 7.

272

Corte Costituzionale, Sentenza, no. 49, 16 March 1971.

273

Revised Penal Code, at 226.

274

Opinion No. 131, s. 1973 (17 September 1973). The opinion took into account one somewhat non-legal factor. This was the shift in government policy favoring family planning.

275

With regard to the IUD, an absence of restrictions on insertion may be found in Canada, Sri Lanka and Thailand, but in practice only physicians insert them. UNFPA Study, note 173 supra, Country Profiles.

276

In fact the delegation principal has been codified in several states. The Oklahoma statute reads: "nothing in this article shall be as construed as to prohibit ... service rendered by a physician's trained assistant, a registered nurse, or a licensed practical nurse, if such service be rendered under the direct supervision and control of a licensed physician ..." Oklahoma Statutes Annotated, title 59, section 492 (1971).

277

Such strategies may be effective interim measures which establish a "practice" upon which the regulation changes can be based. But even these sorts of conditions may be more effectively established through the use of authorized pilot projects.

278

The help in the preparation of this passage of Dr. Jorge Pena, who participated in the organization of the project, is gratefully acknowledged.

279

Ministry of Health Circular, no. 227 (A.2.1, No. 3) of 8 October 1968.

280

People, vol. 1, no. 1, October 1973, at 10.

APPENDIX I

Part A

Recommendation of the National Commission for Family Planning and Responsible Parenthood (Chile) Conferring on the Professional Midwife the Management Functions of Some of the Contraceptive Methods Presently in Use

1. Numerous surveys undertaken and published by the School of Health, CELADE, CELAP and others between 1958 and 1969 demonstrate that more than 70 percent of the Chilean women of a fertile age either support or participate in the programmes or activities of family planning or contraception.
2. The coverage of the family planning programmes of the Chilean health system has not succeeded in reaching systematically more than 20 percent of the fertile women.
3. The incidence of illegally induced abortion in Chile has decreased in the past few years. In the National Health Service the number of cases receiving treatment in hospitals due to abortion has decreased from 55,435 to 44,895 in 1969, a reduction of 19 percent in the rate. This notwithstanding, the rates continue at high levels. This would suggest that present family planning programmes are insufficient to take care of the demand for the prevention of unwanted pregnancies.
4. The new concept of the high obstetric risk linked to increased multiparity adds to the necessity of increasing the coverage of the family planning activities.
5. The National Health Service has recognised that it must take steps to meet the growing demand among fertile women for family planning services. This alternative cannot be brought about if the management of contraceptives is limited to physicians or surgeons, who are either specialised or interested in contraception, because their numbers are insufficient.
6. The Director General of Health and those specialists who advise him support the view that the fulfilment of this responsibility in health and family planning counsels the granting to the professional midwife the authority to handle contraceptive techniques under certain defined conditions.

7. Those contraceptive techniques mentioned above have been sufficiently systematised to support the view that the university obstetric training of the Chilean midwife, a professional medical collaborator, will enable her to obtain the skill required to handle contraceptives efficiently. In practice, this has been done in varying degrees throughout the country.

8. The English and American pilot experiences, and the widespread experiences in South Korea, Barbados, the People's Republic of China, Pakistan, Thailand and in some states of the United States, demonstrate that the handling of contraceptives and/or the insertion of intrauterine devices by professionals of the level of the Chilean midwife does not involve risks that are significantly different than when done by physicians.

9. When consulted by the Director General of Health, the College of Midwives responded positively in favour of performing these functions and solicited regulatory authorisation to do so. On the other hand, the Law Department of National Health Service advised that no legal impediments existed to this shift in policy.

In view of the antecedents set out above, the National Commission for Family Planning and Responsible Parenthood recommends that midwives be authorised to handle reversible contraceptives, under the conditions enunciated below:

1. Institutional Framework

The public institutions in the National Health Services system shall authorise midwives to prescribe and handle all or some of the reversible contraceptive methods presently in use.

2. Professional Qualification

The professional midwife shall be authorised once she has completed the following requirements:

2.1 Preliminary qualifying examination

2.2 Course of training and qualification which conforms in the norms which shall be dictated by the Ministry of Public Health with regard to the proposal of the National Commission for Family Planning and Responsible Parenthood.

3. Supervisor

The prescription and management of contraceptives by the professional midwife will be subject to the control and supervision of the doctor responsible for the family planning activities of in-

stitution or service.

4. Evaluation

The actions taken by the authorised professional midwife shall be appropriately recorded so as to undergo periodic evaluation.

5. Regulation

The Permanent Commission for Family Planning and Responsible Parenthood will elaborate the regulations which will govern the entrusting of these family planning activities to the professional midwife.

Santiago
9 August 1974

Part B

MINISTRY OF PUBLIC HEALTH RESOLUTION No. 9735

WHEREAS the health policy of the present government of the country gives importance to the fertility regulation activities within the Women's Health Care Programme;

Recourse to voluntary abortion continues to produce an important percentage of deaths;

A sustained decrease in the rate of neonatal mortality has not been achieved;

There are not sufficient quantities of gynecological specialists to satisfy the spontaneous growth in the demand for birth control, which could reduce these risks;

The technology and medical indications for the delivery of anovulators and the insertion of intrauterine devices has been simplified;

This General Directorate, by invoking the legal authority conferred on it by Law No. 10,383, dictates the following:

RESOLUTION

1. The birth control activities of the Women's Health Care Programme, in the urban as well as the rural areas of the diverse health regions and zones of the country, should receive the increased attention of its functionaries without impairing the other activities of the programme. The use of any type of contraceptive can be recommended by the professional functionary but the individual decision should be made in the absence of all pressures, and the coverage of the programmes has no other goal and limit but to provide for the free and informed decision of the population.
2. The midwives of the National Health Service who request it shall be authorised, by the Chief of the Maternal Programmes of the respective Health Areas or by the Chiefs of the Maternal Care Units of the class A hospitals of the National Health Service, to prescribe anovulators and/or insert intrauterine devices, once they have completed the qualifying requirements which prove them to be capable of performing those functions. The authorisation shall be forwarded by written decision to the Chiefs of the Basic Establishments of the respective Health Areas.
3. It shall be the responsibility of the Area Health Chief to ensure the training of those midwives who request it in the techniques and procedures for prescribing or inserting reversible contraceptives. The training shall be achieved through programmed courses and practice whose minimum requirements are described in the accompanying scheme (Annex 1),

whether they be dictated by the National Health Service, or the universities of the Chilean Association for Protection of the Family previously accredited by either the General, Regional or Zone Headquarters of the National Health Service. The courses will formally certify the demonstrated competence of the graduating alumnae according to the requirements of the scheme in Annex 1.

4. The responsibility for the delegation or entrusting of the management of these reversible contraceptives to midwives rests upon the Chiefs of the Maternal Care Units of the appropriate establishments.

The Chief of the Maternal Health Programme of the respective Health Area shall systematically supervise and evaluate, including auditing, the effectiveness and performance of the midwife in this activity. He shall especially oversee the completion of the registers which will permit the systematic evaluation of this delegation.

5. The delegation of the management of these contraceptives to the midwife shall be considered transitory until scientific evaluation demonstrates the effectiveness of the delegation.

6. The provisions contained in Circular A.2.1. No. 3 of 8 October 1968 and Resolution No. 7121 of 22 October 1968 in which "The Basic Norms on Birth Control of the National Health Service" were reviewed are revoked, as are any others which would limit the maximum coverage of the fertility regulation activities of the Women's Health Care Programmes or which would impede or limit the delegation to the midwife in the National Health Services of the functions of prescribing anovulatorys and/or inserting intrauterine devices, except to the extent that they refer to the completion of the qualifying requirements contained in this resolution.

7. Those midwives who prior to this date have been trained in the handling of reversible contraceptives and who desire to obtain the authorisation of the National Health Service to exercise these skills should request it within six months of this date. The Director General will decide the procedure to be followed once the requests have been received.

Dr. Darwin Arriagada Loyola
Director General of Health
Santiago
21 October 1974

ANNEX 1

Minimum Qualifying Requirements for Midwives to Prescribe and Insert Contraceptives

Midwives shall be authorised to prescribe contraceptives and insert or remove IUDs when they have shown:

1. The capability to dismiss the possibility of pathologic adnexal inflammation by referring to past and present medical history (repetitive abortions, pelvic pain and fever, etc.)
2. The capability to diagnose normal and/or abnormal uterine positions and by vaginal examination:
 - anteversoflexion
 - retroversion
 - indifferent position
3. The practice of hysteroscopy (measurement of the uterine cavity) in 20 or more patients;
4. The taking of cytological samples - 5 or more cytologies;
5. The taking of vaginal discharge for leucorrhoea - 5 or more samples;
6. The insertion of 20 IUDs under direct supervision after having completed the requirements set out in 2, 3 and 4.
7. Knowledge:
 - 7.1 of the working mechanisms of the contraceptives
 - 7.2 their effectiveness and efficiency
 - 7.3 their indications
 - 7.4 their contra-indications
 - 7.5 their secondary effects
 - 7.6 their absolute and relative indications, by medical reference
 - 7.7 their registration and follow-up
 - 7.8 of the following contra-indications
 - 7.8.1 IUD insertion if there are antecedents of pathologic inflammation
 - 7.8.2 IUD insertion when the patient relates a history of hypermenorrhoea and/or menorrhagia
 - 7.8.3 IUD when the patient relates a previous cesarean section
 - 7.8.4 IUD insertion when unsure of the position of the uterus
 - 7.8.5 IUD insertion when the hysteroscopy is difficult

APPENDIX II

This appendix is designed to provide the reader with a brief overview of the countries which have had experience with the use of paramedicals in the delivery of fertility services. Doubtless there are others, but the countries contained in this appendix are those for which documentation of the practice exists. It should be noted that not all of the profiles will display a legal element relating to the paramedical practice. Indeed, in some of these countries the paramedical involvement runs counter to the legal norms controlling family planning methods. This may occur for either of two reasons: (1) the use of paramedicals has been undertaken as an experimental pilot project; or (2) the authorities acquiesce in practice despite restrictive laws on the subject.

Profiles for the following countries appear here:

Barbados	Nicaragua
Bangladesh	Nigeria
Chile	Pakistan
People's Republic of China	The Philippines
Ghana	Senegal
Indonesia	Sri Lanka
Iran	Sweden
Jamaica	Tanzania
Kenya	Thailand
Republic of Korea (South)	Turkey
Malaysia	United Kingdom
Mexico	United States

In addition to the references found accompanying each profile, the following are useful sources for a number of countries:

Dean and Piotrow, "Eighteen Months of Legal Change," Population Reports, Series E, No. 1, July 1974.

Hall, Bacon, Horvitz and Smallajan, Family Planning Manpower: Problems and Priorities (CPC Working Paper No. 1) (Chapel Hill: Carolina Population Center, 1974).

Nortman, "Population and Family Planning Programs: A Factbook," Reports on Population/Family Planning, No. 2 (6th ed.) (1975). (Cited as "Nortman, 1975" in the text of the profiles).

Smith and Kane, The Pill off Prescription (London: Birth Control Trust, 1975).

Stepan and Kellogg, The World's Laws on Contraceptives (Law and Population Monograph Series No. 17, 1974).

Vumbaco, "Recent Law and Policy Changes in Fertility Control,"
Population Reports, Series E, No. 4 (1976).

BANGLADESH

The experience in Bangladesh with the use of paramedical personnel in the distribution of contraceptives is derived from the Pakistani program. Under that innovative program lady family planning visitors were trained to insert IUDs. The effects of the civil war (1971) which led to the creation of Bangladesh as an independent nation have been felt in the area of family planning. This, coupled with a deep-seeded suspicion as to Pakistan's motives for pushing family planning have created a malaise. Nevertheless, those trained LFPVs who are in Bangladesh continue to perform IUD insertions.

No prescription requirement exists for the pill.

There are presently 12,000 family welfare workers throughout the country who do family planning work as part of their job. They apparently distribute contraceptives. A government announcement in 1975 has strengthened the authorization for the use of such field workers in contraceptive distribution.

Trained female paramedical auxiliary workers have been used in rural Bangladesh on a pilot basis to perform tubectomies (female sterilization). In addition to acquiring a level of performance equal to that of doctors they are seen as a way of providing this service on a wider scale, at lower costs and in a way which bridges the gap between Western medicine and the villagers.

It has been reported (Nortman, 1975) that 500 paramedical personnel work in the family planning program.

References:

Anonymous, "Village Action in Bangladesh," People, vol. 3, no. 1, 1976 at 38.

Chowdhury and Chowdhury, "Tubectomies by Paraprofessional Surgeons in Rural Bangladesh," Lancet, No. 2, 1975.

Tubectomies by Paramedicals in Bangladesh," 9 IPPF Medical Bulletin 4 (1975).

Echols, "Bangladesh Moves into Population Control," 4 INTERCOM 1 (1976).

Franda, "Bangladesh: Perceptions of a Population Policy" in H. Brown, J. Holdern, A. Sweezy and B. West, eds., Population: Perspective 1973, 227-239 (1973).

BARBADOS

In 1964 the Family Planning Association of Barbados, a quasi-governmental agency, undertook one of the earliest experiments in the training of nurse-midwives for the purpose of inserting IUDs. In 1965 with the help of the Population Council, the program was combined with training for taking Papanicolaou smears.

Nurse-midwife teams were trained to operate the family planning clinics in the absence of a doctor.

The training of the nurse-midwife and her assistant was designed to take place over a two-month period with specific attention paid to aspects of surgery, antenatal examinations, loop insertions, gynecological clinics, Pap smears, didactic lectures and in-service experience.

While for a time it was not clear what roles non-physician personnel played in the distribution of orals the situation has now been clarified. At one point in early 1976 the pill was to come off prescription, but at the last moment a decision was taken to keep the requirement that women be screened by a doctor. However, once the medical certificate has been issued, distribution by any person who can read and understand the doctor's instructions is permissible under the law. That would include non-physician personnel.

References:

Cummins and Vaillant, "The Training of the Nurse-Midwife for a National Programme in Barbados Combining the IUCD and Cervical Cytology," in Berelson, ed., Family Planning and Population Programs 451-54 (Chicago: University of Chicago, 1965).

Cummins, "The Role of Paramedical Personnel," Proceedings of the Eighth International Conference of IPPF, Santiago, 9-15 April 1967, 199-203 (London: IPPF, 1967).

Letter to IPPF from the Family Planning Association of Barbados, dated 3 May 1976.

Slavin and Belsborrow, "The Barbados Family Planning Association and Fertility Decline in Barbados," 5 Studies in Family Planning 325-332 (1974).

CHILE

Until recently midwives were prohibited from prescribing pills and inserting IUDs. According to Ministry of Public Health Circular A.2.1. No. 3 of 8 October 1968, these functions were the sole province of a physician. However, midwives were permitted to perform the intermediate examinations - one every three months - on women who had IUDs and to give instructions on the use of the rhythm method.

From 1972 a significant number of midwives with special training were authorized to handle contraceptives, including insertion of IUDs, as a result of a program at the Universidad de Concepcion. This was followed in October of 1974 by a Ministry decision to train midwives to "prescribe and handle" the various modern methods for contraception, including the distribution of oral contraceptives and the insertion of IUDs. It has been reported (Nortman, 1975) that 588 midwives do family planning work.

It is interesting to note that even prior to the recent change, sources estimated that between 20-30 percent of the IUDs inserted at family planning clinics were done by midwives, and that these same personnel distribute contraceptives once they have completed special training in gynecology and insertion of IUDs.

References:

Interview with Dr. Guillermo Adriasola, Director, Department of Health Development, Ministry of Public Health and President of the Asociacion Chilena de Proteccion de la Familia, September 25, 1975.

Ministry of Public Health, "Encargo de Funciones a la Profesional Matrona para el Manejo de Algunos Medodos Anticonceptivos Actualmente in Uso" (9 August 1974).

Decision No. 09735 of the Ministry of Public Health, dated 21 October, 1974 (Annex 1 contains the minimum requirements for qualification).

PEOPLE'S REPUBLIC OF CHINA

Much attention has been focused on the health system of the People's Republic of China, and particularly on its family planning component. It is an example of mass-mobilization, the likes of which many other nations would like to emulate. Though much has been said of the "barefoot doctor," other organizational features of the system of family planning ought not to be overlooked, for there has been a conscious attempt to utilize in the most efficient way possible, the personnel involved. This would include college trained doctors, traditional doctors, feldshers, nurses, midwives and other auxiliary personnel.

Without a doubt, however, the most innovative concept is that of the "barefoot doctor." Selected from the rural setting and trained for 3 to 6 months, "barefoot doctors" serve principally as a task performing personnel at the "grass roots level." As far as family planning is concerned, they provide knowledge and means concerning contraception to the communities they serve. This they do with the help of other health aids and midwives. Yet their advance training prepares them to carry out such medical functions as pregnancy termination by suction, IUD insertion, tubal ligation and vasectomy.

While they may not be the last word in medical care, they have become one of the important links in the health system. One is likely to find a "barefoot doctor" dispensing family planning services in the "co-operative medical stations" in the communes, in factory clinics and neighborhood health centers. Estimates have it that there are between 2-3 million "barefoot doctors" at work. In the last decade alone, more than 1 million have been trained to attend to the basic health needs of the community. That represents at its best 1 for approximately 210 persons in the rural area.

References:

Chen, "China's Population Program at the Grass-Roots Level," 4 Studies in Family Planning 219 (1973).

Djerassi, "Fertility Limitation Through Contraceptive Steroids in the People's Republic of China," 5 Studies in Family Planning 13 (1974).

Faundes and Luukhainen, "Health and Family Planning Services in the Chinese People's Republic," 3 Studies in Family Planning 166, Supplement (1972).

Health Policies and Services in China, 1974 (a report prepared for the Sub-committee on Health of the Committees on Labor and Public Welfare, United States Senate, 93rd Congress, 2nd Session) (1974).

Kilin Medical University, An Instructional Manual for Retraining of Barefoot Doctors (Jen Min Publishing House, 1972).

J.R. Quinn, ed., Medicine and Public Health in the People's Republic of China (Washington D.C., Department of Health, Education and Welfare, 1972).

GHANA

The lists of tasks which nurses and midwives may perform and the regulations in force do not include such things as prescription of pills or insertion of IUDs. In fact, Section 67(2) of the Criminal Code provides a basis for reaching the conclusion that IUDs must be inserted by physicians only.

Despite these barriers at least one source indicates that paramedicals are used to perform all types of physician-like duties, except IUD insertions, as part of the family planning program. But at least 10 midwives have passed the government sponsored course which authorizes them to operate and manage Planned Parenthood Association clinics with a minimum of medical supervision. The tasks they may perform include prescribing the pill, insertion and removal of IUDs and fitting diaphragms. A community based distribution project is also underway in which other non-physicians play a role.

It has been reported (Nortman, 1975) that 75 nurses and 70 auxiliaries are specifically allocated to family planning services.

References:

Addo, "The Midwife in Family Planning in Ghana," 133 Nursing Mirror (1971).

Nortman, supra.

Planned Parenthood Association of Ghana, Annual Report (1974).

INDONESIA

Though in fact the law requires that a physician's prescription accompany the issuance of oral contraceptives, it is known that nurses and midwives participate directly in the distribution process.

Training programs have been underway since 1972 to train a special cadre of health personnel -- family health nurses -- among whose skills will be those associated with family planning. The instruction includes training in the distribution of all types of contraceptives, including the insertion of IUDs in the family home setting if necessary. Once trained they are able to function without direct supervision. They are also able to instruct other non-physician personnel in the technique of contraceptive distribution.

Some 4 million dollars were set aside for the construction of ten training schools in the provinces of Java and Bali capable of graduating 50 nurse-midwives and 490 auxiliary nurse-midwives annually. The training of the auxiliaries lasts two years and of nurse midwives four years.

For a number of years the "bidans" -- nurse-midwives in East Java and in Bali -- have been inserting IUDs. In addition, the role which the "dukans" -- the village midwife or traditional birth attendant -- can play in the delivery of contraceptive services has not been overlooked. This class of personnel is also receiving training in family planning methods.

It has been reported (Nortman, 1975) that 3,777 midwives and 2,857 assistant midwives are specifically allocated to family planning services.

References:

Keeny, "Eyewitness: Over the Green Mountains -- a Report from East Java," People (IPPF) vol. 1, no. 1, October 1973.

Masduki, "Family Planning in Indonesia Village -- An Experience," 8 IPPF Medical Bulletin 3-4 (October 1974).

Muncie, Doctors and Dukans, Puppets and Pills: A Look at Indonesia's Family Planning Programmes (Washington, D.C., World Bank Group, 1972).

Nortman, supra.

Zaidan and Muncie, "Indonesia: Launching a National Programme," 4 Studies in Family Planning 296-300 (1973).

IRAN

The Ministry of Health established training centres for rural midwives in 1968, and special training in family planning is given to other health personnel. Those who complete the course are appointed to serve in designated villages by the Ministry.

Oral contraceptives are available at a modest cost in the 2,050 government health clinics. Commercial distribution is limited to pharmacies, but a Ministry of Health directive in September 1974 authorized the sale of low-dose orals without prescription.

The IUD has never been as popular as the pill, with the ratio in the neighborhood of 20/1. One of the reasons for this may be the limited experience which doctors and midwives have had with insertions. At present there appears to be at least one legal barrier, in addition to medical practice laws, which could be read as a constraint on midwife practice in this area. Article 5 of the By-law on Midwives' Duties, forbids midwives from doing internal inspections during the first four months of pregnancy. Moreover, they have authority to act only in the areas specified in the By-laws. Insertion of IUDs is not mentioned.

As early as 1971 a UN Study recommended that more paramedical personnel, particularly midwives, be trained in the management of clinical contraception and that traditional births attendants be entrusted to carry out certain family planning functions on a pilot project basis.

In spite of specific legislation prohibiting the use of paramedical personnel to insert IUDs and prescribe oral pills, a model project under the combined sponsorship of the Ministry of Health and the Population Council in two districts of the Isafahan Province has been doing so for over two years. In 1974 with increased government funding the project was to be expanded. The project had doubled, partly due to the wider use of paramedicals, the proportion of men and women practicing family planning in that area.

It has been reported (Nortman, 1975) that 120 nurses and midwives and 2,400 "health corps women" work full time in providing family planning in combination with other health services.

References:

- Anonymous, "Special Report -- Law and Population," 2 Future 8-9 (1975).
- Friesen and Moore, "Iran," Country Profiles, October 1972 (New York: The Population Council).
- Nortman, supra.
- Personal communication from Robert W. Gillespie, The Population Council, dated June 30, 1974.

Population and Family Planning in Iran, UN Da ST/SOA/SFR.R/13,
pp. 75-79 (7 April 1971).

Rural Midwives Training Act, 1968.

Saney, Iranian Laws Affecting Population (1974) (mimeo, available
at the Law and Population Programme, Tufts University, Medford, Ma.)

JAMAICA

Jamaica is one of a growing number of countries that has eliminated the prescription requirement for oral contraceptives. The impact of this shift on the use of paramedical personnel for their distribution is not crystal clear, though it may be assumed that the withdrawal of the requirement will make it possible for them to distribute pills directly to the consumer at the clinic level.

In addition it is known that trained nurses and other personnel have been given instruction in the insertion of IUDs. This, however, was done as a pilot project basis and it is not known whether the practice is more widespread. Though it appears that there are no limitations imposed by the law.

It has been reported (Nortman, 1975) that the full-time equivalent of 62 public health and clinic nurses and 32 midwives are specifically allocated to family planning services.

References:

Nortman, supra.

Rosenfield and Asavasena, "Rural-oriented Maternity Services," 115 American Journal of Obstetrics and Gynecology 1013-1020 (1973).

KENYA

In October 1969 the Ministry of Health ruled that selected non-physician personnel should be allowed, after adequate training, to perform pelvic examinations and insert IUDs.

A paper presented by a Kenyan midwife in late 1973 describes how midwives attend to the health clinic duties while a health team rides the circuit in rural areas. Among the family planning duties listed in the paper which midwives regularly perform are: insertion of IUDs, prescription and issuance of orals, fitting diaphragms and supplying condoms. This, for example, is in contrast to the fact that the Pharmacy and Poisons Ordinance Article 25 requires that orals be issued on "prescription of a duly qualified medical practitioner," usually taken to mean by a physician.

References:

Fendall, Auxiliaries in Health Care 93 (Baltimore: Johns Hopkins Press 1972).

"Kenya," Country Profiles May 1971 at 7 (New York: The Population Council, 1971).

M'muthera, "Maternal and Child Care Services in a Rural Area," Report of the Anglophone East African Working Party (The International Confederation of Midwives, Nairobi, Kenya, 29 November - 8 December 1973).

REPUBLIC OF KOREA

Under the provisions of the Maternal and Child Health Care Law, Article 7, midwives, nurses and nurses' aides, who have undergone specialized training are authorized to "give general practical guidance on contraception." There is no prescription requirement for the pill, but if purchased they must come from a pharmacy. Yet, government clinics distribute them directly.

Article 7 of the law also provides that "physicians or those who are designated by a presidential decree" be allowed to insert IUDs. A subsequent Decree stated that "licensed midwives and nurses" fall within that class of personnel. In order to be certified for IUD insertion, however, they must undergo a course of training which lasts at least two months.

These shifts in the law were preceded by three factors: (1) a shortage of trained physicians, nurses and midwives providing contraceptive services; (2) a 1968 study indicating that there were no practical differences between IUD insertions done by physicians, by paramedicals who were supervised, and by paramedicals who were unsupervised; (3) a recommendation in the Report on the Population and Law Conference (1973) which urged the government to "eliminate legal inhibitions on access to contraceptive information, procedures and supplies."

It has been reported that the full-time equivalent of 1,100 nurses and 1,550 field workers are employed in the family planning program and that the "field workers recruit for all methods and distribute pills and condoms through mothers' clubs and door-to door." (Nortman, 1975)

References:

Maternal and Child Health Care Law, Law No. 2514 of 8 February 1973, Article 7.

Nortman, supra.

Presidential Decree No. 6713 of 28 May 1973, Article 2.

Yang, Bang, Song and Choi, "Improving Access to the IUD: Experiments in Koyang, Korea," 1 Studies in Family Planning 4 (1968).

MALAYSIA

Section 8.18 of Poisons Ordinance No. 29152 can be read to require that oral contraceptives be given only on prescription. However, the prescription in practice is not required. In fact, pills are widely distributed by nurses and midwives and sometimes even given out by lay people.

Since 1972 a program has been underway which utilizes the kampung bidans (traditional birth attendants) in recruiting and motivating family planning acceptors and resupplying pills. Initial screening of the client is given a one-month cycle of pills and six coupons for resupply. The latter may be given to the bidans in exchange for more cycles.

According to some sources IUDs are inserted only by physicians. But at least one paper presented in 1969 describes the use of nurses and midwives in the insertion of IUDs in Malaysia.

It has been reported (Nortman, 1975) that family planning program employs the following: 17 nursing sisters, 30 staff nurses, 88 trained assistant nurses, 131 family planning assistants, and 153 midwives. Some of the personnel also provide other health services.

References:

Hashnah, "The Role of the Nurse and Midwife in Family Planning Services," in Family Planning and National Development, Proceedings of IPPF Conferences Bandung, June 1969 (London: IPPF, 1969).

"Midwives Carry Information, Supplies to Rural Malaysia," IEC Newsletter, No. 16, January 1974, at 1 (Honolulu: East-West Center, 1974).

Nortman, supra.

Peng, Bakar and Marzuki, "Village Midwives in Malaysia," 3 Studies in Family Planning 25-27 (1972).

Rosenfield, "Family Planning: An Expanded Role for Paramedical Personnel," 110 American Journal of Obstetrics and Gynecology 1030-1039 (1971).

MEXICO

The general rule has it that oral contraceptives can be issued only on prescription and from a pharmacy or government clinic. This rule would normally prohibit paramedicals from playing a role in distribution. But in practice pills are available without a prescription. Experts from the Ministry of Health and Welfare have recently indicated that pilot projects will be entertained which enable paramedicals to give out contraceptives where physicians are in short supply. This appears to be in keeping with the recent overhaul of Mexican population policy.

Though the IUD has been classified as a medical apparatus which must be administered (inserted) by medical personnel with gynecological experience, this is not confined to physicians. Recent legislation has authorized that paramedicals be trained in IUD insertion. This the Ministry of Health and Welfare is presently doing.

At present injectables also need to be prescribed by a physician, though they may be administered by paramedicals under their supervision.

It has been reported (Nortman, 1975) that the full-time equivalent of 61 nurses, 123 auxiliary nurses, 61 field workers are employed in the government family planning program and the private family planning association (FEPAC).

References:

Codigo Sanitario (as amended 1973), 28 February 1973, Diario Oficial, March 13, 1973.

Cornejo, Keller, Lerner and Azuara, Ley y Poblacion en Mexico (Mexico City: Fundacion para Estudios de la Poblacion, A.C., 1974).

Nortman, supra.

NICARAGUA

During the last quarter of 1975, the FPA in Nicaragua utilized 31 midwives as distributors of various methods of family planning, including pills, condoms and spermicides. They were able to recruit 2,440 new acceptors during the three month period.

In addition AID has granted funds to assist the Nicaraguan Government in running 78 family planning clinics. As part of the program some 700 midwives will be trained during 1976 in courses of 4-6 days to distribute pills and condoms.

In early 1976 the nurses in charge of the paramedical work in the 6 clinics run by the FPA were to receive the training necessary for insertion of IUDs so that other paramedicals in the clinics could be trained also.

It has been reported (Nortman, 1975) that the full time equivalent of 36 nurses, 34 auxiliary nurses and 18 health workers are specifically allocated to family planning services.

References:

IPPF/WHR Field Trip Report, 4-7 February 1976.

IPPF/WHR Field Trip Report, 6-7 November 1975.

NIGERIA

Between the years 1966-70 registered nurses at the Wesley Guild Hospital in Ileshaland were trained to insert IUDs by working alongside physicians. During that time, the seven trained nurses inserted 377 loops. After 1968, the nurses specialized in inserting IUDs without medical supervision when they paid visits to the seven maternal and child health stations within a 25 miles radius of the hospital. Statistics kept during the time indicates that nurses performance was comparable to that of physicians.

Midwives from Nigeria have also been trained in the United States for IUD insertions.

Non-physicians are trained to distribute oral contraceptives, condoms, and diaphragms. In certain training centers in Nigeria, non-physicians are also instructed in the use of menstrual regulation. (Wortman, 1975).

References:

Hartfield, "The Role of the Nurse in a Family Planning Programme," 3 Contraception 105-114 (1971).

"Nigeria," Population Programme Assistance Annual Report (Washington, D.C.: Agency for International Development, 1974).

"Nonphysicians in Family Planning," 3 Family Planning Perspectives 2-3 (1971).

Wortman, "Training Nonphysicians in Family Planning Services and a Directory of Training Programs," Population Reports, Series J, No. 6, Sept. 1975, pp. 94-95.

PAKISTAN

The use of "lady family planning visitors" (LFPVs) in Pakistan has often been referred to as the paradigm of efforts to utilize paramedicals in the provision of contraceptive services. Yet, the program, despite its statistical successes, has not been without its problems. In the face of physician shortages, particularly female physicians, the LFPVs were, as early as 1966, recruited and trained to insert IUDs. At one point in 1969 these personnel were inserting between 75 and 80 percent of all IUDs.

Along parallel lines the Pakistan program also utilized the services of the "dais" -- indigenous midwives. These were trained as motivators and as dispensers of conventional contraceptives.

It has been reported that there are 2,837 such "dais". In addition, there are reported to be 1717 contraceptive distributors and 26,131 retail contraceptive agents (Nortman, 1975).

Recently, the prescription requirement for oral contraceptives was lifted though commercial distribution is still limited to pharmacies.

References:

Gardezi and Inayatullah, The Dai Study (Second Edition) (Lahore: West Pakistani Family Planning Association, 1969).

Jafarey, Hardee and Satterthwaite, "Use of Medical-Paramedical Personnel and Traditional Midwives in the Pakistan Family Planning Programme," 5 Demography 666 (1968).

Ministry of Health, Decree of 4 May, 1974.

Nortman, supra.

THE PHILIPPINES

With the issuance of Presidential Decree No. 79 of 1972, the Commission on Population was granted the authority to train and authorize nurses and midwives to "provide, dispense and administer all acceptable methods of contraception." However, the issuance of the pill and insertion of the IUD were technically subject to the prescription requirement under the provision of Republic Act No. 4729 of 1966. With regard to the pill at least, the requirement was widely ignored.

In June 1975 Department of Justice ruled that the Presidential Decree No. 79 repealed the 1966 law requiring a prescription for sale of contraceptives. Thus, condoms and pills may be sold through various commercial channels, including local Barraugays centers and women's clubs, without prescription.

Recently a three-man Paramedic Certifying Board has been established within the Commission on Population to regulate the accreditation and certification of nurses and midwives to prescribe pills and insert IUDs. Under the program, nurses and midwives are trained at four training institutions and posted to doctor-less areas. As of April 1976, 338 nurses and midwives have been trained. The target is to train 542 trainees by June, 1976.

At least one pilot project has been undertaken to train "hilots", the traditional birth attendants in the ways and means of family planning. That project, however, had them participating only as motivators not as distributors. Indeed, as the present law now stands, only registered nurses and midwives will be able to do that. During 1974-75, however, 75 FPAs underwent a 6 day training program in procedures relating to distribution of the pill including checklist screening of acceptors. This pilot project is to determine TBA effectiveness in distributing the pill without a prior examination by a physician.

It has been reported that the family planning program employs 1,847 rural health nurses and 3292 rural health midwives. The majority of these appear to provide other health services as well as family planning services (Nortman, 1975).

References:

del Mundo, Echeverria, Leuterio and Sarcia, "Better Utilization of Traditional Birth Attendants (Hilots) in the Delivery of Maternal-Child Health Services in Philippines Rural Communities," 21 Philippine Journal of Pediatrics 238-48 (1972).

Commission on Population, Public Information Unit, Press Release dated 5 April 1976.

Nortman, supra.

SENEGAL

A family planning program at the Clinique La Croix Bleue in Dakar was begun under the supervision of a nurse-midwife in late 1965. Since that time family planning services at the clinic have been provided by midwives. The participating midwives are trained by the director of the program, herself a midwife. During the first three months of 1973, 208 clients had IUDs inserted and 404 were given oral or other types of contraceptives.

With the cooperation of the Ministry of Health and financial support of the Pathfinder Fund training programs have been organized for midwives at the Clinique from other French-speaking West African countries.

References:

Whest-Allegre, "The Case for Midwives and Paramedics in Africa," in Moorehead, ed., Paramedical Personnel in Family Planning - A Creative Partnership 15-21 (Boston: The Pathfinder Fund, 1974).

SRI LANKA

It is not commonly known that Sri Lanka was one of the first countries to permit oral contraceptive distribution by paramedicals. In April of 1968 the Ministry of Health, in conjunction with a move to reduce the price per cycle of the pill by one-half, authorized, as a pilot project, trained field midwives to prescribe and supply the pill outside the clinic setting. Some form of medical supervision was, however, maintained. In order to prepare them for this task, midwives were given a one-week specialized course in family planning.

The upshot of this change in the policy was to increase acceptance rates for the pill. Continuation rates among motivated users also increase

In 1974, the Ministry of Health adopted the policy to permit properly trained nurses and midwives to prescribe and distribute oral contraceptives. In the past a prescription for the sale of the pill has been a facet of the Control of Prices Act, not part of the drug regulations.

Depo-Provera injections are administered in Sri Lanka but only under the FPA scheme and by physicians.

Family planning and maternal and child health services are fully integrated. It has been reported that the integrated program uses the services of 6,494 nurses and 3,625 midwives on a full or part-time basis. In addition, 786 public health inspectors distribute condoms in the field. (Nortman, 1975)

References:

Davies and Jones, "Doctors and Community-Based Pill Promotion in Sri Lanka," 9 IPPF Medical Bulletin 1 (June 1975).

Nortman, supra,

Wright, "Sri Lanka: The Impact of Allowing Paramedical Prescription and Resupply of Oral Contraceptives," 6 Studies in Family Planning 102-105 (1975).

*According to Davies and Jones under the Sri Lankan law only licensed doctors can prescribe, and only they and licensed pharmacists are authorized to distribute oral contraceptives.

SWEDEN

In 1972 the National Board of Health and Welfare began courses for midwives in matters relating to the distribution of contraceptives. Instruction is now given as part of the curriculum in the schools of midwifery. After completing the course, the midwives are competent to insert IUDs, prepare the prescription of orals (not to actually prescribe them), and give information on all types of contraception.

References:

Ordinance No. 109, Section 6 (3 April 1975).

TANZANIA

Because of a shortage of personnel to handle clinical services, nurses midwives and other paramedicals are used to give information, prescribe contraceptives, including the pill, and in some cases insert IUDs.

The medical and nursing schools include family planning as part of their curriculum, with some emphasis given to traditional methods as well as the more modern ones. Only 8.5% of the doctors in the country have family planning training.

Since 1970, 1,768 persons have received training under the auspices of the FPA. 33.2% were nurse-midwives; 27.5 were students at medical or nursing schools.

References:

Corvalan, "Review of Achievements of the Training Programme of the Family Planning Association of Tanzania"(mimeo) (7 October 1974).

TURKEY

The difficulty in distributing family planning supplies to its 35,000 villages, deficiencies in the health infrastructure in the rural areas and shortage of health workers have moved the Turkish Government to consider changes in the law so as to permit nurses and midwives to distribute and administer contraceptives.

At least one pilot project, begun in the Etimesgut District in 1966, has utilized to advantage the assistance of nurses and auxiliary nurse-midwives in the family planning element of its health program. While the medical officer is responsible for prescribing pills and inserting IUDs, he is free to train nurse-midwives or their auxiliaries to insert IUDs for cases where women request that a female do the insertion.

It has been reported (Nortman, 1975) that the family planning program employs 889 nurses, 2,067 male nurses and 2,879 midwives.

References:

Fisek, "An Integrated Health/Family Planning Programme in Etimesgut District, Turkey," 5 Studies in Family Planning 210-20 (1974).

2 Intercom 12 (1974).

Nortman, supra.

THAILAND

Perhaps the most widely written about, the Thailand experience with paramedical distribution of oral contraceptives has been used as the point of departure for the argument favored increased use of paramedicals in contraceptive distribution.

Begun as a pilot project, the mid-1970 Ministry of Public Health ruling that auxiliary midwives could prescribe and distribute oral contraceptives made it possible to provide family planning services in more than 3,400 clinics which had no physician. From the date of the Ministry decision new acceptors of oral contraceptives jumped from 46,719 to 85,668 (first and last six months of 1970) then from 139,169 up to 155,439 (first and last six months in 1971).

The auxiliary midwives can be trained within a week's time to screen potential pill users with the aid of a simplified checklist.

In 1974 the Ministry of Health also approved a plan whereby special family planning personnel will also distribute orals.

In practice both physicians and nurses insert IUDs. The Ministry of Health is currently conducting a project which trains nurse-midwives to insert IUDs.

Experience in the Chiangmai Province has demonstrated the popularity of injectable contraception. About 70 percent of the family planning acceptors there prefer Depo Provera injections over other forms of contraception. Qualified nurses give the injection. A mobile unit visits 36 village centers once every three months to dispense the injections. A pilot project was undertaken in 1974 to assess the possibilities of using auxiliary midwives to administer Depo Provera.

It has been reported (Nortman, 1975) that the full time equivalent of 2,483 nurses and 2,494 auxiliary midwives are specifically allocated to family planning services, but many of those provide other health services as well.

References:

Keating, "Good Medicines Come by Needle," People (IPPF), vol. 2, no. 2, 1975, at 35-36.

Nortman, supra.

Pardthaisona, McDaniel and Tray, "Acceptance and Use of Depo Provera in Chiangmai," 9 IPPF Medical Bulletin 1 (1975).

Peng, Keovishit and MacIntyre, eds., Role of Traditional Birth Attendants in Family Planning 11 (1974).

Rosenfield, "Family Planning: An Expanded Role for Paramedical Person-

nel," 110 American Journal of Obstetrics and Gynaecology 1030-1039 (1971).

Rosenfield, "Auxiliaries and Family Planning," The Lancet, No. 1, 1974, at 443-45.

Rosenfield, Hemachudha, Asavasena, and Varakamin, "Thailand: Family Planning Activities 1968 to 1970," 2 Studies in Family Planning 181-191 (1971)

Rosenfield and Limcharoen, "Auxiliary Midwife Prescription of Oral Contraceptives," 114 American Journal of Obstetrics and Gynaecology 942-49 (1972).

UNITED KINGDOM

Though the law requires that a physician prescribe oral contraceptives, it has recently been revealed that many trained nurses in the clinics run by the Family Planning Association have been dispensing the pill under the supervision of the clinic doctor.

There appear to be no legal barriers existing to the insertion of IUDs by paramedicals. IUDs are not generally subject to provisions of the Medicines Act of 1968. But doctors, as a matter of practice, do the insertions, though there is some indication that if the client consents a trained paramedical can do the insertion.

An experimental family planning clinic was established in 1975 at King's College Hospital, London with the financial blessing of the Department of Health and Social Security which utilizes trained nurse specialists to prescribe the pill and insert the IUD. After a year, a follow-up study indicated that the nurses adequately diagnosed all side effects and inserted IUDs in 187 patients without perforation or excessive rates of expulsion. Prior to participating the nurses received two weeks introductory courses fashioned to the standards of the Joint Colleges' (obstetricians/gynaecologists and general practitioners) certificate in family planning.

References:

The Times, 6 June 1975, p. 2, col. 7.

IPPF Report on Legal and Policy Aspects of Wider Distribution of Oral Contraceptives (Draft), July 1975.

Newton, Barnes, Cameron, Toldman, and Elias, "Nurse Specialist in Family Planning," British Medical Journal, No. 1, 1976, at 950.

UNITED STATES

Due to the shortage at all levels of professional personnel to provide family planning services, various programs have been undertaken which attempt to involve paramedicals more directly in the distribution of contraceptives. One of the earliest of these is the Frontier Nursing Service in eastern Kentucky. Because of the use of midwives there, a practice somewhat alien to the rest of the United States, it was possible to train nurse-midwives to insert IUDs. They also were trained to play a role in the supplying and encouraging the use of other types of contraceptives.

Similar programs training paramedicals in IUD insertion have been run in California, New York and elsewhere. And it is estimated that 6 percent of all IUD insertions are done by non-physicians. Of the two, the one in New York is the more significant, if only for the reason of its involvement in training midwives from other countries in all sorts of problems associated with contraceptive use. Between 1966 and 1973 more than 170 midwives (family planning trainees) from 48 countries were trained at Downstate Medical Centre in Brooklyn to provide all types of contraceptive services.

One other category of medical personnel deserves mention here -- the physician's assistant. There are non-physician personnel who, protected by special legislation, are authorized to assume many physician type duties. They also can be trained to specialize in family planning work and those sorts of duties can be delegated to them by the physician with whom they work.

Because of the prescription requirement, little can be done by the paramedical unless it is to screen patients and then fill out a blank prescription form previously signed by the doctor.

References:

Beasley, "The Nurse-Midwife as a Mediator of Contraception," 98 American Journal of Obstetrics and Gynaecology 201-207 (1967).

Beasley, Kohl, Pendleton and Okrent, "The Training of Nurse-Midwives in Family Planning at Downstate Medical Center," in Moorehead (ed.) Paramedical Personnel in Family Planning -- A Creative Partnership 1-14 (Boston: The Pathfinder Fund, 1974).

Kohl, Majzlin, Burnhill, Jones, Solish, Okrent, and Pendleton, "The Nurse-Midwife as a Family Planner," 62 American Journal of Public Health 1448-1450 (1972).

Ostergard and Broen, "The Insertion of Intrauterine Devices by Physicians and Paramedical Personnel," 42 Obstetrics and Gynaecology 257-58 (1973).

Ostergard, Broen and Marshall, "The Family Planning Specialist," 15 Clinical Obstetrics and Gynaecology 370-78 (1972).

Tyler, "IUD Insertion Practices in the United States," 7 Family Planning Perspectives 209 (1975).

- 19/ *Legal Aspects of Menstrual Regulation*, by Luke T. Lee and John M. Paxman (1974).
- 20/ *Symposium on Law and Population: Text of Recommendations*, Tunis, June 17-21, 1974.
- 21/ *Law and Population Growth in Iran*, Parviz Saney (1974).
- 22/ *Law and Population Growth in Kenya*, U. U. Uche (1974).
- 23/ *Law and Population Growth in Mexico*, by Gerardo Cornejo, Alan Keller, Susana Lerner, Leandro Azuara (1975).
- 24/ *The Impact of Law on Family Planning in Australia*, by H.A. Finlay (1975).
- 25/ *The World's Laws and Practices on Population and Sexuality Education*, by Edmund H. Kellogg, David K. Kline and Jan Stepan (1975).
- 26/ *Pregnancy and Abortion in Adolescence: Legal Aspects*, by Luke T. Lee and John M. Paxman (1975).
- 27/ *Law and Population Policy: Some Suggestions for Determining Priorities and Estimating Impact*, by John U. Farley and Steven S. Tokarski (1975).
- 28/ *Legal Implications of the World Population Plan of Action*, by Luke T. Lee (1975).
- 29/ *Law and Population in Lebanon*, by George M. Dib (1975).
- 30/ *Annual Review of Population Law, 1974*, International Advisory Committee on Population and Law (1975).
- 31/ *Law and Population Growth in Chile*, by José Sulbrandt and María Alicia Ferrera (1975).
- 32/ *Law and the Status of Colombian Women*, by Josefina Amezcua de Almeyda (1975).
- 33/ *Law and Population Growth in Ghana*, by Richard B. Turkson (1975).
- 34/ *Law and Population in Brazil*, by Walter Rodrigues, João Antônio Gordilho de Proença, Maria Alice Paiva, Fernando de Queiroz Mattoso, Leo de Affonseca, Otávio Augusto de Paiva, Theognis Nogueira and Benjamin Moraes Filho (1975).
- 35/ *Law and Population Growth in Ethiopia*, by Daniel Haile and Erku Yimer (1976).
- 36/ *Reform of Laws Affecting Population Growth: Recent Developments*, by Edmund H. Kellogg (1976).
- 37/ *North African Migrants Under West European Law*, by Peter B. Maggs and Luke T. Lee (1976).
- 38/ *Law and Development Classification Plan*, by Morris L. Cohen, Luke T. Lee and Jan Stepan (1976).
- 39/ *Annual Review of Population Law, 1975*, International Advisory Committee on Population and Law (1976).
- 40/ *Law and Population Growth in Sri Lanka*, by D.C. Jayasuriya (1976).
- 41/ *Expanded Roles for Non-Physicians in Fertility Regulation: Legal Perspectives*, by John M. Paxman, Luke T. Lee and Samuel B. Hopkins (1976).

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