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Law and Family Planning

We devote this entire issue of the bulletin to a paper by Luke T. Lee, J.D., Ph.D., Director of the Law and Population Programme at the Fletcher School of Law and Diplomacy at Tufts University (administered with the cooperation of Harvard University). It was originally prepared for a meeting of the Expert Committee on Family Planning in Health Services of the World Health Organization on 24-30 November 1970. Richard K. Gardiner, Assistant Director of the Law and Population Programme, assisted in the preparation of the paper.

INTRODUCTION

The attitudes of a state always have a hold on the development of its population, whatever the end pursued by law, and that, even when the law pretends indifference.

In its turn, the population, by its very structure, exercises an influence on every sort of law: constitutional, organic, and statutory.¹

This, in essence, underlies the legal approach to population and family planning. The message, so succinctly propounded 21 years ago by M. Jacques Doublet, a member of the French Conseil d'Etat, has, however, gone unheeded in a field that has

¹ Jacques Doublet, "Des Lois dans Leurs Rapports avec la Population," *Population*, 4 (1):39-56 (1949). Translation by Miss Margaret Hershey, of the staff of the Law and Population Programme.

hitherto held lawyers to be irrelevant. Lawyers themselves are not without blame for this situation. Directing themselves to more technical aspects of the law, both in their training and in practice, they have, with but a few exceptions, persistently evaded the challenge of a problem of serious proportions. As recently as 1965, for example, out of some one thousand participants and observers at the United Nations World Population Conference in Belgrade, there was only one lawyer, and none of the hundreds of papers presented at the Conference dealt with the legal aspects of the population problem and family planning.

Since 1965, two major events have lent particular urgency to the legal approach:

(1) the Declaration on Population by 12 heads of state in 1966 (increased to 30 in 1967) that family planning is a basic human right, and (2) the unanimous adoption in 1968 by the United Nations Conference on Human Rights of the Teheran Proclamation that family planning is a basic human right, and of a resolution that couples also have the right to be sufficiently instructed and informed on family planning.² Since "human rights" impose a *legal*, and not merely moral, responsibility upon states, there is a legal duty on the part of each government to see that laws and policies which conflict with the implementation of such rights be amended or abolished and that new laws and policies be adopted to conform with and further these rights. Furthermore, "Human rights, *ex hypothesi*, are rights which attach to all

² United Nations Conference on Human Rights, Teheran, 1968. U.N. Doc. A/CONF.32/4! Resolution XVIII, on Human Rights Aspects of Family Planning, is reprinted with the text of the Proclamation of Teheran in *American Journal of International Law*, 63:678-79, 674-77, 1969.

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human beings equally, whatever their nationality."³

Nevertheless, on the national level, official recognition that family planning is a basic human right has seldom been followed by systematic legal reforms to bring the existing laws into line with that recognition. Thus, restrictions continue to hamper the importation, manufacture, advertisement, and transportation of contraceptives; the minimum marriage age remains low; education laws continue to forbid the teaching of family planning or sex education in schools; public health services remain unresponsive to the need for birth control counsel and clinics; the social welfare and income tax systems may favor large families; and abortion codes contribute to high-cost, high-risk illegal operations. Even where legal reforms have been instituted, important gaps exist owing to the lack of coordination. Low priority accorded to law codification in many emergent countries means retention of archaic laws inherited wholesale from former colonial powers, which often defeats the official policy favoring family planning.

On the international level, it is encouraging that the United Nations and its agencies, after a long period of inaction, are now becoming increasingly involved with population and family planning. However, the autonomous character of U. N. agencies and the newness of their population programs have so far prevented the U. N. system from utilizing its maximum capacity. Not only do many gaps in and overlappings of functions exist among U. N. agencies, but the unity of purpose and division of labor within each agency are by no means assured. And yet the potential role of U. N. agencies in this area should not be underestimated. To give but one example: There are very few adequate teaching materials on family planning or sex education available for use in schools, thus denying many states one of the most effective means of implementing family planning as a basic human right. Might not the United Nations Educational, Scientific, and Cultural Organization (UNESCO), whose purpose is, according to Article 1 of its Constitution,

³ Sir Humphrey Waldock, "Human Rights in Contemporary International Law and the Significance of the European Convention," in *The European Convention on Human Rights, International and Comparative Law Quarterly*, Supp. Publication No. 11, p. 3, 1965.

"to further universal respect for . . . the human rights," sponsor the preparation of such a textbook in line with what it has done in the field of race, in collaboration with the World Health Organization (WHO)?

The present survey on national legislation from the viewpoint of the promotive or constraining effects on family planning must, of necessity, be of a selective and tentative nature. In the first place, no country has systematically compiled all of its laws bearing on family planning; statutes and decrees are often scattered throughout the body of law, and administrative and judicial decrees and interpretations are usually buried and in many instances not generally known.⁴ In the second place, the answers to many jurisprudential questions await in-depth research. Only a few of these need be mentioned:

(1) While law does have a certain impact upon the behavior of people, the extent of impact varies not only from state to state, but also according to the subject matter. For example, violators of abortion laws often go unpunished, while prohibition of advertisement of contraceptives is more strictly enforced. Since divergences between law and practice usually favor one segment of the society more than the others, the problem is one that should loom large in the consideration of law-makers and law-enforcers.

(2) Although law often reflects contemporary social norms and mores, its potential as catalyst for social change should not be ignored. For example, did the liberalization of the Japanese abortion law merely follow a prior change of social and cultural climate favoring abortion, or did it trigger off or at least help shape public acceptance of and recourse to abortion?

(3) What are the effects of a law contradicted in purpose by another law or frustrated in its implementation by inadequate or inconsistent administrative decrees? The effects of the French legalization of the sale and distribution of contraceptives in 1967, for example, must be weighed against yearly increases in family allow-

⁴ It is hoped that a comprehensive and periodically revised legislative series on population and family planning can be compiled by the Law and Population Programme, preferably in conjunction with an international organization, for publication at an early date.

ance payments, on the one hand, and the nonenactment of administrative decrees to implement the 1967 law, on the other. As of this writing, many French gynecologists still refuse to counsel or prescribe contraceptives to patients in the absence of such administrative decrees. Similarly, despite the recent liberalization of an abortion law in the State of New York, confusion reigns in New York City because of local health regulations restricting the performance of abortions on an outpatient basis.⁵

(4) What are the relations between municipal and international law through the medium of human rights, which include the rights of family planning? Are there inherent conflicts between "individual" and "collective" human rights with regard to family planning? What constitute the legal bases and limits for inter-governmental and inter-organizational (U. N. agencies, regional organizations, private international organizations, etc.) cooperation and coordination? Obviously, the constitutional laws as well as foreign policy laws of each country are relevant to these questions.

(5) Finally, it is simply not known how such laws as those governing polygamy, divorce, migration, homosexuality, inheritance, and land affect fertility.⁶ In addition, there may well be other areas of the law that may affect fertility but have thus far not been identified because the legal approach to family planning is just beginning to be seriously considered. All of these must await systematic exploration and examination.

Subject to the above caveats, an attempt is made in the ensuing space to discuss and assess the effects of national legislation in family planning, particularly in the areas of family planning activities, standards of practice, administrative channels, and social and welfare factors.

BIRTH CONTROL

The designation "birth control laws" is used here to refer to laws on contraception, abortion, and sterilization. These will be discussed under separate headings, with the interrelationship of the laws and their

⁵ *New York Times*, 20 October 1970.

⁶ See the second section of this paper, "Social and Welfare Factors" pp. 88 ff.

possible impact on fertility left to the end of this section.

Contraception

In a number of ways legislation has been brought to bear on contraception, for example, by prohibiting importation of contraceptives and the dissemination of birth control information, as well as advertisement, display, distribution or sale, manufacture, and use of contraceptives. Prohibition still survives in some countries.⁷ The observance of the laws, however, is quite another matter. The great majority of countries have no absolute ban on contraceptives, and the trend is toward increasing liberalization.

The ensuing discussion will focus on the various aspects of contraception.

DISTRIBUTION AND SALE

Sale of contraceptives is prohibited in Ireland and Spain,⁸ as it was in France (except in the case of condoms)⁹ prior to the law of 1967.¹⁰ Sweden, by contrast, actually requires pharmacists to stock contraceptives for sale during daylight hours.¹¹

The People's Republic of China also requires pharmacists to "maintain reasonable stocks" of contraceptives.¹² All Chi-

nese department stores, trading companies, drug stores, and cooperatives from the rural branches up, must participate in the sale of contraceptives. Where facilities permit, sales to male and female customers must be conducted by males and females, respectively. The latter are given short-term training by local health authorities on such subjects as contraceptive theories and methods, storage, and sanitation. It should be noted that all the above regulations apply only to the Han people. In territories belonging to minority (non-Han) peoples, only the Han people are targets of birth control propaganda and have access to contraceptives.¹³

The general rule seems to be that drugs may be sold only by pharmacists, while other types of contraceptives are not so restricted. Sale through vending machines, however, lends itself to tighter control, as in Sweden and the United Kingdom. In the latter, sale through slot-machines is generally prohibited in public places through local by-laws which may be the product of regional determination, or may be the result of direct enactment of the centrally suggested "model" by-laws.

India provides an example of a system that prevails in a large number of countries: devices needing clinical administration must be obtained through government clinics; conventional contraceptives, including chemical contraceptives, go through licensed drugstores; and condoms are sold openly—even by general stores and grocers.¹⁴

In Japan, the restricting of sale to that by registered pharmacists has been relaxed to allow sale by authorized family planning advisers. This is an example of law being adapted to take account of the special needs of family planning rather than blindly categorizing contraceptives with drugs.

Until July 1970, Massachusetts laws had prohibited the sale of "any drug, medicine, instrument or article whatever for the prevention of conception"¹⁵—except in the case of married persons to whom registered physicians could prescribe, and registered pharmacists could provide, such

drugs or articles for contraception.¹⁶ The prohibition was removed on the ground of unconstitutionality by the U. S. Court of Appeals for the First Circuit on July 6, 1970.¹⁷

ADVERTISEMENT

Legal restrictions relating to display, advertising, and promotion of sale of contraceptives are common. Where sales of contraceptives are forbidden by law, their advertisement is, of course, also forbidden, as was the case in the recently voided Massachusetts law.¹⁸ But even where sales are legal, advertisement may remain proscribed as is the case in Belgium, France, the Federal Republic of Germany, and Sweden.

Laws restricting dissemination of false or misleading information relating to drugs extend also to those contraceptives that are drugs.

EDUCATION AND DISSEMINATION OF INFORMATION

In addition to the laws restricting the advertisement of contraceptives for gain, one must consider those that govern the dissemination of contraceptive information, whether through the educational system or as a special service. Many countries, such as Ireland, Spain, and Italy, still have laws restricting the distribution of contraceptive information or instruction, although the laws are not strictly enforced.

Few states have made much progress through the general education system, except Sweden, which is to date the only state in which sex education has been made compulsory in public schools. The provision of the Swedish Criminal Code that forbids material which can "coarsen or otherwise involve serious risk for the moral nurture of the young" has constituted no bar to sex instruction.

Failure of the general educational system to disseminate knowledge of contraception has in certain countries been remedied, at least in part, by the assumption of this function by such governmental and private organizations as the Eugenic Protection Consultation Offices in Japan

⁷ Until 1965, for example, Connecticut had prohibited without exception the use by any person of any drug, article, or instrument for purposes of preventing conception. This law was declared unconstitutional by the U. S. Supreme Court in *Griswold v. Connecticut*, 381 U. S. 479 (1965), for violating, among other things, the right of "marital privacy."

⁸ U. N. ECOSOC, *Measures, Policies and Programmes Affecting Fertility, with Particular Reference to National Family Planning Programmes: Provisional Report of the Secretary General* (U. N. Doc. E/CN.9/232, 17 September 1969, hereinafter abbreviated as U. N., *Measures*), pp. 70-71. This report provides a substantial amount of information on many of the matters dealt with in this paper. It is also a valuable source for references to basic material.

⁹ Elizabeth Draper, *Birth Control in the Modern World* (London, 1965), p. 181.

¹⁰ Law No. 67-1176 of 28 December 1967 concerning birth control and repealing Articles L. 648 and L. 649 of the Public Health Code (*Journal Officiel de la République française*, 29 December 1967, No. 302, pp. 12861-62); *International Digest of Health Legislation*, 19:620, 1968.

¹¹ Swedish Association for Sex Education, "Sweden," in *Population and Law*, Lee and Arthur Larson, eds., forthcoming in 1971 (hereinafter referred to as *Population and Law*).

¹² *C-hung-hua Jen-min Kung-ho-kuo Kuo-wu-yuan Kung Pao* [People's Republic of China, State Council *Bulletin*], 1957, No. 14, pp. 259-262.

¹³ See Huang Yu-chan, *Chung-kung Chih-yu Yung-tung* [Birth Control in Communist China] (Hong Kong, 1967), pp. 80-81.

¹⁴ Saran Gurdev Singh, "India," in *Population and Law*, *op. cit.*

¹⁵ Massachusetts Annual Laws (1966 Supplement), Section 21.

¹⁶ Section 21A.

¹⁷ See *William R. Baird, Petitioner, Appellant v. Thomas S. Eisenstadt, Sheriff of Suffolk County, Massachusetts, Respondent, Appellee*, 429 F. 2d 1398.

¹⁸ See note 15 above.

and the family consultation offices in West Germany. Even in Belgium, where the legal environment can be described as hostile to contraception, there are centers providing information.¹⁹

A high abortion rate, as well as a high birth rate, may lead to legislation to encourage contraception or dissemination of contraceptive information. Japan is a case in point. Sometimes, the law may take advantage of the special situations in which the idea of contraception would lend itself to hospitable reception, as is the case in Poland, where the law requires the teaching of contraception to a woman before an abortion is carried out, and in Denmark, where the offering of family planning instruction is compulsory after a childbirth or an abortion.

The existence of restrictive laws on publicity and information, sometimes of doubtful interpretation and unpredictable application, may exercise an inhibitory influence on those who would otherwise be active in promoting contraception. Once restrictions are relaxed, the result may be the unleashing of valuable press and public debate as well as the actual enabling of the spread of contraceptive practices, as was the case in Pakistan.

PRESCRIPTION AND PRACTITIONERS

The restrictions on persons authorized to prescribe drugs and to provide technical services, such as the insertion of IUDs, may be generally classified as being on medical grounds. Thus there may be inherent limitations of certain methods within a particular country, if the law of the country requires that contraceptives, or certain types of contraceptives, be prescribed only by a medically qualified person. Further limitations would occur if the law provided the conditions on which such a person may issue a prescription.

For example, in India only qualified doctors may perform loop insertions. In both the German Democratic Republic²⁰ and the Federal Republic of Germany²¹ the drug laws require medical prescrip-

tions for any chemical contraceptives. The French law of 1967 empowers the Minister of Social Affairs to draw up a special list of contraceptives that may be supplied only on prescription; in addition, intrauterine contraceptives may be inserted only by physicians in hospitals or other approved centers, in conformity with administrative regulations.

MANUFACTURE AND IMPORTATION

Manufacture and importation of contraceptives are generally permitted in the former British colonies in Africa and in many Asian countries where family planning is a national policy, but are banned in the Francophone African states, except Tunisia, and in certain Latin American countries. Sometimes, prevention of importation is the result of a general tightening of exchange control due to an unfavorable balance of payments, rather than a population policy.

In the absence of domestic production, reliance may have to be placed on foreign-produced contraceptives, which may be difficult to obtain because of import controls, unless supplies are guaranteed through receipt of foreign aid. Where the government itself undertakes production, there is the consideration whether centralization of the means of production might not result in a limitation of choice, thus affecting couples who may need a different contraceptive method.

QUALITY CONTROL

The aim of a government in assuming quality control of contraceptives may be to protect users from health injury or to ensure the contraceptive efficacy. In the Federal Republic of Germany, manufacturers of contraceptive chemicals, but not of mechanical contraceptives, are required to obtain a license certifying that they have met the standards of technical qualification and competence. This indicates that concern is not directed toward contraceptive efficacy, since if it were such controls would also be extended to mechanical devices; rather, the concern of the law is to protect against the harm that could ensue from uncontrolled production of potentially noxious substances. In Sweden, where governmental control through the Board of Health and Welfare in the form of random sample quality testing is applied to both imported and home-produced contraceptives—mechanical as well as

chemical—a greater degree of reliability can be expected from the products.

Abortion

INTRODUCTION

Examination of the abortion laws of governments reveals a marked disparity in many cases between law and practice. While this disparity is often evident from the number of illegal abortions, it may also in part be caused by the lack of clarity and uniformity in interpretation and application of the laws.

Often this is the case when a trend away from a rigid prohibition of abortion takes the form of exceptions to the prohibition, rather than comprehensive new legislation. Even in Japan, where the possibility of having a legal abortion is not subject to the considerable restriction prevalent in most countries, the criminal code²² contains an unambiguous prohibition of abortion, while the law specifically permitting abortion constitutes part of the Eugenic Protection Law. It is perhaps partially because these laws conflict that, when the number of abortions was at its peak in Japan, there were estimated to be nearly as many illegal abortions as there were legal ones.

The prominent areas for comparative survey of legal provisions are: the grounds for performing an abortion; the procedures required for establishing grounds and authorizing the abortion; and the nature and extent of government controls. These will be discussed separately.

GROUND FOR ABORTION

In few countries does the law permit abortion merely because it is sought by the person or persons concerned. Where abortion appears to be available on demand, it is usually by *de facto* extension of an already liberal law. Where the right to abortion is dependent on grounds being established, these grounds usually fall within four principal categories to be discussed below. (It should be noted, however, that these categories are not mutually exclusive. A case in point is the Bulgarian law authorizing abortion for women aged 45 or more. The age element has relevance not only to medical, but also to socio-economic and perhaps even eugenic considerations.)

¹⁹ J. de Deken-Geairain and Marthe Engelborghs-Bertels, "Belgium," *Population and Law*. These centers circumvent the repressive legislation on contraception by remaining nonprofit-making.

²⁰ Gunther G. Schulz, "German Democratic Republic," in *Population and Law*, *op. cit.*

²¹ Schulz, "Federal Republic of Germany," in *Population and Law*, *ibid.*

²² Arts. 212-214; Lee, "Japan," in *Population and Law*, *ibid.*

Medical

Medical reasons are the most widely accepted grounds for abortion. Examination of the laws relating to medical indications focuses on two major areas: first, the list of medical conditions and the formulation of the test to be applied, and second, who is to make the decision.

The Czech ordinance, for example, contains in its schedule an extensive list of pathological conditions in which continued pregnancy constitutes a hazard to the health of the woman. The authorization of a special abortion board is required before an abortion can be performed.²¹

The most commonly found provision is permission by way of exception to the criminal law, rather than as part of a medically oriented law. The strictest provisions are those that authorize abortion only to save the *life* of the woman, or rather permit such a ground to be raised as a defense. This is a feature of some of the American jurisdictions, of a number of Latin American laws, and of French law.

On the other hand, some countries allow abortion to preserve the *health* of the woman. For example, in Peru,

abortion performed by a doctor with the consent of a pregnant woman is not punishable when there is no other means of saving the mother's life or to avoid serious and permanent damage to her health.²²

Interpretation of the law may depend to a large extent on the formulation adopted. One may contrast the wording of the Peruvian provision specifying "serious and permanent damage" to health, with the equivalent exception in Thai law, permitting abortion performed by a medical practitioner "if it is necessary for the sake of the woman's health."²³ Though in principle not very different, the latter affords a much greater opportunity for the exercise of the doctor's discretion.

Such provisions may be amplified by providing criteria, as in the case of the Danish law of 1956, which allows abortion when the interruption of pregnancy is

necessary to avert grave danger to the woman's life or health:

... In evaluating this danger, due consideration must be given to all relevant circumstances, including those conditions under which the woman must live, and not only to her physical and psychic health, but also to any condition of physical or psychic weakness, present or threatening.²⁴

The United Kingdom Abortion Act of 1967 leaves the decision on termination to the opinion of two registered medical practitioners:

... that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the woman or any existing children of her family, greater than if the pregnancy were terminated; ...

In addition to the fact that the test that is to be applied—whether continuance involves a greater risk than termination—permits termination in order to secure a relatively small improvement in the woman's medical condition, the Act allows consideration of the pregnant woman's "actual or reasonably foreseeable environment." While this does not create a "social" ground for termination, since it requires the presence of health considerations—present or foreseen—factors of a social or economic nature, including the woman's marital status and existing family size, may be taken into account.

It is also significant that even in those East European countries where the indications for abortion cover a wide range of medical, eugenic, social, and economic reasons, the legal controls nevertheless prohibit abortion in a number of cases, for example, when there are medical contraindications of a specified nature, where pregnancy has exceeded three months, or where an induced abortion has been performed within the immediately preceding six months.²⁵

Socioeconomic

An example of legal abortion based on socioeconomic grounds is that provided by the 1961 amendment of Czechoslovakia's 1957 law to prescribe "the exist-

ence of at least three children"; also specified as a ground is "risk to the standard of living in cases where predominant economic responsibility for the maintenance of the family or the child devolves upon the woman."²⁶ Bulgarian laws also permit women with three or more children to have abortions.

The Tunisian Law Number 24 of 1 July 1965, which amended Article 214 of the Penal Law and the Decree of 25 February 1949, authorizes abortion to be performed if the woman has had "at least five living children."²⁷

Also classified under this category are grounds of a combined economic and health nature, with the former clearly predominant. The law in Japan is a case in point. Article 14(1) of the Eugenic Protection Law of 1948, as amended, authorizes a designated physician to perform an abortion "at his discretion" if a mother's "health may be affected seriously by the continuation of pregnancy or by delivery, from the physical or economic viewpoint." Although "economic" reasons alone would not, according to the letter of the law, constitute a sufficient ground for abortion, the difficulty or impossibility of proving conclusively their serious adverse effect upon health has resulted in such a liberal interpretation of the law that, in practice, even wealthy and healthy women may obtain abortions.²⁸ Most of the operations for induced abortions have indeed been performed on this ground.²⁹

Humanitarian

Some laws allow abortion on humanitarian grounds: to terminate pregnancies that are the result of such criminal acts as rape, incest, or sexual intercourse with a mentally defective woman or a girl below the minimum age. Viewed from the standpoint of population limitation, the humanitarian grounds are of minor importance. However, that abortion is not permitted in many countries even in cases where the

²¹ Annex to Instructions of the Ministry of Health, No. 72/1962 Sb. NV; Kazimierz Grzybowski, "Czechoslovakia," Annex 1, *Population and Law*, *ibid.*

²² Decree of 24 May 1946.

²³ Penal Code of Thailand, BE 2499 (1956), Chapter 3, Section 305.

²⁴ Act No. 177 of June 23, 1956, Section 1, Sub-Section 1, para. 1.

²⁵ Report of the Committee to Study the Question of Legalization of Abortion, Ministry of Health and Family Planning, India, 1966, p. 42.

²⁶ Ruth Roemer, "Abortion Law: The Approaches of Different Nations," *American Journal of Public Health*, 57 (11):1906, 1911, November 1967.

²⁷ Lee, "Tunisia," in *Population and Law*, *op. cit.*

²⁸ Lee, "Japan," in *Population and Law*, *ibid.*; based on the author's interview with Mr. Hisao Aoki of the Ministry of Health and Welfare, Tokyo, 15 March 1967.

²⁹ Minoru Muramatsu, *Some Facts about Family Planning in Japan* (1955), p. 9.

child will be born in such inauspicious circumstances is symptomatic of the unyielding position many states have adopted in their laws.

Eugenic

Eugenic reasons are closely allied in principle to those in the medical category, being based on the desirability of maintaining the live population in good medical health, though the foundation of laws allowing eugenic grounds to be invoked may be as much the interest of the state and the family as the expected medical condition of the child in embryo.

PROCEDURES

Many of the Scandinavian and East European countries require the authorization of a board or commission before abortion can be performed. These vary in composition and procedure, the Scandinavian boards being generally composed of medically qualified persons (though Denmark includes a social worker on its committees), while the East Europeans tend to select on a wider basis, including nonmedical personnel as well. Czechoslovakia, for example, requires an elected district deputy and a woman member of the district people's council to participate in the decision. The German Democratic Republic includes a social worker and a representative of the local women's organization. In Hungary, the board is under a chairman designated by the chief medical officer of the town or region and includes two members appointed by the executive committee of the competent people's council, the head of the social affairs council, the head of the social affairs section, and a woman appointed by the trade unions.

Scandinavian procedures require the consent of two or more physicians. The Danish law distinguishes between dangers to the woman's life or health due to illness and dangers of a medico-social nature. In the former case, the decision to terminate a pregnancy is taken by medical personnel, whereas in the latter case, the matter must be referred to the committee at the "mother's aid center" which issues authorization after consultation with the woman's general medical practitioner and a specialist.

In Finland, there is the possibility of direct application to the medical board if approval cannot be obtained from two physicians, one of whom is appointed by

the board. Once the medical board has decided to grant approval, it will also make provisions for sterilization to be performed at the same time, unless there are valid reasons for not doing so.

Some of the boards in East European countries do not merely perform the function of granting or refusing consent. In Bulgaria and Hungary, for example, the board is required to attempt to dissuade women from having an abortion, though applications will be approved where the woman persists, and in Bulgaria abortion is available on request without commission approval for women who are aged 45 or more or who already have three or more children.

There are also appeal systems in some countries, of which the German Democratic Republic's is probably the most developed, allowing an appeal to a regional commission and even to the Ministry of Health.

In contrast with those laws that institute abortion boards, there are examples of liberalized laws that leave the matter entirely in the hands of the doctor.

In Japan, the 1948 Eugenic Protection Law established Eugenic Protection Committees to authorize abortions where other than strictly medical conditions were involved. An amendment of April 1952 eliminated the need for a designated physician to apply to a Committee for authorization to perform an induced abortion.

The United Kingdom legislation, as noted earlier, leaves the decision on abortion to two registered medical practitioners, who must jointly concur in good faith that prescribed conditions are fulfilled.

Comparing the two systems, one might point to the drawbacks inherent in a procedure involving a board or commission—a problem which has been recognized in Sweden. Though the Czech procedure provides a district board and a possible appeal to a provincial board within a three-month period, it is admitted that these boards have not always conducted a thorough examination of the circumstances of the applicant.

Yet one must equally question whether a doctor's opinion, though more expeditiously arrived at than the decision of a board, is the most suitable means of taking into account the pregnant woman's actual or reasonably foreseeable environment. Leaving the decision in the hands of the doctor may reflect the state's concern that considerations of a medical nature be

paramount, even in the consideration of medico-social grounds. Nevertheless, one would expect that such considerations would not be left exclusively in the hands of the medical profession in the cases where environmental considerations are to be entertained.

Poland has attempted a synthesis of the two systems. Adopting the view that the use of a commission, with the delay that it entails, encourages resort to criminal abortion, the law allows a single medical practitioner to issue the certificate of permissibility (though the certifying physician may not perform the operation). In the event of refusal by a doctor, there is a provision for appeal to a medical board.

It should also be mentioned that most laws impose a time limit within which an abortion that is to be performed on other than strictly medical grounds must be carried out, the most common limit being three months. In most cases this time limit can be extended where there is a serious threat to the mother's life if the pregnancy continues.

FACILITIES AND PRACTITIONERS

Where the law permits abortions, they are subject to varied safeguards. Hungary, the United Kingdom, Tunisia, and Singapore are examples of the many countries that require the operation to be performed in an approved or designated hospital or on approved premises. In New York State, shortly after the new abortion law took effect in July 1970, abortions were performed on doctors' premises or in small clinics. However, new municipal regulations effective October 1970 have virtually prevented such operations in New York City by requiring equipment seldom found outside large clinics or hospitals.³²

Requirements that the operation be performed by a physician, in a properly staffed hospital, where the woman is admitted as an inpatient—common in the East European laws—have largely eliminated the risks in the case of legal abortions. However, many women still seek illegal abortions because of reluctance to go before a board or commission, rejection of prior applications, or expiration of the time limit.

³² See note 5 above.

Sterilization

INTRODUCTION

Sterilization constitutes part of the birth control program in a number of countries. It is unacceptable to Islamic cultures at present, but has met with success in non-Muslim Asian communities. Legal problems relate to the lack of certainty as to grounds on which sterilization may be performed.

GROUND

In the United States, 28 States have laws on sterilization. Of these, 26 permit compulsory sterilization to be performed on mentally infirm persons maintained at State institutions; while only five States allow voluntary sterilization on therapeutic or socioeconomic grounds. The Scandinavian countries generally have laws allowing voluntary sterilization. In Sweden, for example, sterilization may be authorized by the National Board of Health and Welfare on medical, eugenic, or social grounds. It should be noted that a woman may be permitted sterilization on grounds of physical weakness while her husband's application to undergo sterilization on account of her weakness will not be accepted.

The East European countries do not as a rule have laws on sterilization. The exception is Czechoslovakia, where sterilization may be authorized on medical or eugenic grounds, provided the patient consents. In India, the legal position with regard to sterilizations is uncertain, though sterilization has been performed on a considerable number of persons with their consent. In Japan, possible grounds on which a sterilization may be performed on a person who consents, provided there is also consent of the spouse (a term that includes one who enjoys actual, even though unregistered, marital status), include hereditary psychopathy; bodily disease or malformation; mental disease on the part of the person in question, his spouse, or a blood relative of either; leprosy if liable to be transmitted; possibility of the mother's life being endangered by conception or by delivery; and declining health of the mother who already has several children and whose state of health seems to be seriously affected by each delivery.

PROCEDURE

Few countries have developed any special procedure relating to sterilization.

However, in Japan, the Eugenic Protection Law provides the possibility of compulsory sterilization where the operation is in the public interest, subject to an inquiry being held by the Eugenic Protection committee. There are safeguards whereby the person to undergo the operation, the spouse, the person in parental right or the guardian who has an objection to the decision, may within two weeks apply to the Central Eugenic Protection Commission for a review of the case. In the absence of any objection to the decision, or when the court's decision has become final and conclusive, the designated physician carries out the operation.

In Czechoslovakia, an application for sterilization must be submitted in writing by the person concerned (or by the physician with his consent) to the chairman of a special board appointed by the director of the District Institute of Public Health. The board's membership includes the director of the hospital or polyclinic, the physician in charge of the gynecological or urological department, and a physician specialist in the branch of medicine in the area of indication or contraindication of sterilization. The application is followed by a medical examination, an expert opinion, and, where sterilization is sought for genetic reasons, also a genetic consultative committee. If the application is rejected, there is a right of appeal to higher medical authorities.

Impact on Fertility

A key question that must be asked when considering the laws relating to birth control is whether any cause-and-effect relationship can be shown between the laws concerned and fertility. This question is part of a broader field of consideration: the examination of the policies that underlie the various laws on birth control. For laws establishing the circumstances in which pregnancy may be prevented or terminated have been introduced or changed for eugenic, health, and religious reasons, as well as to affect population trends; and the Japanese and East European developments suggest that it is desirable that liberalization of abortion laws should be accompanied by legislation to encourage prevention of conception, reserving abortion for health, eugenic, and humanitarian grounds, or when contraception fails.

With respect to those laws that restrict the availability of contraceptives, it must

be said that the factor that directly affects fertility is the *use* of contraceptives rather than their availability. That the motivation to restrict the number of births is a more important factor than the availability of contraceptives is suggested by the evidence that decline in birth rates has preceded relaxation of the laws relating to contraception in some instances, although it has usually followed relaxation of abortion laws.

One important reason for relaxing the law to align with the practice lies in the discrimination between rich and poor to which the divergence may lead. For example, those of sufficient means can usually buy contraceptives privately, even if anti-contraceptive legislation is theoretically in force; but the state or local government cannot contradict itself by providing contraceptives to those who cannot afford to buy them, nor can it put into effect large-scale programs for the promotion of birth control, so long as the prohibitory laws remain on the statute books.

In trying to assess the relationship of abortion law to the birth rate, the experience of the East European countries and Japan provides some evidence for consideration. In the first place, though changes in abortion laws have not led to the elimination of illegal abortion, they have invariably been followed by changes in birth rates. Nevertheless, one must not ignore such other factors as economic motivations and increase in contraceptive knowledge and supplies, which could have contributed to such declines.

Particularly significant are those instances where liberalization has been followed by "back-peddling." In the Soviet Union, after abortion was made illegal in 1936, the birth rate rose considerably above the 1935 level until the outbreak of World War II. The present law legalizing abortion in the Soviet Union was adopted in 1955 in recognition of the fact that many illegal abortions were taking place and that, basically, women should have the right to regulate the size of their families and to resort to abortion when other methods fail. Similar legislation was adopted in the 1950s by other East European countries except Albania and the German Democratic Republic, where abortion was allowed only for medical reasons. By the early 1960s, the birth rates had declined markedly in all Eastern Europe except Albania and the German

Democratic Republic, where birth rates showed much smaller declines over the same period.

The most recent evidence on the cause-and-effect relationship between abortion law and birth rate is that provided by the repeal in 1966 of the law permitting abortion in Romania. The repeal was followed by an immediate upsurge in birth rates.

Sterilization is unlikely to have a significant impact on fertility where the law limits its use to cases based on eugenic grounds alone or where there exists a strong religio-cultural taboo against its use. This also applies to abortion. However, abortion is more often resorted to than sterilization because, although prevention is better than cure, pregnancy is an already accomplished fact whose termination constitutes the last clear chance to avert an unwanted baby; in the case of sterilization, a considerable amount of foresight is required since the pregnancies to be prevented are only potential.

In Japan, the statistics show a rapid rise in the number of sterilizations following the increase, under the Eugenic Protection Act of 1948, in the number of grounds on which it was allowed.

In a number of Asian countries, sterilization forms part of family planning programs. Financial or material incentives have been offered in some of these countries to encourage sterilization. It is difficult, however, to evaluate the effect of such programs on population patterns.

SOCIAL AND WELFARE FACTORS

Family Allowances

Following the depression of the 1930s, many governments assumed a greater responsibility for the economic and social well-being of their people, and the introduction of family allowance programs became widespread in the post-war period. The United States and Japan are now the only two industrialized nations without a general family allowance program.

Eligibility for a family allowance is determined in most cases by age and order of birth. Thus, some countries only start payments for the second or third child born, and a few countries have imposed an upper limit on the number of children within any one family for whom the allowances will be granted. Some countries vary the amount of the allowance as the number or age of children increases or grant

supplementary allowances while the children are attending school. In some countries the system of family allowances is related to employment, by means of a payroll tax, which may have a depressing effect on wages or an inflationary effect on prices. If marriage grants may be analogized to family allowances, we may also mention here outright grants on the occasion of marriage, as in the case of Portugal, or interest-free loans that are increased if the bride gives up her employment or are partially cancelled with the birth of each child, as in the case of Spain. Because of the great variety of possible systems it is statistically difficult to make useful comparisons of allowances paid and their impact on the size of families.

A comparative study of birth rates in Sweden and Norway after the last war suggested that the evidence concerning Sweden did not "exclude the possibility that family allowances have had some [positive] effect upon fertility in young marriages." Such effect was not present in Norway, where payments begin only with the second child and are not part of a comprehensive family program as they are in Sweden.³³

It may be safely stated, however, that the impact of family allowances on fertility depends much on the size of payment per child. Where the size of payment exceeds or approximates the actual cost of bringing forth, rearing, and educating a child, it may act as a stimulant to fertility, as is reputed to be the case in post-war France, especially in increasing the frequency of births of second and third parity. On the other hand, if the payment is only nominal, the causal relationship between family allowances and fertility may be tenuous at best, as seems to be the case in most of the developing countries.

Since Belgium allotted 3.01 percent of its national income to family allowances in 1963, the second highest percentage after France, at a total expenditure of 16,607 million Belgian francs, it may be useful to follow in detail the Belgian system of family allowances.³⁴ The motives behind the granting of family allowances are those of social justice and population expansion. From the social point of view, it is a ques-

tion of providing for each family resources proportional to its real responsibilities.

The system of family allowances is organized in the following manner: Whoever in Belgium employs one or more persons must be affiliated with a Compensation Fund, free or special, or with the National Office of Family Premiums for Wage-Earners (ONAFTS). All employers therefore pay an assessment to one of these organizations. The assessment is the same for each employee, regardless of his marital or parental status. These organizations then redistribute the sums received as family allowances to eligible persons.

The recipient (the mother or the person who raises the child) receives monthly:

	<i>Francs</i>
(1) for the first child	594
(2) for the second child	957
(3) for the third and each subsequent child	1,375

The rates are raised according to the child's age:

	<i>Francs</i>
(1) for the 6 to 10 year old child	130
(2) for the 10 to 14 year old child	228.75
(3) for the child over 14	340.50

To obtain allowances for a child over 14 years of age, it is necessary to prove that he or she is a student, an apprentice, a young woman housekeeper replacing an incapacitated mother, or one incapable of working. The child is entitled to allowances until the age of, respectively, 25, 21, 21, and, in the last case, without age limit.

There is also a system of family allowances for self-employed workers. Such workers pay an annual fee to a Mutual Fund of Family Allowances or to the National Office of Family Allowances for Independent Workers (ONAFI). These organizations make allocations to the independent working members with families. The following monthly allowances are provided:

	<i>Francs</i>
(1) for the first child	202
(2) for the second child	273
(3) for the third and each subsequent child	1,375

³³ H. Gille, "Scandinavian Family Allowances: Demographic Aspects," *Eugenics Quarterly*, 1 (3):188-189, 1954; U. N. *Measures*, p. 36.

³⁴ See note 19 above.

Family allowances for government employees are the same as those for other wage-earners, plus the following supplements:

	<i>Francs</i>
(1) first child	144
(2) second child	144
(3) third child	149
(4) fourth child	179
(5) fifth and subsequent child	190

Czechoslovakia furnishes another example of how family allowances work. Constituting 2.57 percent of its national income of 172,900 million crowns, at a total budget of 4,443 million in 1963, the Czech family allowances assume the form of payments of standard additions to the income or pension of the head of the family for children of school age or receiving university education up to 26 years of age, provided they are enrolled in universities and have no income of their own in excess of 500 crowns per month.

Until the birth of the fourth child, family allowances are calculated at a progressive rate: 90 crowns per month for one child, 330 for two, 680 for three, and 1,030 for four. Beyond that number the standard rate of 240 per month per additional child is given.

Another form of family allowance is rent reduction in government housing: 5 percent reduction for one child, 15 percent for two, 30 percent for three, and a maximum of 50 percent for four or more. Additional indirect forms of family allowances are government subsidies to industries making children's clothing which is sold at below cost, free distribution of textbooks and school supplies, and free school meals. Although scholarships have as their primary aim the proper training of cadres of specialists and skilled manpower, they become a population measure when the material and social situation of the applicants is given heavy weight in the determination of allocations.³⁵

Maternity Benefits

Leaving aside the few instances of countries that actually award prizes to prolific mothers, several countries provide prenatal allowances or birth grants as part of the family allowance program. A consid-

erable number also provide maternity insurance programs, sometimes linked to employment; and frequently the labor laws require such programs for women who are employed.

Such provisions act as a mitigating force on the well-established negative relation between female employment and fertility. Sometimes maternity benefits, such as paid leave, may defeat family planning programs, as was the case in the Kerala region in India. Two state governments of India (Mysore and Uttar Pradesh) subsequently limited the maternity leave that tea plantations may make available to their female employees to the birth of the first three children.

Since maternity benefits may be considered a form of family allowance, it would be appropriate to continue with the Belgian and Czech examples in the interest of continuity. Belgian legislation provides quite substantial maternity benefits, representing for many workers an amount almost equal to their monthly salary in the case of the first child. These benefits are given to wage-earners by the Compensation Fund or by public authorities. Self-employed workers receive benefits from the organization in charge of paying family allowances.

The rates of benefits are regressive. The mother (or the person who raises the child) receives:

	<i>Francs</i>
(1) for the first child	8,841
(2) for the second child	6,097
(3) for the third and each subsequent child	3,281

These benefits are given "at the birth of any child" qualified for family allowances. They may be requested after the sixth month of pregnancy, regardless of the number of previous childbirths.

In the case of Czechoslovakia, the length of paid leave for working women depends upon their marital status, number of children, and length of employment. They receive portions of their average wages at a decreasing rate during leave.

A comparison of Law Number 88 of 27 June 1968 with the Law of 2 March 1964 will be useful in showing the change in Czech population policies. Under the 1964 law, maternity leave for women employed in government institutions was set at 22 weeks for each pregnancy. Single

women—unmarried, divorced, widowed or deserted—were entitled to 26 weeks of paid maternity leave, while mothers of two or more children were entitled to 35 weeks of leave. The pay during the first 18 weeks of leave was calculated at 75 percent of a woman's average earnings if she had been employed for less than two years, or at 80 percent if for more than two years. After the first 18 weeks, the rate was reduced to 40 percent. However, if the woman had one child, she would receive 50 percent instead of 40 percent, and if she had two children, 60 percent. Single women were entitled to 75 percent for the remainder of their maternity leave.

Under the 1968 law, basic maternity leave has been extended from 24 to 26 weeks with additional benefits. A working woman is entitled to an equalizing allowance in the event of her being transferred on account of pregnancy from a higher to a lower paid job. The allowance survives the termination of her maternity leave if she is unable to resume her previous higher paid job. The same equalizing allowance is given to a pregnant woman or one who has recently become a mother if she was accustomed to working overtime and is unable to do so either before or after the delivery.

Rates of maternity leave pay have been revised upwards: The basic rate is set at 90 percent of the average earnings, but not to exceed 600 crowns per week for a period of 26 weeks. Paid maternity leave may be extended to 35 weeks if the woman has two other children under her care or is single. In addition, a grant of 1,000 crowns is made on the birth of each child.

Another sign of the pronatalist policy is the reduction of the retirement age for working women. While childless women retire at 57 years of age, women with children may retire sooner on a scale descending to 53, depending upon the number of children they have.

Taxation on Income

Nearly all countries provide some system of income tax reduction for persons who have family responsibilities, as a means of easing their financial burden incurred by additional expenditures. This reduction is similar to family allowances in purpose. Occasionally, as in the case of the Soviet Union and Romania, a special tax is levied on the unmarried as well as on childless couples. Such a tax on unmarried

³⁵ Grzybowski, *op. cit.* note 23 above.

persons in India was abolished by the Finance Bill of 1965;³⁶ a tax exemption is still retained there for those who are married with two or more dependent children and an income below a certain level.

In assessing the effects of taxation systems that allow deductions for a family with children, it would be wrong to assume that these effects would be directly analogous to those of family allowances. Tax exemptions are a less perceptible addition to the family wealth; and, more significantly, in the case of most developing countries, the minimum taxable income is already far above average *per capita* income, thus allowing the benefits of such tax exemption to only a small part of the population. Furthermore, an effective system of tax exemption is predicated *a priori* on the existence of an effective income tax system, which does not always obtain.

In view of the analogy between tax exemptions and family allowances, a comparison of their rates may be useful. The following are relevant Belgian tax laws, supplementing the laws governing family allowances and maternity benefits given earlier:

Article 77 provides: For the taxpayer whose taxable income does not exceed 160,000 Frs, the tax is fixed according to a scale established by the King, to an amount varying from 360 to 28,300 Frs; on this tax a discount is given for dependents at least equal to the one provided for in Article 81, paragraph 1.

Article 79 of the law on income taxes provides that the tax is not due until taxable income reaches: 26,000 Frs for a taxpayer having no dependents; 31,000 Frs for a taxpayer having 1 dependent; 36,000 Frs for a taxpayer having 2 dependents; 41,000 Frs for a taxpayer having 3 dependents; 61,000 Frs for a taxpayer having 4 dependents; 61,000 plus 30,000 Frs per dependent beyond the fourth one, for taxpayers having more than 4 dependents.

Article 81, paragraph 1, provides that on the tax calculated in accordance with Article 78, there is a discount of: 5 percent for a taxpayer having 1 dependent; 10 percent for a taxpayer having 2 dependents; 20 percent for a taxpayer having 3 dependents; 30 percent for a taxpayer

having 4 dependents; 50 percent for a taxpayer having 5 dependents; 70 percent for a taxpayer having 6 dependents; 90 percent for a taxpayer having 7 dependents; 100 percent for a taxpayer having 8 or more dependents.

Paragraph 2 provides that no discount is given on that part of the taxable income which exceeds 250,000 Frs plus 25,000 Frs for each additional dependent in excess of four. This tax is calculated at the rate specified for those increments of taxable income above that amount.

Child Labor and Education

Of all the measures of social reform that have an effect on the family, compulsory education laws and child labor laws must be considered in the forefront. The two are closely interrelated in that without compulsory education laws, a minimum age for employment is less easy to enforce and more difficult to justify; and conversely, without the minimum age for employment, the parents' temptation to disregard compulsory education laws will be increased because of their desire to benefit from their children's earning power as early as possible.

The great majority of countries now have some laws for compulsory education although their enactment is no assurance that all children within the stipulated age range will enroll in school. Statistics gathered by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) indicate a marked lack of correlation between law and fact.

Although the International Labor Organization (ILO) conventions on minimum working ages have not been widely ratified (particularly in relation to non-industrial employment), the principle of prohibiting child labor is now almost universally accepted. Once again, however, problems of implementation and ease of infraction lead to large-scale breaches of the principle. This complicates any attempt at measuring the precise effect of the law on fertility. Assuming that the minimum age for child labor corresponds with the maximum age for compulsory education, a strict enforcement of these laws would certainly have a negative effect on fertility. School attendance by children would not only deny their parents a source of income, but would also involve them in such expenses as school supplies, uniforms, and transportation.

Status of Women

The status of women has increasingly been undergoing changes of a kind that can be expected to have a considerable effect on fertility levels. The move toward a global recognition of the equal rights of men and women is recognized in the preamble to the Charter of the United Nations. Governments have little power to change the status of women directly, but by making women equal to men before the law, and by increasing equality of opportunity in education and employment, they can upgrade the status of women in the long term.

Nevertheless, guarantees such as the U. N. Declaration on the Elimination of Discrimination against Women of 1967 and guarantees in states' constitutions have little impact unless reinforced by practical steps and actual facilities. The Soviet Union and the East European countries are the best examples of progress toward these aims. Many less developed countries have recognized the principle but have difficulty in implementing it; thus, for example, most of the Arab countries have laws and decrees providing equal educational opportunities for boys and girls, but only very recently has there been an increase in the facilities available for girls.

The link such laws have with the fertility of populations lies in the increased role of the woman outside the home. Increased educational opportunities delay the age of marriage, while increased employment opportunities for women seem to lead to a reduction in the number of children desired by the family.

The importance of laws in this field is summed up in the Pakistan Second Five-Year Plan:

Educated women can comprehend the possibilities of family planning more readily; gainfully employed women tend to marry later and to have fewer children. . . . The motivation for fewer children and more abundant life is more important than more dissemination of knowledge of the means of contraception.³⁷

Age at Marriage

That the number of children a marriage produces is related to the age at marriage is beyond doubt. One survey conducted in the early 1950s in India shows that

³⁶ See B. L. Raina, "Possible Effects of Public Policy Measures on Fertility in India," in U. N., *World Population Conference, 1965*, Vol. II, p. 102.

³⁷ Government of Pakistan, *Second Five-Year Plan (1960-1965)* (Karachi 1960), pp. 334-335, as quoted in U. N., *Measures, op. cit.*, p. 62.

women marrying between 14 and 17 years of age gave birth to 5.9 children, while those marrying between 18 and 21 gave birth to only 4.7 children.³⁸ A slightly different but essentially similar result obtains in a separate study of India.³⁹

Although higher legal minimum ages for marriage generally obtain in developed countries and lower ages in the less developed, there are interesting exceptions. For example, in Ireland, the minimum ages are 12 for girls and 14 for boys, while in Ethiopia and Peru, they are 18 for girls and 18 and 21 for men, respectively.

In recent years several countries have raised the minimum age for marriage and several other countries are considering proposals for changes in the minimum age. However, proposals for raising the minimum ages in order to reduce the birth rate should be discounted as long as the existing law is not enforced, as in the case of India. Nor would raising the ages have an appreciable effect in those instances where a considerable proportion of the population marry later than the minimum established by law.

Perhaps the People's Republic of China (PRC) provides the best example of how a country can put enormous pressure on its people to postpone marriage. The traditional Chinese custom favors early marriage, and the institution of the child- or infant-bride dates back many centuries. Since the practice of contraception is not in the Chinese tradition, the PRC has relied heavily on late marriage as an instrument for birth control. In 1950, immediately upon coming to power, it raised the minimum marriage ages from 18 to 20 for men and from 16 to 18 for women. Proposals were made in 1956 to raise further the minimum ages to 23 for men and 20 for women, but they were not adopted. Public attention was directed instead to the harmful effects—physical, economic, and educational—that an early marriage would bring. After 1962, the campaign for late marriage was intensified, urging men and women not to marry before reaching the ages of 28 and

25, respectively. Many pressures were brought to bear. Thus, students face immediate dismissal from schools if they marry before graduation; party cadres are especially required to comply with this age guideline. In the communes, men who have not attained 30 years of age and women under 25 are frequently refused marriage licenses, not on any legal ground, but rather through official procrastination, such as subjecting the applicants to repeated discussion sessions aimed at changing their minds and, failing this, insisting that the applications must be referred to higher authorities for decision. Denial of such licenses means that the applicants and their children born out of wedlock do not receive rations to which legally married couples and their children are entitled.

Sometimes, people who respond to government appeals for late marriage are given wide publicity and acclaim, as for example, a woman worker at a production brigade in Hunan Province who postponed her marriage date six times between 1956 and 1966, and a woman textile worker who refused to marry until reaching 33 years of age.

On the whole, the campaign for late marriage has exerted a greater impact upon workers than upon peasants, who remain more tradition-bound and less susceptible to governmental exhortations. One estimate placed the total number of women responding to the late marriage appeals in 1965 at 2,400,000 who postponed their marriages from one to seven years.⁴⁰

Divorce and Remarriage

There is no universal right to divorce. In many predominantly Catholic countries, divorce is absolutely prohibited. In countries where divorce is possible, it often requires a judicial decision based on such grounds as adultery, desertion, imprisonment, or cruelty. The Soviet divorce law, which previously allowed divorce by consent or at the will of one party alone, was changed in 1944 to permit divorce only by judicial decision. The overall effect of the 1944 regime was to tighten financial obligations of spouses and parents in family relations, but in registered marriages only.⁴¹

⁴⁰ Huang, *op. cit.*, p. 130

⁴¹ Grzybowski, "Soviet Union," in *Population and Law, op. cit.*

Significantly different are the laws of Islamic countries which traditionally allow the husband to divorce his wife without the intervention of a judge and without any grounds, and which grant divorce to the wife only through a court decision or through a special provision in the marriage contract.

Tunisia led the Muslim world in placing men and women on an equal footing in its reform of divorce laws in 1956.⁴² Under the reform, the unilateral right of a husband to terminate a marriage—sanctioned by the Muslim tradition—was abolished. Instead, a divorce may only be granted by a court on the basis of mutual consent or, in the event of a demand by one of the parties, on assessing the damages or reparations due to the innocent party. The divorce may be pronounced only after an attempted reconciliation made by the president of the court or his deputy and after a specific period has elapsed without reconciliation. Detailed regulations were also adopted governing alimony and guardianship.⁴³

The effect of the divorce laws on fertility may depend on the strictness with which they are applied, as well as the prevailing customs or social and economic conditions. Remarriage is allowed now by virtually all laws where death or divorce has terminated a marriage (although in India, a century after its legalization, remarriage of widows has remained uncommon because the traditional attitudes remain strong). Thus, divorce may be a factor in increasing potential childbearing, by replacing childless marriages with marriages that result in children. On the other hand, the legalization of divorce, while stimulating marriages, may reduce prospects for stability, thus discouraging childbirth.

Polygamy

While polygamy is permitted virtually throughout the large segment of the world's population that follows the Islamic faith, it is not this custom but rather the traditional Muslim belief that celibacy is abnormal for men and virtually unthinkable for women that encourages fertility

⁴² Code du Statut Personnel, Décret de 13 aout 1956 (6 Moharrem 1376) (J. O. T. du 28 décembre 1956, p. 1742); République Tunisienne, Secrétariat d'Etat à la Justice, *Etat et Capacité des Personnes* (1955).

⁴³ Lee, "Tunisia," in *Population and Law, op. cit.*

³⁸ *The Mysore Population Study. A Cooperative Project of the United Nations and the Government of India* (U. N. publication, Sales No.: 61.XII.3), p. 119; cited in U. N., *Measures, ibid.*, p. 80.

³⁹ S. N. Agarwala, "Effect of a Rise in Female Marriage Age on Birth Rate in India," paper summarized in U. N., *World Population Conference, 1965*, Vol. II, p. 172.

in Muslim peoples. Several studies comparing the fertility of monogamous and polygamous marriages have concluded that the polygamous ones were less fertile, but the overall fertility of a polygamous society might be greater by reason of the larger number of women who are married at any one time.⁴¹

Polygamy is not without limitation in Islamic law, since men entering plural marriages are enjoined to treat all their wives equally or forgo the privilege. On the basis that equal treatment is impossible, the Tunisian Government abolished polygamy in 1956.

Even where polygamy is still legally permitted, the trend is toward placing increasing restrictions on its practice. Section 6 of the 1961 Muslim Family Laws Ordinance of Pakistan, for example, provides:

(1) No man, during the subsistence of an existing marriage, shall, except with the previous permission in writing of the Arbitration Council [a council consisting of a representative nominated by the wife, one nominated by the husband, with the chairman of the Union Council acting as its chairman], contract another marriage, nor shall any such marriage contracted without such permission be registered under this Ordinance.⁴²

In the United Arab Republic, the practice of polygamy is restricted to special circumstances, as for example, when the first wife has a chronic or incurable disease, which must be proved by the husband in court. Another government measure is the introduction of family identity cards showing the marital status of the bearers. As these cards are required for marriage licenses, plural marriages based on deception can be avoided.⁴³ The total number of polygamous marriages in the United Arab Republic does not exceed 3 percent of all marriages anyway.⁴⁴

⁴¹ See U. N., *Measures*, *op. cit.*, p. 82.

⁴² Fazlur Rahman and Lee, "Pakistan," in *Population and Law*, *op. cit.*

⁴³ Aziza Hussein, "The Status of Women in Family Law in the United Arab Republic," paper presented at the U. N. 1964 Seminar on the Status of Women in Family Law, Lome, Togo (Mimeographed, August 18-September 2, 1964), p. 7.

⁴⁴ Magdi M. El-Kammash and Gloria F. El-Kammash, "The United Arab Republic," in *Population and Law*, *op. cit.*

Social Security Programs

Social security programs are a means of insuring against the absence of income due to old age and retirement, unemployment, temporary sickness, and long-term illness. As the duty to protect against such contingencies previously fell upon the family to which the affected individual belonged, the provision of support by the state can have a direct correlation with the size of the family.

Virtually all countries now provide some kind of assistance in old age, although in a number of countries this assistance is available only to former government employees. Great variation is found in the amount paid; in some cases it is a flat rate; while in others it is related to past earnings or present need. Few countries have provisions for health and unemployment insurance to be provided by the government.

When pensions are paid, or when other assistance is given, this could be expected to have a negative effect on the size of the family in that the need for a large number of children as a potential source of support for old age is reduced. On the other hand, where social security programs enable the wife to stay at home, or encourage her not to undertake employment by rendering her income less valuable by reason of the deductions necessary to finance the social security program or by taxing her income on a collective high rate with her husband's, the effect could be to encourage fertility, although the principle that reduced need for children as wage earners leads to smaller families may nevertheless still apply.

Other Social and Welfare Factors

There exist other areas of the law that could bear directly or indirectly on fertility, but have thus far eluded systematic inquiry. It will suffice to identify six possible areas for investigation.

MIGRATION

Although migration—emigration, immigration, and internal movement—is not generally associated with fertility, its impact on fertility should not be ignored. Is there a difference in the fertility rate of people, for example, who migrate to another country as compared to that of those settled at home or involved in internal migration? What are the compara-

tive fertility rates between permanent migrants and seasonal migrants, or between migrants accompanied by wives and those who are not? Are there some psychocultural or socioeconomic factors that affect the fertility rates of people "on the move"? In sum, how do government regulations on migration of both nationals and aliens affect fertility?

VENEREAL DISEASE

It is general knowledge that venereal diseases affect fertility. In some countries the number of people afflicted with such diseases is very high. It seems probable that public health regulations such as requiring immediate reporting of patients, tracing of carriers, and compulsory treatment of diseases would have a positive effect on fertility as well as reducing the number of births with congenital disorders. On the other hand, the effect upon fertility of marriage laws requiring Wassermann tests or the like as a precondition to issuing marriage licenses is more problematical.

PROSTITUTION

While prostitution is generally regarded as a moral or health issue, its relevancy to fertility needs to be explored. Does prostitution have a positive or negative effect on fertility? Is the effect the same in a society with a relatively balanced male-female ratio as in one in which men vastly outnumber women? What if legalization is associated with the requirement of a rigid sanitary or medical inspection and safeguard?

HOMOSEXUALITY

Where homosexuality is illegal even between consenting adults, those with homosexual tendencies may be pressured into heterosexual marriage and produce children, in the interest of conformity. Repeal of anti-homosexual laws would no doubt affect social attitudes toward homosexuality, thereby reducing the number of such marriages and births.

ADOPTION

The institution of adoption, being closely related to the institutions of marriage, property, and succession, has existed from time immemorial. In addition to fulfilling the personal needs and interests of both the adopted and the adopter, it serves

a useful social function by leveling off, to a certain extent, the size of families. Whether liberalization or restriction of adoption laws will affect fertility rates remains to be studied.

INHERITANCE AND LAND TENURE

Last, but not least, what is the impact on fertility of an inheritance law based on primogeniture or one under which women are denied the right of succession? Does fragmentation of land encourage or discourage fertility? Conversely, what is the impact of collectivization, communization, or kibbutzism on the fertility rate?

ADMINISTRATION

That the success or failure of a family planning program hinges very much on the legal framework for the organizational structure of family planning is not open to doubt. Jurisdictional disputes or rivalries between or within ministries could defeat an otherwise well-conceived substantive program. In one case the national family planning program of a country came to a virtual stand-still because two ministries—Health and Social Affairs—contended for control, while a third—Education—remained inactive because of inertia. Other examples, however, can be found pointing to a successful program achieved through a well-coordinated administration. For the purpose of the present paper, it suffices to draw attention to the administrative machinery of five countries, namely, the People's Republic of China (PRC), Japan, Pakistan, the United Arab Republic, and the United States.

China

The People's Republic of China (PRC) is selected because it has the largest population on earth—800 million—between one-third and one-quarter of the world's population. Notwithstanding its official anti-Malthusian stance, the PRC has taken great pains to mobilize and coordinate its governmental machineries and resources to combat rapid population growth.

In a speech reportedly given at a closed session of the Supreme State Conference in Peking on 27 February 1957, Chairman Mao attributed China's 30 million births per year to progress made in medical service and the general rise in living stand-

ards, especially in the countryside. He was also quoted as saying:

But this figure must also be of great concern to us all. I will quote two other figures. The increase in grain harvest for the last two years has been 10 million tons a year. This is barely sufficient to cover the needs of our growing population. The second figure concerns the problem of education. It is estimated that at present 40 percent of our youth have not been placed in primary schools.

Steps must therefore be taken to keep our population for a long time at a stable level, say of 600 million. A wide campaign of explanation and proper help must be undertaken to achieve this aim.⁴⁸

Shortly after Mr. Mao's speech, three decrees were issued by the State Council within the span of two weeks: (a) Guides for Increasing the Supply and Reducing the Prices of Contraceptives, adopted by the Ministry of Commerce, the Ministry of Health, and the Chinese National Association of Marketing Cooperatives, 23 March, 1957;⁴⁹ (b) Notice by the Ministry of Finance concerning Exemption from Commodity and Business Taxes on the Manufacture and Importation of Contraceptive Devices and Chemicals, 2 April, 1957;⁵⁰ and (c) Notice Issued by the Ministry of Health Stressing the Protection of Women and Youth Engaged in Rural Labor, the Intensification of the Campaign for Women's and Infants' Hygiene, and the Improvement of Health Service in the Nursery System, 2 April, 1957.⁵¹ These decrees aim at making contraceptives available and as cheap as possible for people throughout the country, except the minority peoples, in addition to promoting birth control campaigns in the guise of protecting women's and infants' health.

The purported goal of Mr. Mao to stabilize China's population at 600 million—in effect the adoption of a zero-

⁴⁸ *New York Times*, 13 June 1957, p. 8. The edited text subsequently released by Hsin-hua News Agency on 18 June 1957 merely alluded to the "difficulties" posed by a huge population, though at the same time regarded it as both an established fact and an asset. See Lee's statement on "Population Controls in China," in *Economic and Social Problems of the Far East* (Hong Kong University Press, 1962).

⁴⁹ *Chung-hua Jen-min Kung-ho-kuo Kuo-wu-yuan Kung Pao* [People's Republic of China, State Council Bulletin], *op. cit.*, pp. 259–262.

⁵⁰ *Ibid.*, p. 308.

⁵¹ *Ibid.*, No. 17, pp. 313–315.

growth policy—has for various reasons failed of achievement, since China's present population is estimated to have passed the 800 million mark. A less ambitious target, however, was set to reduce the growth rate from the present 2 percent to 1 percent by 1978.⁵² Of particular relevance to this paper is the administrative machinery devised for promoting birth control in a country not only large in size and population, but also beset with many problems in communication, transportation, economic development, educational standards, and a traditional Confucianist doctrine favoring fertility.

An Office of Birth Control was established under the immediate jurisdiction of the State Council. A policy-making body, it had representation from such organizations as the Ministries of Health, Information, Culture, Commerce, All-China Women's Federation, the Communist Youth League, the All-China Red Cross Society, and the Chinese Medical Association.⁵³

A pivotal role was assumed by the Ministry of Health, whose functions included: (a) formulation and promulgation of birth control regulations and measures; (b) supervision of subordinate units; (c) sponsorship of the Chinese Medical Association's research on various contraceptive methods; (d) training of high-level birth control personnel; (e) compilation and distribution of birth control literature and materials; and (f) mobilization and coordination of relevant ministries and mass organizations in birth control campaigns. On each lower level of province and *hsien* (county), the basic organizational set-up and functions of the Office of Birth Control were duplicated. On the village level, contacts with people took place in health stations, infirmaries, or clinics attached to communes and on production brigades or teams (through maternal and child health workers, midwives, nurses, women pioneers, or part-time health workers). The magnitude and pervasiveness of such contacts may be seen by the fact that in Hopei Province alone in 1957, there were established 9,334 birth control clinics, or an average of 770 clinics per county. Since each county had an average population of 300,000, this means

⁵² Huang, *op. cit.*, p. 131.

⁵³ *Ibid.*, p. 77. For English summary version, see Pi-chao Chen, "China's Birth Control Action Programme, 1956–1964," *Population Studies*, 24 (2):142–144, July 1970.

there was one clinic servicing the needs of every 400 persons.⁵⁴

For disseminating public information, the following channels have been used.

(1) Publications—newspapers (including editorials and question-and-answer columns), magazines, handbooks, pictorial posters, and even calendars. According to information obtained in 1966, one calendar devoted three days out of a month to the theme of birth control. On the 8th day of the month, the calendar cautioned that a large family would affect adversely not only the quality of work, production, and study, but also the health of parents and children; hence the people should practice birth control. On the 12th day, it reminded the reader that those needing abortion could go to any hospital for operations with all expenses taken care of by the government. On the 18th day, the calendar urged late marriages—women should not marry before 24 years of age, nor men before 28—in the interest of learning, raising the political, cultural, and skill levels, and serving the cause of socialism.

(2) Meetings—public addresses, group discussions, and home visits by health personnel, union and party cadres, representatives of street committees, women's organizations, and members of cooperatives.

(3) Movies and television.

(4) Exhibitions.

While the birth control campaigns have received some set-backs from time to time, particularly during such mass movements as the anti-rightist campaigns following the Great Leap Forward, the governmental machinery, approach, and rationale for family planning have survived substantially intact, if not even strengthened through accumulation of experience.

Japan⁵⁵

Japan also provides an excellent example of how a coordinated governmental administration can successfully implement a population program.

⁵⁴ Huang, *op. cit.*, p. 97.

⁵⁵ Information on this section is drawn largely from Muramatsu, ed., *Japan's Experience in Family Planning—Past and Present* (Tokyo, 1967); and Lee, "Japan," in *Population and Law, op. cit.*

In the face of an acute population problem after World War II, the Government of Japan appointed a Population Planning Committee which proposed a comprehensive revision of the National Eugenic Law of 1940. The result was the adoption of the Eugenic Protection Law of 1948, which allowed abortion by designated physicians and authorized the creation of the Eugenic Protection Committees to investigate the validity of the grounds for abortion. Members of the Eugenic Protection Committees were appointed "from among physicians, welfare commissioners, judges, prosecutors, officials of the government and municipal offices concerned, or those of learning and experience, by the Minister of Health and Welfare in the case of the Metropolitan, Hokkaido or prefectural Eugenic Protection Committees respectively." However, subsequent amendments to this law have eliminated the need for a designated physician to apply to the Committee if he has the consent of the woman or her spouse.

In 1949, a Population Problems Council was established to examine the economic measures necessary to support the population of Japan, and to discuss methods to reduce the birth rate. The Council recommended a shift of emphasis from light to heavy industry in the face of increasing difficulty in supporting the population through agriculture; the upgrading and extension of the work of health centers and Eugenic Protection Consultation Offices in order to promote family planning; financial assistance for making available the means of contraception; and the expansion of the work of the Institute of Population Problems (concerned with economic and social aspects of population problems), and the Institute of Public Health (concerned with demographic and training programs).

The decision to promote use of contraceptives on a broad front was taken by the Cabinet in 1951, when abortion was found to have an undesirable effect on maternal health. This decision was put into effect by the Ministry of Health and Welfare in a plan sent out to all prefectures apportioning various roles to the prefectural governments and the prefectural (or municipal) Eugenic Protection Consultation Offices. It also encouraged private organizations to play a part.

At the regional level the matter is in the hands of the prefectural governments, the Eugenic Protection Consultation Offices,

and the workers in the field. In addition, an important part is played by the Family Planning Federation of Japan and by the numerous companies and factories that include family planning in the health and welfare services for their workers.

In a later phase (after 1955) the government recognized the need to extend family planning and in particular to make it available to indigent persons. Although the government itself has financed the program to reach indigents, it proved difficult to administer as it is hard to define and locate the indigent, and the remuneration for those giving instruction has proved inadequate to motivate a proper service.

Population program activity in Japan can be summarized as follows: The government is involved in family planning through the Ministry of Health and Welfare, the Institute of Population Problems, and the Institute of Public Health, as well as through the Ministry of Foreign Affairs which is concerned with family planning assistance in foreign countries, and the Overseas Technical Cooperation Agency which provides developing countries with technical cooperation including that in the medical field. Evaluating the organizational structure for family planning in Japan, one may suggest that, while the extreme situation experienced after the last world war may have favorably influenced acceptance, the plan also benefited from the central determination to carry it through to the grass roots, and the system has proved successful where information and materials have reached local levels in a digestible form.

Pakistan⁵⁶

The Third Five-Year Plan (1965-1970) of Pakistan aimed at reducing the fertility rate from 50 per thousand to 40 by 1970—a decrease of 20 percent. Directing himself to this ambitious target, former President Ayub Khan incorporated family planning as a campaign platform. On his election, he set up a Family Planning Division in the Central Ministry of Health, budgeting 284 million rupees for the family planning program in the Third Plan. To underscore the importance of family planning, the government upgraded the Family Planning Division in March 1968 into a sepa-

⁵⁶ Information on this section is drawn from Rahman and Lee, "Pakistan," in *Population and Law, ibid.*

rate ministry, with the Minister of Health holding the additional title of Minister of Family Planning.

At the central level, the Pakistan Family Planning Council was established as an autonomous body with the Minister for Family Planning as chairman and the two provincial Ministers as vice-chairmen. The Council has a number of central secretaries, and some of its members are nonofficials. Its primary functions are: (1) policy, planning, and over-all implementation of the program; (2) research, evaluation, and training; (3) coordination between interdisciplinary, inter-service and inter-provincial family planning activities; (4) procurement and management of foreign exchange requirements needed for the import of contraceptives, export advisory service, etc; and (5) advice to the central government on family planning.

The Council has three important units: the National Research Institute of Family Planning, the Central Evaluation Unit of Family Planning for East Pakistan, and that for West Pakistan. These are located in Karachi, Dacca, and Lahore, respectively.

In addition to these units, the West Pakistan Research and Evaluation Centre under the Johns Hopkins University Medical Social Research Project at Lahore and the East Pakistan Research and Evaluation Centre under the University of California Health Education Project at Dacca operate under the direct control of the Central Secretaries.

Each of the two provinces has a provincial family planning board with the provincial Minister for Health as its chairman and the Secretary of the Health Department as its vice-chairman. The members of the board include secretaries of other relevant government departments and some nonofficials. A senior civil servant is member-secretary of the board and provincial administrator of the program, and his deputy is drawn from the medical profession. The provincial boards are responsible for the implementation of the program in their respective provinces.

Under the provincial boards there are training-cum-research institutes (three in each province) for the inservice and pre-service training of the personnel engaged in the program.

Each administrative district has its own family planning board vested with the full authority to operate according to local conditions and requirements. It is headed

by a deputy commissioner (a civil servant), with membership drawn from other relevant departments at the district level and from among prominent citizens. A publicity-cum-executive officer serves as secretary of the board and chief executive of the program for the district. He is assisted by a district technical officer (a medical doctor), family planning officers, family planning doctors (both full-time and part-time), family planning counsellors, lady family planning visitors, lady health visitors, family planning organizers, and contraceptive distribution agents. The basic unit for field implementation is the district family planning organization, which has three major functions: (1) publicity and education; (2) distribution and sale of contraceptives; and (3) provision of clinical services.

The *dais* or midwives, who are the most effective field workers for the family planning program (besides lady health and family planning visitors), particularly in the rural areas, have recently been reduced in numbers and the inactive among them have been retired.

The technical personnel are trained in the two provincial centers and in the three training-cum-research units in each province. The central and provincial research centers have been and are carrying out various research projects and surveys on such subjects as methods of motivation, contraception, and the availability, acceptability, and effectiveness of various contraceptive methods and devices. Although, in view of the newness and the massiveness of the program, it is difficult to obtain complete and accurate data, it is reasonably safe to accept the claim that the program achieved, in the first 34 months of its establishment, up to June 1968, about 54 percent of the target fixed for 1965-1970. In all, about three million couples have been covered by the program out of a total target of 5 million couples for the Third Plan. A more important development is the *acceleration* rate in the number of users of various types of contraceptives during the last three years (over 500 percent).

United Arab Republic

The first recognition of the need for institutional examination of a possible population problem came in 1953 when the Permanent Council for Public Services formed the National Committee for Popu-

lation Problems. This committee consisted of those ministers whose departments were concerned with population questions and also experts in such matters as gynecology, economics, demography, and sociology. The composition remained the same when the committee became the Egyptian Association for Population Studies, a nongovernmental organization financed through an annual government subsidy.

The organization's activities included instituting research programs and advising on the formulation of policy in the realm of practical activities. It also established a number of family planning centers in conjunction with various public service organizations, such as the Red Crescent Association and the Women's Association for Health Improvement.⁵⁷

A new initiative was launched by the President's Decree of November 1965 establishing a Supreme Council for Family Planning.⁵⁸ Following is the text of the decree establishing the Council and outlining its structure:

DECREE NUMBER 4075-1965 of the President of the United Arab Republic concerning the Establishment of the Supreme Council for Family Planning, November, 1965.

Item One: A Council shall be established, entitled "The Supreme Council for Family Planning," in the city of Cairo, which shall enjoy independent personality.

Item Two: The Council shall have the following responsibilities: comprehensive planning of family planning programmes in the Republic; establishment of a schedule for the execution, supervision, follow-up, and evaluation of the programmes; the study, promotion, and coordination of all population affairs—medical, statistical, social, and economic—as well as the conducting of scientific research connected with family planning; coordination of all organizations taking part in these programmes.

Item Three: The Council shall consist of the following members: the Prime Minister (chairman), the Minister of Public Health, the Minister of Higher Education, the Minister of National Guidance, the Minister of Planning, the Minister of State for Prime Minister's Affairs, the Minister of State for Local Administration, the Deputy Minister of Wakfs

⁵⁷ See Hasan M. Hussein, "Evaluation of Progress in Fertility Control in the U. A. R.," in U. N. *World Population Conference, 1965*, Vol. II, p. 142.

⁵⁸ See El-Kammash and El-Kammash, "United Arab Republic," in *Population and Law, op. cit.*

[welfare organizations] and Social Affairs, and the Head of the Central Agency for Mobilization and Statistics. The Prime Minister has the power to add one or more additional members interested in family planning. The Council has the power to form, from its own membership or other persons, permanent or *ad hoc* committees to study matters for the Council. If the Prime Minister is absent, the Minister of Public Health presides over the Council. The Council meets at least twice a month on the initiative of its chairman. The decisions of the Council shall be put into effect only after the approval of the Prime Minister or his Deputy.

Item Four: The Council shall establish a general secretariat composed of the Minister of Public Health, the Minister of National Guidance, and the Deputy Minister of Wakfs and Social Affairs, which shall provide the necessary administrative apparatus.

Item Five: The decisions of the Council shall be final and binding on all ministries, governorates, and public and private organizations conducting any activities in family planning.

Item Six: The Council shall have a separate budget from funds supplied by the State or gifts and grants accepted by the Council.

Item Seven: The Council shall not be subject to the rules and regulations governing other governmental departments, particularly those pertaining to personnel, salaries, and overtime.

Item Eight: This decree shall be published in the official gazette.

Under the Supreme Council is the Executive Board chaired by the Prime Minister. The Board has the assistance of three general departments: the Department of Technical Affairs, the Department of Financial and Administrative Affairs, and the Department of Provincial Executive Bureaus. Under the jurisdiction of the last-mentioned department come the 25 governorate bureaus. In addition, the Executive Board has three advisory committees specializing respectively in family planning methods, demographic research, and statistical research.

This structure enables policy making, target selection, examination of methods, and other coordinating functions to be carried out at national level. Training of medical personnel and research in demography, family planning, and reproductive physiology are also directed on the national level, inasmuch as the funds for such work to be carried out in medical

schools are provided from a budget of 1.5 million pounds (US\$3.54 million) and a Ford Foundation grant of \$440,000.

Implementation and day-to-day supervision are in the hands of each governorate acting through a family planning committee established pursuant to a decree of the Prime Minister issued in 1966. Each committee is composed of representatives from several governmental departments and from the private sector, under the chairmanship of the governor. The task of the committees is to execute the decisions of the Supreme Council's Executive Board, to study proposals made at governorate level, and to examine and overcome difficulties at the local level.

Each governorate has an executive bureau of which the director of health is the president. The executive bureau is composed of representatives from several governmental departments and is responsible for coordinating the work of the Executive Board and the Governorate Board for Family Planning, implementing regulations of the Executive board, and supervising and inspecting units administering family planning services in the governorate.

The existing program was augmented in 1966, when the President launched a further campaign to promote family planning, by the addition of a network of combined service units throughout the country. Each of these units includes a social center and a clinic through which birth control services are provided.

In sum, the government of the United Arab Republic has spent large amounts of money expanding the family planning services and has established a comprehensive structure for implementing its population policy. Its program may well provide a model for the other Muslim countries.

United States

In the United States, the existence and nature of family planning programs have until recently been essentially a local matter. Thus, on the federal level, official involvement with family planning has been indirect—mainly through such means as providing funds for research on demographic or medical problems, administered by the Department of Health, Education, and Welfare, in particular, through its National Institutes of Health and of Child Health and Human Development. Since 1967, the Congress has provided strong backing for family planning within the Agency for International Develop-

ment's foreign aid program and the Office of Economic Opportunity's anti-poverty program. On 17 March, 1970, the Congress passed an act to establish a Commission on Population Growth and the American Future. The Committee is conducting an inquiry into the following aspects of population growth and its foreseeable social consequences:³⁹

- (1) The probable course of population growth, internal migration, and related demographic developments between now and the year 2000;
- (2) the resources in the public sector of the economy that will be required to deal with the anticipated growth in population;
- (3) the ways in which population growth may affect the activities of federal, state, and local government;
- (4) the impact of population growth on environmental pollution and on the depletion of natural resources; and
- (5) the various means appropriate to the ethical values and principles of this society by which the nation can achieve a population level suited to its environmental and other related needs.

An interim report to the Congress was issued on 17 March, 1971, calling attention to the possibility that by the year 2071, the United States population could be as low as 340 million or as high as a billion, depending on whether the average family would have two or three children. Stressing that this series of small differences in family size could produce dramatically large differences in population, the Commission urged a rational, popular discussion on the national policy, leaving, however, its own recommendations for its comprehensive final report in March 1972.

That concern over family planning has been growing at the federal level and is likely to increase still further is indicated by the passing of the Family Planning Services and Population Research Act, which entered into effect on 24 December, 1970. A landmark legislation (Public Law 91-572), it authorizes a total of \$382 million in federal funds for family planning services, population research, manpower training, and educational activities in fiscal

³⁹ Public Law 91-213, 91st congress, S. 2701, March 17, 1970.

years 1971, 1972, and 1973. Its main objectives are: (1) to make family planning fully available to the 5 million American women now lacking such services; (2) to support research for new and better methods of family planning; (3) to create an Office of Population Affairs in the Department of Health, Education, and Welfare with full authority for family planning programs in the United States; and (4) to support the training of personnel and the preparation of information materials.

On the state level, while legalization of abortion in such states as Hawaii and New York represents a major breakthrough for the birth control movement in the United States, equally significant, though less dramatic, is the steady increase in the number of state legislatures establishing family planning programs—with increasingly liberal content. Thus, while only Alabama, New York, North Carolina, South Carolina, and Virginia had included birth control in public health and welfare services in their statutes or decrees prior to 1965, the following states joined the ranks in the three years between January 1965 and January 1968: Alaska, California, Colorado, Florida, Georgia, Illinois, Iowa, Kansas, Louisiana, Michigan, Nevada, Ohio, Oklahoma, Oregon, and West Virginia.⁶⁰

As an example of state administration of family planning programs, one may cite the 1966 Georgia Family Planning Services Act as amended in 1968, which provides:⁶¹

Section 1. This Act shall be known and may be cited as the "Family Planning Services Act."

Section 2. Definitions.

(a) The word "agencies" as used in this Act shall mean the State Department of Health, county boards of health, health districts, the State Department of Family and Children Services, county departments of family and children services, and district departments of family and children services.

(b) "Family planning services" shall mean counselling and interviews with trained personnel regarding birth control, infertility

and family planning methods and procedures; distribution of literature relating to birth control, infertility and family planning; referral to licensed physicians or local health departments for consultation, examination, tests, medical treatment and prescriptions for the purposes of birth control, infertility, and family planning; and, to the extent prescribed, the distribution of rhythm charts, drugs, medical preparations, contraceptive devices, and similar products used for birth control and family planning.

Section 3 (As changed by Act 947, Ga. Laws 1968).

Within the limitations of the funds available to such agencies, all agencies, as defined in this Act, are hereby authorized to offer family planning services to persons in any one or more of the following classifications: (1) married, (2) the parent of at least one child, (3) pregnant, (4) any person requesting such services.

Section 4. Such agencies may support such family planning services at no cost to the recipients of such services in accordance with rules and regulations of said agencies.

Section 5. The refusal of any person to accept family planning services shall in no way affect the right of such person to receive public assistance or public health services or to avail himself of any other public benefit. The employees of the agencies engaged in the administration of the provisions of this Act shall recognize that the right to make decisions concerning family planning and birth control is a fundamental personal right of the individual, and nothing in this Act shall in any way abridge such individual right, nor shall any individual be required to state his reason for refusing the offer of family planning services.

Section 6. Any employee of the agencies engaged in the administration of the provisions of this Act may refuse to accept the duty of offering family planning services to the extent that such duty is contrary to such employee's personal religious beliefs, and such refusal shall not be grounds for any disciplinary action, for dismissal, for any inter-departmental transfer, for any other discrimination in his employment, or for suspension from employment or for any loss in pay or other benefits. The directors or supervisors of such agencies shall be authorized, however, to reassign the duties of any such employees in order to effectively carry out the provisions of this Act.

Section 7. The State Department of Health and the State Department of Family and Chil-

dren Services are hereby authorized and directed to develop plans and programs to carry out the provisions of this Act, and representatives from each of said departments shall cooperate in developing such plans and programs. Such plans and programs shall include, but shall not be limited to, provisions for:

(1) A training program offered by the State Department of Public Health for the employees of the State Department of Family and Children Services who are in contact with and counsel those persons likely to desire family planning services. Such training program should be designed to provide such employees with complete information regarding family planning and birth control and all matters related thereto.

(2) A systematic plan for coordinating the activities of the two Departments and their counterparts at the county and district level in the area of family planning services.

Section 8. The State Department of Health and the State Department of Family and Children Services are hereby authorized and directed, by and through their respective boards, to adopt and promulgate rules and regulations to carry out the provisions of this Act. Such rules and regulations shall provide the necessary requirements and guides for county and district departments of public health and departments of family and children services.

Section 9. This Act shall be liberally construed to protect the rights of all individuals to pursue their religious beliefs, to follow the dictates of their own consciences, to prevent the imposition upon any individual of practices offensive to the individual's moral standards, to respect the right of every individual to self-determination in the procreation of children, and to insure a complete freedom of choice in pursuance of his constitutional rights

Section 10. All laws and parts of laws in conflict with this Act are hereby repealed.

It may be noted that prior to the 1968 amendment, the family planning services were restricted to persons married, pregnant, or having at least one child. The amendment broadened the categories of eligible persons to include "any person requesting such services." Furthermore, the Georgia State Department of Family and Children Services has interpreted "any person" to include "unmarried minors."⁶²

⁶² See Planned Parenthood—World Population, Order #873/269.

⁶⁰ See *Laws Relating to Birth Control and Family Planning in the United States* (as of January 1968), prepared for Planned Parenthood Federation of America, Inc., by its general counsel, Greenbaum, Wolff & Ernst; Mrs. Harriet F. Pilpel and Mrs. Nancy F. Wechsler, of counsel, p. 5.

⁶¹ Georgia Code Annual 1959 (1967 Supplement), Ch. 99-31, as amended by Act No. 974, Georgia Laws 1968.

CONCLUSIONS

To date, the field of law and population study has received little attention. The categories of laws that evince an impact on population size and growth are characterized by:

- disparity: frequently laws in a given country contradict one another, one cancelling out the other;
- insufficient definition: the presentation of the law may create limitations beyond those of the intent of the law;
- problems in enforcement: countries often lack the instruments with which to implement the law;
- inability to evaluate the effect of the law: there is little information available currently on the extent to which laws in this field can alter behavior.

Beyond these immediate problems concerning already extant or potential laws, there are far broader questions that must be raised in considering the use of law in the field of population. These questions have been discussed in the course of this paper, and four of them will be reviewed briefly here.

The first question involves the delimitation of the field of law and population. Retrospective examination of the laws now in operation suggests that a much wider range of laws affect population size and growth than merely those which directly concern births and the possibility of their prevention or planned spacing. For example, it seems very clear that the number of children which a marriage produces is inversely related to the age at

which a woman is married. What is more difficult to determine is the effect of the laws specifying the minimum age at marriage. Clearly the methods of enforcement of any such laws are matters for primary consideration. But it is of equal significance to assess the causes of a rise in the actual age of marriage, i.e., to assess the roles of such motivational factors as a rise in the standards of living and education, and public opinion or pressure—variables upon which both the adoption and implementation of legislation of this kind may be contingent.

A second question involves the compatibility of social measures with population policy. Adoption of such social measures as family or child allowances and maternity benefits may, depending on their magnitude, have the dual effect of meeting the needs of children, and of encouraging childbirths in view of the benefits attached thereto. While social legislation of this sort would present no problem in a pronatalist country, its formulation in an antinatalist country is a formidable task: it should meet the actual needs of the family without constituting a bonus for a large family.

Third, there is the question of motivation versus contraceptive availability. The experience of several countries clearly indicates that mere availability of contraceptive devices and information is not enough; a much greater emphasis needs to be placed on motivation. However, motivational formulae vary according to the religion, culture, and social, economic, political, and legal conditions of each society. The relationship of legislation to motivation is complex; it is uncertain to

what extent legislation can be a motivating factor and to what extent it is dependent on motivation for its initiation. (Japan's Eugenic Protection Law and its reception in Japan illustrate both these relationships.)

Fourth, is the question of human rights. Among the most difficult problems for the future will be the charting of a proper relationship between the "individual" and the "collective" human right to family planning or, put another way, between "right" and "duty." Exactly when does the individual's right to have as many children as he or she wants begin to be subordinated to the community interest dictating limitation of population growth in the light of limited resources and opportunities? This jurisprudential-philosophical question will undoubtedly remain for a long time to come. However, inability to draw a precise line at this time should not invalidate the human rights approach to family planning, just as failure through the centuries to define with exactitude the right to freedom of speech has not negated that basic human right.

These questions may soon receive increasing attention. There is hope for a certain degree of coherence in the future. There is evidence of a growing recognition of the potential significance of the law in relation to population. The most important move to date is the unanimous adoption in 1968 by the United Nations Conference on Human Rights of the Teheran Proclamation that family planning is a basic human right and of a resolution that couples also have the right to be sufficiently instructed and informed on family planning.



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