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**Law and Population Policy: Some Suggestions
for Determining Priorities and
Estimating Impact**

by John U. Farley
and
Steven S. Tokarski

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Legal Restrictions on the Distribution of Contraceptives in the Developing Nations: Some Suggestions for Determining Priorities and Estimating Impact of Change*

By

John U. Farley** and Steven S. Tokarski***

ABSTRACT

In order for countries to succeed in reducing their population growth rates to levels desired under established policies a long term and concerted campaign must be waged by both the public and private sectors, and the skills of medical, legal, political and numerous other professions must be employed. Nevertheless, the continuing pressure of 3-4 percent population growth rates on the world's natural resources (particularly food and fuel) compels the consideration of simpler, less costly measures which hold the promise of some immediate relief.¹ A study of eight developing countries by the Westinghouse Population Center suggests that the relaxation of legal restrictions on the distribution and use of contraceptive products may present an opportunity for effecting a fairly immediate and significant reduction in population growth rates.

* The authors gratefully acknowledge the assistance of the Westinghouse Population Center, especially Gary L. Dankoehler and Robert H. Smith, in the preparation of materials for this article.

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1. If current fertility levels continue into the future, world population will be nearly 7 billion in the year 2000, over 21 billion in 2050, and about 34 billion in 2070—or nearly ten times today's size within a century. See WORLD POPULATION: STATUS REPORT 12 (Reports on Population/Family Planning No. 15, 1974). See also, F. Thomas, REFERENCE TABLES TO "THE FUTURE OF POPULATION GROWTH" (1973).

INTRODUCTION

Various aspects of law are recognized to have some impact on population development, particularly on the recent efforts in many countries to reduce population growth by the implementation of family planning programs. Official recognition of the importance of law in population planning is evidenced by the Declaration on Population by thirty heads of state in 1967² and by the unanimous adoption of the Teheran Proclamation by the United Nations Conference on Human Rights in 1968.^{3,4} On a more pragmatic level, substan-

2. Conclusions of the Declaration were:

"As Heads of Governments actively concerned with the population problem, we share these convictions:

"We believe that the population problem must be recognized as a principal element in long range national planning if governments are to achieve their economic goals and fulfill the aspirations of their people.

"We believe that the great majority of parents desire to have the knowledge and the means to plan their families; that the opportunity to decide the number and spacing of children is a basic human right.

"We believe that lasting and meaningful peace will depend to a considerable measure upon how the challenge of population growth is met.

"We believe the objective of family planning is the enrichment of human life, not its restriction; that family planning, by assuring opportunity to each person, frees man to attain his individual dignity and reach his full potential.

"Recognizing that family planning is in the vital interest of both the nation and the family, we, the undersigned, earnestly hope that leaders around the world will share our views and join with us in this great challenge for the well-being and happiness of people everywhere." See *Declaration on Population: The World Leaders' Statement* 3 in 1 *STUDIES IN FAMILY PLANNING* 26 (1968).

3. U.N. Conference on Human Rights at Teheran, U.N. Doc. A/CONF. 32/41 (1968). Resolution XXIII, on "Human Rights Aspects of Family Planning," is reprinted with the text of the Proclamation of Teheran in 63 *AM. J. OF INT'L LAW* 674 (1969). It contains the following operative paragraphs:

1. *Observes* that the present rapid rate of population growth in some areas of the world hampers the struggle against hunger and poverty, and in particular reduces the possibilities of rapidly achieving adequate standards of living, including food, clothing, housing, medical care, social security, education and social services, thereby impairing the full realization of human rights.
2. *Recognizes* that moderation of the present rate of population growth in such areas would enhance the conditions for offering greater opportunities for the enjoyment of human rights and the improvement of living conditions for each person.
3. *Considers* that couples have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect.
4. *Urges* Member States and United Nations bodies and specialized agencies concerned to give close attention to the implications for the exercise of human rights of the present rapid rate of increase in world population.

In 1974, the World Plan of Action, adopted by 135 participating nations at the Conference on Population in Bucharest, went even further by extending the right to education and information to individuals as well as couples. See *A Report on Bucharest* 371 in 5 *STUDIES IN FAMILY PLANNING* 12 (1974).

4. For other examples of international concern for population problems, see D. PARTAN, *POPULATION IN THE UNITED NATIONS SYSTEM* (Law and Population Book Series No. 3, 1973).

tial legal research has been conducted in the effort to compile those elements of various legal systems thought to have an effect on population growth rates.⁵

While the connection between law and family planning is now widely accepted,⁶ analysis in this field has rarely advanced beyond speculation that a particular statute or regulation has the effect of contributing to increasing or decreasing population growth rates.⁷ It is acknowledged, for example, that some laws are likely to have a greater impact than others and that some changes can be achieved only at great political, economic or other social cost.⁸ Yet in many countries, even those with national population policies, no attempt has been made to identify priorities from among the many changes suggested by legal studies. This is due in part to the difficulty of performing quantitative analysis in so complicated a subject area as family planning.⁹ Projection of the impact of one law or even of a set of laws requires isolation of legal factors from religion, family economic status and culturally based beliefs and practices. Nevertheless, sufficient data are now available in some countries to allow rough calculations that identify changes in law that would have immediate and not insignificant impact at relatively low cost.

Information gathered in a study of eight developing nations¹⁰ shows that

5. Most notable of these efforts is the Law and Population Programme of the Fletcher School of Law and Diplomacy, Tufts University. See especially, M. COHEN, LAW AND POPULATION CLASSIFICATION PLAN (1973).

6. The connection between law and population has been recognized at the policy level for many years:

"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."

J. Doublet, *Des Lois Dans Leurs Rapports Avec La Population* 39-56 in 4 POPULATION 1 (1949). Cited in L. Lee, *Law and Family Planning* 81 in 2 STUDIES IN FAMILY PLANNING 4 (1971).

7. D. Berman, *Working Paper for Proceedings of the Sixteenth Hammerskjold Forum in ASSOCIATION OF THE BAR OF THE CITY OF N.Y., THE ROLE OF LAW IN POPULATION PLANNING* (1972).

8. B. Berelson, *Beyond Family Planning* 163 SCIENCE 533 (1969). See also T. Lyons Jr., *The Political Process and Legal Change* in PROCEEDINGS OF THE AMERICAN SOCIETY OF INTERNATIONAL LAW REGIONAL MEETING AND THE JOHN BASSETT MOORE SOCIETY OF INTERNATIONAL LAW SYMPOSIUM, THE WORLD POPULATION CRISIS: POLICY IMPLICATIONS AND THE RULE OF LAW (1971).

9. "For example, in failing to forecast the continuing decline in fertility that began in the United States during the late 1950's the demographer in the mid-sixties had no basis for believing that the rash of teenage marriages would subside; women's liberation would become a major social force; the divorce rate could take another sharp swing upward; family planning services, including abortion, would become both acceptable and available to large segments of the population; or that both inflation and unemployment would soar during the last two years of the decade." Berman, *supra* note 7, at 5.

10. During 1971-2 the Westinghouse Population Center (Columbia, Md.) and research firms in eight countries (Turkey, Iran, Thailand, S. Korea, the Philippines, Venezuela, Panama and Jamaica) sponsored by the U.S. Agency for International Development, conducted a three part study of the current and potential role of the commercial sector in family planning: (1) a survey of importers and distributors of contraceptives in each country to examine sales levels of

substantial groups of persons in the developing nations have already decided to limit their family size but cannot do so because contraceptive products are either physically or economically unavailable to them. Analysis of the same data shows also that elimination of legal restrictions directly affecting contraceptive product distribution is likely to result in a visible reduction of population growth rates over a relatively short period of time. This analysis proceeds in the following steps: (1) outline of the current laws affecting the availability and use of contraceptive products; (2) identification of potential users of contraceptives who are currently barred from access to contraceptive products and information; (3) proposed changes and estimation of impact; (4) obstacles to implementation; and (5) a look to the future.

I. OUTLINE OF CURRENT LAWS AFFECTING THE AVAILABILITY AND USE OF CONTRACEPTIVE PRODUCTS

The spectrum of laws affecting population growth rates is very broad, touching both the public and private sectors¹¹ and both product and natural methods¹² of contraception.¹³ Analysis presented here, however, is primarily

commercially distributed contraceptives and to determine the factors impeding and/or facilitating commercial distribution; (2) a survey of operators of retail outlets was undertaken with the following objectives: to profile retail outlets which sell contraceptive products; to determine customer profiles, to determine the degree of knowledge sellers have about family planning and their attitude towards selling family planning products; to determine the role played by contraceptive sellers in family planning, to determine the types of contraceptives sold in retail outlets; and to determine the source of supply of retail outlets and degree of availability of contraceptive products; (3) a stratified multi-stage random sample survey of the fertile population of each country was conducted in order to evaluate the potential for increasing availability and usage of contraceptive products. Data relevant to marketing decisions were sought as well as information of a more traditional, demographic nature. In particular, data were collected in order to distinguish groups that might differ in their receptiveness to family planning (i.e. to identify market segments) and to target policies toward these groups. A structured questionnaire was used to survey the fertile population and to obtain information relevant to the hypothesized factors affecting the use of contraceptive products. To obtain a comprehensive picture of the target population, both men and women were interviewed. A sample of 1,000 cases evenly divided between males and females was selected for the survey. The questionnaire was prepared in English, translated locally in each country and was then pre-tested for appropriateness, wording, sequencing of questions and revised accordingly. All respondents were married (except where cultural circumstances legitimized unmarried couples) and the female was fertile and between the ages of 15 and 44 years. It should be noted that not all rural areas were sampled and that data indicating usage of contraceptives is probably slightly overstated. See WESTINGHOUSE POPULATION CENTER, *DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF SELECTED DEVELOPING COUNTRIES: SUMMARY REPORT* (1974). (Hereinafter cited as Westinghouse, SUMMARY REPORT).

11. In this article, the terms "private sector" and "commercial sector" are defined to include profit making companies engaged in the manufacture, distribution and sale of contraceptive products. The "public sector" is defined as official family planning programs supported by the national or local government and nongovernmental organizations engaged in family planning activities supported by private or nonprofit institutional funds.

12. In this article, the term "product methods" includes only contraceptive products that may be self-administered: oral contraceptives, condoms, spermicides, injectible contraceptives. The term "natural methods" is used to mean rhythm and withdrawal.

13. L. Lee, *Law and Family Planning* 81 in 2 *STUDIES IN FAMILY PLANNING* 4 (1971).

concerned with laws regulating availability and use of contraceptive products which may be self-administered (oral contraceptives and condoms) and which are available through the private sector. Before considering the laws affecting contraceptive distribution, a brief description of family planning delivery systems is in order.

Traditionally, family planning program services and information have been provided through regular medical channels (operating hospitals, private physicians and the social security network are often used)¹⁴ which are themselves subject to many of the barriers discussed above. Where national family planning policies and programs exist, implementation is often through clinics specially staffed for distributing information and contraceptives, and clinics operated by volunteer organizations are also important in many cases.¹⁵ In general, though, family planning is a low priority activity of the conventional medical system.¹⁶

Because organized family planning services originated in the public sector or with volunteer organizations, private sector activity has been viewed as superfluous, frequently ignored and occasionally discouraged. As a result, until recently, little special attention was paid to the impact upon population policy of laws affecting commercial sales, distribution or promotion of contraceptive products. Contraceptives were often grouped with other products (oral contraceptives with ethical drugs¹⁷ and condoms with miscellaneous rubber goods) and were subjected to the same rate of taxation and type of regulations and restrictions as these other products. Since direct consumer advertising of explicit information on ethical products is generally prohibited or controlled, couples who have decided to limit or space children may not know where to obtain or how to use oral contraceptives. Similar limitations often govern communication about other contraceptives.

Over the past few years, increased attention has been focused on the actual and potential role of the commercial sector in supplying contraceptive products in the developing nations. One reason for this interest is the surprising ability of this system (even when confronted by legal barriers) to move contraceptives at relatively high prices, often in competition with government programs which usually provide materials free or at nominal cost (Table 1). There are several reasons for this. First, in most developing nations medical resources and governmental spending power are simply not sufficient to provide services to the entire eligible population, particularly in rural areas

14. D. Seidman, *Alternative Modes of Delivering Family Planning Services* 6-12 in 1 *STUDIES IN FAMILY PLANNING* 52 (1970). See also B. Berelson, *Beyond Family Planning* 163 *SCIENCE* 533 (1969).

15. *Id.*

16. *Id.*

17. An ethical drug is one which may be legally obtained only by physician prescription in a registered pharmacy. Proprietary drugs are sold over-the-counter in both pharmacies and other retail stores.

TABLE I
 PERCENT OF TOTAL FERTILE COUPLES SURVEYED, IN EIGHT COUNTRIES,
 CURRENTLY USING A CONTRACEPTIVE PRODUCT, BY SOURCE
 OF SUPPLY, 1972¹⁸

Country	Private Sector	Public Programs	Total % Using Contraceptives
Turkey	27%	5%	32%
Iran	16%	17%	33%
Thailand	20%	20%	40%
S. Korea	10%	25%	35%
Philippines	3%	10%	13%
Venezuela	19%	18%	37%
Panama	27%	13%	40%
Jamaica	20%	17%	37%

where the majority of these populations live.¹⁹ The private sector in these same countries, however, can reach almost all segments of the population and can in many cases deliver products more cheaply than clinic based government programs. For example, the large numbers of pharmaceutical and non-pharmaceutical outlets (which usually do not now sell contraceptives) to be found even in the most remote rural areas, are channels through which more products and even some information could be delivered. Moreover, pharmaceutical manufacturers and importers have the selling skills, and local advertising agencies have expertise in communications to help design and implement needed advertising or promotional campaigns.²⁰ Private sector potential, however, is particularly limited, in part because of legal regulations affecting availability of contraceptives as well as their price.

Laws affecting contraception can be broken down into two groups. First, there are laws which are primarily directed toward family planning and birth control practices. The "primary-effect" category includes laws regulating abortion and sterilization; laws establishing family planning programs and clinics; laws authorizing or prohibiting para-medical personnel from prescribing contraceptives; laws relating to public education about sex and birth control practices; and laws which regulate the use, sale, display, advertising, importation and manufacture of contraceptive products.

Relaxation of any of these legal constraints can be expected to increase the quantity and variety of contraceptives available through the commercial

18. Westinghouse, SUMMARY REPORT, *supra* note 10, at 25.

19. "The inequities of a physician-distributed method such as oral contraceptives are apparent in the following example. Over half of the 5,000 physicians in Thailand are practicing in Bangkok (population 3 million), and a majority of the rest are practicing in large capital cities and towns. There are less than 200 rural health centers with a physician for the 80% of the population living in rural areas, and very few doctors are in private practice in these areas." L. Atkinson, R. Castadot, A. Cuadros & A.G. Rosenfield, *Oral Contraceptives: Considerations of Safety in Non-Clinical Distribution* 246 in 5 STUDIES IN FAMILY PLANNING 8 (1974).

20. See Farley & Leavitt, *Private Sector Logistics in Population Control: A Case in Jamaica* 449-459 in 5 DEMOGRAPHY 1 (1968) and LEVIN & BELSKY, COMMERCIAL PRODUCTION AND DISTRIBUTION OF CONTRACEPTIVES I (Reports on Population/Family Planning No. 4, 1970).

sector. Any legal changes which would facilitate the freer flow of materials and information should be particularly effective in reaching those segments of the fertile population which are receptive to the notion of contraceptive usage, but are presently unable to gain access to contraceptive products. The impact of such changes on segments which display negative or indifferent attitudes toward the use of contraceptives would clearly be more limited.

There is also a large variety of laws (not included in this study) which though mainly designed to implement other social or administrative policies, incidentally affect population patterns. Laws which have a secondary effect on population include laws relating to family and personal status (minimum marriage age, divorce and remarriage, adoption and succession), social welfare measures (family and child allowances, maternity leave and benefits, child and female labor laws, old age security, housing policies), educational programs (compulsory education, education for women, medical education), public health and medical practices (regulation of medical practice, required health standards for public services), taxes (income tax exemptions related to family size) and controls on migration, internal movement and urbanization. More specifically, insofar as social security programs replace children as the guarantors of support during old age, the perceived importance of children for this role may decline. Families might be induced to plan to have fewer children or to increase the years separating each birth. It may be reasonable to anticipate that population growth rates will decline as a result of the institution of a social security program or of some of the other "secondary-effect" measures listed above. However, these broad social policies are rarely, if ever undertaken for the purpose of meeting population program goals. In many cases, they are adopted because of their primary effect and little or no thought is given to their secondary effect on population growth.²¹ In addition, the timing and size of any decline in growth is not readily determinable without considerable expensive and time consuming research. Consequently, the "secondary-effect" measures are not likely to be effective in achieving any immediate change in population patterns.

In the eight countries surveyed the "primary" legal impediments to the more extensive use of birth control methods varied in type and number. These laws are derived from diverse sources and generally do not comprise a monolithic body of national law relating to the distribution and usage of contraceptives. Some of these laws originate from public health codes or from regulatory schemes covering commercial trade, both domestic and foreign, while others represent examples of governmental supervision over quality and safety in the medical and pharmaceutical spheres of activity.

21. R. Ravenholt, POLICY, TECHNOLOGY AND THE CONTROL OF FERTILITY, in PROCEEDINGS OF THE AMERICAN SOCIETY OF INTERNATIONAL LAW REGIONAL MEETING AND THE JOHN BASSETT MOORE SOCIETY OF INTERNATIONAL LAW SYMPOSIUM, THE WORLD POPULATION CRISIS: POLICY IMPLICATIONS AND THE RULE OF LAW (1971).

Legal restrictions affecting the availability of contraceptive products generally fell into the following categories:

- (1) *Laws Related to Price*
 - (a) High duties and taxes on raw materials needed for local production of contraceptive products and on imported finished contraceptive products;²²
 - (b) Government controls on price and fixed margin controls often encouraged resale through multiple levels of wholesalers with resultant higher prices to ultimate consumers.²³
- (2) *Laws Restricting Channels of Distribution and Sales Outlets*
 - (a) Laws restricting distribution of oral contraceptives, vaginal tablets, and in some cases, condoms, to registered pharmacies;²⁴
 - (b) Requirements of physician's prescription and medical supervision for oral contraceptives and some vaginal products, and restriction of activity of para-medical personnel;²⁵
- (3) *Laws Contributing to Inadequate, Irregular Supply*
 - (a) Complicated customs clearance procedures, time consuming import license requirements and restrictions on the availability of foreign exchange;²⁶
 - (b) Restrictive quotas or total exclusion of imported contraceptives;²⁷
 - (c) Limitations on local manufacturing; alternatively, a requirement of domestic production;²⁸
 - (d) Re-export requirements imposed on imported raw materials;²⁹
 - (e) Internal regulations relating to approval of drugs prior to sale on the market and trade agreements according preferential treatment to certain countries' products; (these restrictions limit not only the quantity of supply but limit the variety and range of products available on the market);³⁰
 - (f) Lack of legal incentives (tax credits, etc.) to encourage holding inventory at the retail level;³¹
- (4) *Laws Barring Advertising and Dissemination of Information*
 - (a) Prohibition or censorship of advertisement and/or store display of contraceptives, vaginal tablets and condoms;³²

22. Westinghouse, SUMMARY REPORT, *supra* note 10, at 106-135.

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

- (b) Restrictions on the role of para-medical and non-medical personnel as family planning consultants;³³
 - (c) Laws restricting promotion of contraceptive products to conventional detailing to physicians, i.e. sampling and retail promotions;³⁴
- (The important identifiable barriers in each country appear in Table 2.)

II. IDENTIFICATION OF POTENTIAL USERS OF CONTRACEPTIVES WHO ARE CURRENTLY BARRED FROM ACCESS TO CONTRACEPTIVE PRODUCTS AND INFORMATION

Legal systems, particularly those components with the primary effect just discussed, do not deal with population dynamics in the aggregate, since population growth rates are the product of independent decisions made by large numbers of couples acting in private, outside the general control of law enforcement. Consequently, analysis must focus on the effect of law on the decision making process of individual couples. One major component of this process is the decision (implicit or explicit, conscious or by default) to practice some form of modern contraception. For the purpose of developing workable proposals to influence this decision it is necessary to focus on specific groups in the fertile population most likely to be affected by the lowering of legal barriers³⁶—i.e. comprising the most promising segments for family planning:

33. *Id.*

34. *Id.*

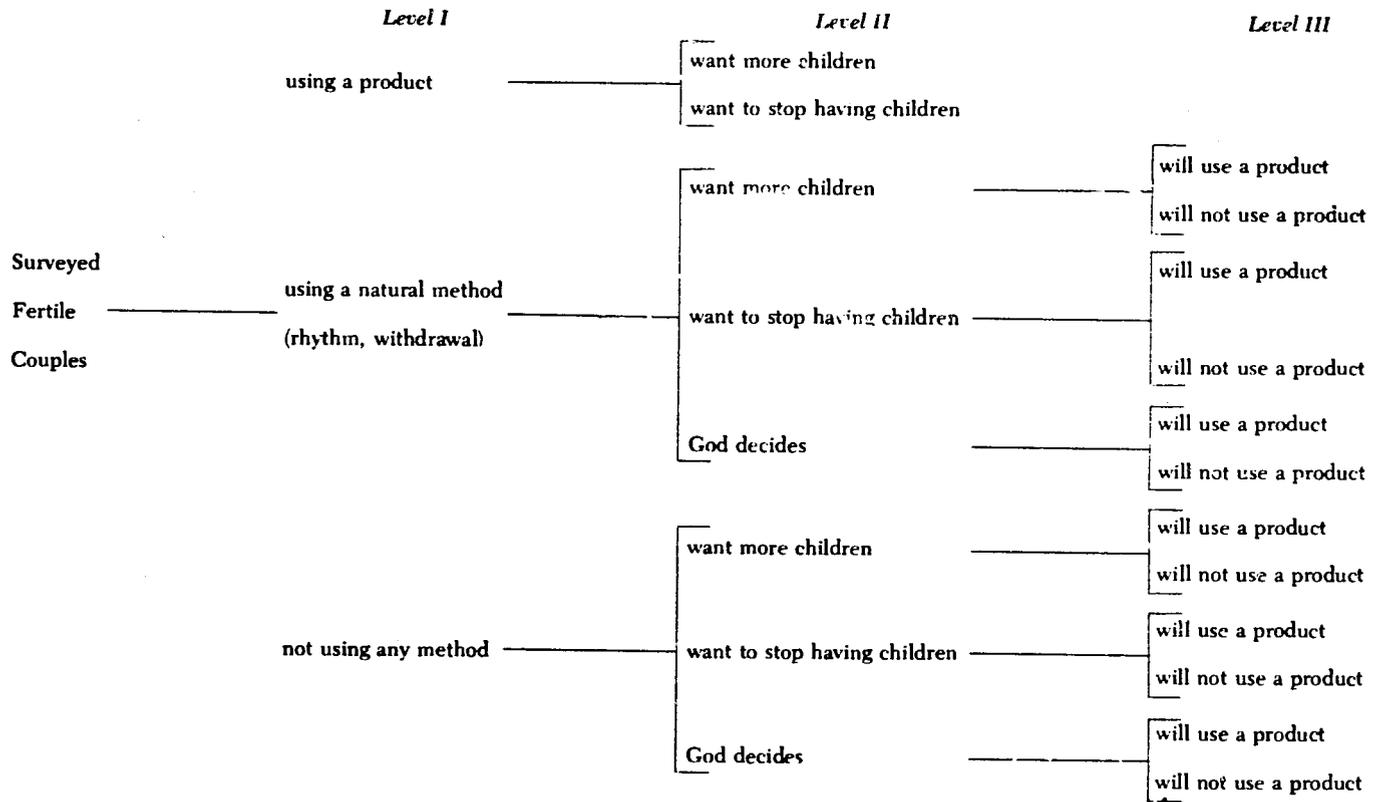
35. Information summarized in Table 2 was gathered from the following sources: U.S. Dept. of Commerce Regional Desk Officers; Dept. of Health in each country; Customs Bureau in each country; Office of Price Control where present; and interviews with importers, manufacturers, distributors and retailers of contraceptive products. It appears in the Westinghouse, SUMMARY REPORT *supra* note 10, at 106-135.

36. From the marketer's point of view, there are three basic steps in developing a plan for increasing the use of contraceptives. The first step is to group the total fertile population according to those likely and unlikely to be receptive to the promotion of contraceptive products. Current contraceptive practice, the desire for more children (complete or incomplete ideal family size), and the intention to use a contraceptive product in the future are the factors which best indicate to which group a fertile couple should be assigned. While the value of these factors as absolute predictors is as yet undetermined, they do seem a fair indication of current receptiveness to promotion of contraceptive products. The second step is to analyze demographic and behavioral profiles in order to develop appropriate means of reaching each group (target audience) and introducing it to the use of contraceptive methods. The third step is to determine which activities will have the greatest impact toward reaching this objective, so that resources available to the private and public sectors can be allocated to them. Participants in random sample surveys conducted in eight countries were segregated into three groups (Level I): those using contraceptive products, those using natural methods and those not using any method. Each of these groups was then subdivided into groups of couples expressing the desire to have more children or to stop having children and into groups who believe that God rather than their own actions determined family size (Level II). In addition, non-users and those using natural methods were also subdivided according to whether or not they intend to use contraceptive products in the future (Level III). The figure below displays these market segments.

TABLE 2 (continued)

Legal Restrictions*	Turkey	Iran	Thailand	S. Korea	Philippines	Jamaica	Panama	Venezuela
(4) <i>Laws Barring Advertising and Dissemination of Information</i>								
(a) prohibition or censorship of advertising								
1. oral pills	x	x	x	x	x	x	x	x
2. condoms	x	x	—	—	x	x	x	x
(b) restrictions on role of paramedical and non-medical personnel	x	x	—	—	x	x	x	x
(c) restrictions on promotion of contraceptives	x	x	—	—	x	x	x	x

* A description of the study which gathered this information is found in footnote 10.



- (1) Couples currently practicing some contraceptive method and not desiring to have more children in the future.
- (2) Couples not practicing contraception who
 - (a) do not desire to have more children, and
 - (b) are willing to use a modern contraceptive method.

The percentage of the fertile population in each of these groups in eight developing nations appears in Table 3.

TABLE 3
PROPORTIONS OF SAMPLES,*IN EIGHT COUNTRIES, COMPRISING MOST
PROMISING SEGMENTS FOR FAMILY PLANNING, 1972³⁷

Country	Current Product Users Wishing To Stop Having Children**	Non-Users, Who Do Not Want To Have More Children, and Are Willing To Use Some Form of Birth Control Device
Turkey	21%	23%
Iran	26%	16%
Thailand	26%	18%
S. Korea	30%	20%
Philippines	9%	17%
Venezuela	22%	11%
Panama	26%	11%
Jamaica	4%	13%

* Sampling frame leads to some overstatement of usage and perhaps intention as well.

** The remainder of product users are probably using contraceptives for child-spacing. However, there is not sufficient data to analyze this group carefully.

In practice, the law affects these and other segments of the population in different ways. For example, those not practicing contraception and wanting to stop having children will be more affected by various prohibitions on the flow of information than will those already practicing a modern family planning method. In addition, a given person may shift several times over a lifetime from one category to another (i.e., starting as a non-contraceptor wanting more children early in marriage, becoming a practitioner wanting more children later in life as spacing of children becomes a concern, and finally, as the family approaches completion, perhaps shifting into the category of wanting to stop having children). The strategy of approach for each group might also be different:

- (1) Those couples practicing contraception who want to have more children might be encouraged to continue practice for a longer than usual period between children.
- (2) Those couples not practicing contraception who do not want more

children and who would consider using some form of contraception might respond to easier access to information and materials.

Of course, both strategies imply that removing legal restrictions is only a part of the solution because attitudinal and behavioral problems not amenable to legal solution also constitute major barriers to influencing these couples' decisions towards the practice of family planning. For example, nearly two-thirds of the couples surveyed were not using any effective contraceptive method (Table 4) and between one-quarter and one-half stated that they would *never* use any contraceptive product.³⁸ Probably more important, most couples expressed a desire for large families. Three or more children (Table 5)

TABLE 4
PERCENTAGE OF SURVEYED COUPLES IN EIGHT COUNTRIES USING
MODERN CONTRACEPTIVE METHODS,* 1972³⁹

Country	Percent of Sample Using Modern Contraceptive Method	Percent of Sample Not Using Modern Contraceptive Method
Turkey	32%	68%
Iran	33%	67%
Thailand	40%	60%
S. Korea	35%	65%
Philippines	13%	87%
Venezuela	36%	64%
Panama	40%	60%
Jamaica	38%	62%

* Oral contraceptives, condoms, spermicides or injectibles. IUD excluded.

TABLE 5
EXPRESSED IDEAL FAMILY SIZE OF FERTILE COUPLES
IN EIGHT COUNTRIES, 1972⁴⁰

Country	Number of Children Desired			
	1 to 3	More than 3	God Decides	Don't Know
Turkey	NA	NA	NA	NA
Iran	28%	48%	21%	3%
Thailand	43%	39%	3%	15%
S. Korea	56%	42%	2%	0%
Philippines	30%	55%	14%	1%
Venezuela	42%	57%	0%	1%
Panama*	27%	69%	1%	3%
Jamaica*	27%	55%	7%	11%

* First column designates 1 or 2 children, second designates more than 2.

38. Id.

39. Id. at 17-24.

40. WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF IRAN 76-132 (1974); WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF THAILAND 103-160 (1974); WEST-

was the expressed ideal family size of 40% of South Korean and Thai couples and as many as 70% of Philippine and Iranian couples (if "God decides" is included as meaning more than three children). As to reasons for non-practice of family planning (Table 6), non-users most often cited the "danger" or

TABLE 6
REASONS NON-USERS OF CONTRACEPTIVES CITE FOR NOT PRACTICING
FAMILY PLANNING, EIGHT COUNTRIES, 1972⁴¹

Country	"Dangerous"	Prefer Natural Methods*	"Immoral"	Want More Children
Turkey	34%	11%	NA	4%
Iran	11%	15%	19%	1%
Thailand	36%	1%	5%	16%
S. Korea	7%	10%	—	41%
Philippines	39%	5%	7%	24%
Venezuela	38%	15%	9%	7%
Panama	11%	3%	—	19%
Jamaica	11%	10%	10%	9%

* Rhythm or withdrawal.

"immorality" associated with contraceptives or that they wanted more children.

Nevertheless, there is now a significant group of fertile couples who do not want to have more children (Table 7). Also, while most couples desire

TABLE 7
PERCENT OF FERTILE COUPLES IN EIGHT COUNTRIES, BY DESIRE
FOR MORE CHILDREN, 1972⁴²

Country	Want More Children	Want To Stop Having Children
Turkey	34%	61%
Iran	29%	55%
Thailand	39%	57%
S. Korea	32%	67%
Philippines	39%	50%
Venezuela	42%	46%
Panama	38%	58%
Jamaica	62%	38%

more than three children, many couples surveyed said that they already had more children than they considered desirable (Table 8). While some of these

INGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF SOUTH KOREA 82-136 (1974); WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF THE PHILIPPINES 70-132 (1974); WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF VENEZUELA 63-72 (1974); WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF PANAMA 71-156 (1974); WESTINGHOUSE POPULATION CENTER, DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF JAMAICA 61-168 (1974).

41. Westinghouse, SUMMARY REPORT 92.

42. Id. at 87.

TABLE 8
RELATIONSHIP OF ACTUAL AND EXPRESSED FAMILY SIZE OF FERTILE
COUPLES IN EIGHT COUNTRIES, 1972⁴³

Country	Ideal Family Less than Current Actual Family Size ^a	Ideal Family and Current Actual Family Size Are Equal ^b	Ideal Family Greater than Actual Family Size ^c
Turkey	15%	34%	51%
Iran	24%	33%	43%
Thailand	11%	34%	55%
S. Korea	25%	38%	37%
Philippines	19%	34%	47%
Venezuela	35%	32%	33%
Panama	26%	41%	33%
Jamaica	20%	17%	63%

^a Already have more children than they want.

^b Have as many children as they want.

^c Want more children.

couples will not use contraceptive methods for one reason or another, a not insignificant minority said they were willing to use a contraceptive product (Table 3, supra). Changes in regulations affecting contraceptives, particularly those affecting price and availability, could help these segments of the population implement their decision to limit family size.

III. SUGGESTIONS FOR CHANGE AND ESTIMATION OF IMPACT

Potential users are confronted by four types of barriers: (1) prohibitively high cost of products; (2) inadequate and irregular supply of products; (3) restricted access to sources of supply; and (4) lack of information concerning contraceptives. Some remedies for these problems are presented here and in the case of the problem of product cost, followed by an effort to calculate the impact of the remedy on population growth rates. Estimation of the impact of price reductions is possible because survey data are available regarding price sensitivity of consumers in seven of the eight developing nations surveyed. While lack of similar data concerning the other potential remedies precludes an attempt at making even rough estimates, the information that is available (see below) clearly implies that wider distribution of contraceptives is likely to achieve significant results at low cost to national governments. In addition, market experiments currently under way in at least three developing nations may soon generate data which will make these calculations possible.⁴⁴

43. Id.

44. Market experiments are now in progress in Jamaica (supervised by the Westinghouse Population Center, Columbia, Md.), Kenya and Sri Lanka (supervised by Population Services International New York, New York).

A. Prohibitively High Cost of Products

The sheer cost of contraceptives relative to income prices them out of the range of a large part of the population in the developing nations.⁴⁵ The average cost of using an oral contraceptive or condoms effectively for one year ranged from 2% to 6% of per capita GNP (Table 9) in the eight countries surveyed as compared to a small fraction of one percent of income in the developed countries.

TABLE 9
MEDIAN COST OF CONTRACEPTIVE USE PER YEAR IN EIGHT
SELECTED COUNTRIES, 1971⁴⁶

Country	GNP/ Capita	Oral Pill Price/ Year for Regular User	Oral Pill Price/Yr. as % of GNP/ Capita	Estimated Condom Price/ Yr. for a Reg- ular Condom User	Condom Price/Yr. as % of GNP/ Capita
Turkey	\$350	\$9.10	2.6%	\$7.20	2.1%
Iran	327	11.05	3.4%	6.00	1.8%
Thailand	400	7.80	2.0%	8.40	2.1%
S. Korea	200	7.00	3.5%	12.00	6.0%
Philippines	200	11.70	5.9%	10.80	5.4%
Venezuela	1,100	29.00	2.6%	27.60	2.5%
Panama	600	24.00	4.0%	19.20	3.2%
Jamaica	543	16.90	3.1%	18.00	3.3%

At the same time, duties and taxes on imported raw materials or finished contraceptive products contribute to these high prices (Table 10). The taxes are, of course, based on legislation enacted prior to the initiation of a population policy but in most cases left unchanged after an official policy is adopted or a program is started. Mexico, for example, recently reversed its pro-natalist policy but did not remove barriers to the import of contraceptives. Table 11 shows that retail price reductions resulting from abolition of taxes and duties may range as high as 30% on oral contraceptives and over 50% for condoms. In virtually all cases, there is potential for some substantial consumer price reduction, provided the benefits are passed on through the conventional mark-up structure usually used with these products.

Estimation of the impact of price reductions resulting from the elimination of taxes and duties may be done in the following way. First, taxes and duties are subtracted from the landed price of oral contraceptives and the prevailing market margins are added to calculate the decrease in retail price (see Table 11). Next, the price sensitivity of the most responsive market segment (non-users who want to stop having children and are willing to use a

45. Levin & Belsky *supra* note 20.

46. Westinghouse, SUMMARY REPORT 73.

TABLE 10
 IMPORT TARIFFS AND OTHER CONTROLS FOR CONTRACEPTIVES IN EIGHT COUNTRIES, 1972^{a,b}

Country	Oral Pills		Condoms	
	Raw Materials	Finished Goods	Raw Materials	Finished Goods
Turkey	5% ad valorem ^c 10% cif ^e +35% fees ^f	5% ad valorem 10% cif +35% fees	NI ^d	22% cif +45% fees
Iran	5-20% ^g +15-20% fees	10% cif +15-20% fees	NI	30% cif
Thailand	30% cif +1.5% sales tax	10% cif +7.7% sales tax	NI 3% on packaging materials	60% cif +7.7% sales tax
S. Korea	5% cif	Import Prohibited	30% cif (70% on latex)	Import Prohibited
Philippines	10% cif +30-40% packaging	30% cif	NI	20% cif +7% sales tax
Venezuela	1% cif	1% cif	1% cif ^h	20% cif
Panama	NI	20% ad valorem +2.5% fees	NI	10% ad valorem +2.5% fees
Jamaica	NI	(US Prod.) 36.5% +5% fees (GB Prod.) 24.5% +5% fees	NI	22% +0.125/hundred wt.

^a Source: U.S. Dept. of Commerce and Westinghouse Population Center.

^b Duties and taxes have changed in many countries since these data were collected.

^c ad valorem—appraised value.

^d NI—no importation.

^e cif—cost, insurance, freight.

^f fees—licenses and consular fees.

^g Depends on form.

TABLE 11
 PROJECTED CHANGE IN RETAIL PRICE OF ORAL CONTRACEPTIVES AS A
 RESULT OF ELIMINATION OF TARIFFS AND TAXES
 IN EIGHT COUNTRIES, 1972⁴⁸

Country	Current Median Price Per Cycle (US \$)	Projected Percent Decrease in Price	Estimated Price Per Cycle After Removal of Tariffs and Taxes (US \$)
Turkey	30.70	NA	\$NA
Iran	0.85	25.9%	0.63
Thailand	0.60	3.3%	0.58
S. Korea	0.54	11.1%	0.49
Philippines	0.90	13.3%	0.78
Venezuela	2.23	7.6%	2.06
Panama	1.85	13.5%	1.60
Jamaica	1.35	23.7%	1.03

contraceptive product; column 1 in Table 12) is examined. The response of couples in this segment to the question, "How much would you be willing to pay per month to stop having children?"⁴⁹ allows estimation of the percent of couples in the group that would be able to purchase contraceptives at the reduced price calculated above (Table 12, column 2). Third, the projected percentage increase of all couples able to purchase contraceptives is obtained by multiplying this figure by the total population percentage this segment represents (columns 1 and 2 in Table 12). In the countries surveyed, the projected increase ranges up to 12.6% of all fertile couples (Table 12, column 3).

Extrapolation of the next effect of this estimated increase in contraceptors on the population growth rate of each country is, of course, a complicated task even with the use of state-of-the-art demographic tools. Analysis here is limited to attempting only a rough calculation using the approach illustrated by the following model.

In a country with a total population of ten million persons, the following factors influencing population growth might be expected:⁵¹

- | | |
|---|-----------|
| (1) Fertile age, married females | 2 million |
| (2) Live births per year (at 45 per
1,000 persons in the population) | 450,000 |

48. *Id.* at 55 & 71.

49. See WESTINGHOUSE POPULATION CENTER, *DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF IRAN* 160 (1974).

51. Forty-five percent of the population may be expected to be between the ages of 15 and 44; slightly less than half of these are female and (assuming an early age of marriage/consensual union) most are married. D. BOGUE, *PRINCIPLES OF DEMOGRAPHY* 147-366 (1969). Birth and death rates used to derive net increase in population here are similar to those common in many of the developing nations. D. NORTMAN, *POPULATION AND FAMILY PLANNING PROGRAMS: A FACTBOOK 7* (Reports on Population/Family Planning No. 2, 1974).

TABLE 12
 PROJECTED INCREASE IN PERCENTAGE OF FERTILE COUPLES ABLE TO PURCHASE ORAL CONTRACEPTIVES
 AS A RESULT OF REMOVAL OF TARIFFS AND TAXES IN EIGHT COUNTRIES, 1972⁵⁰

Country	Percent of Non-Users, Willing To Use a Contraceptive, Wanting To Stop Having Children	Percent of Non-Users, Willing To Use a Contraceptive, Wanting To Stop Having Children, Who Said They Would Pay as Much as the Reduced Price*	Projected Additional Percent of Fertile Couples Able To Purchase Oral Contraceptives as a Result of Decrease in Price
Turkey	NA	NA	NA
Iran	16%	79%	12.6%
Thailand	16%	0%	0%
S. Korea	20%	30%	6.0%
Philippines	17%	26%	4.4%
Venezuela	11%	17%	1.8%
Panama	11%	32%	3.5%
Jamaica	13%	25%	3.3%

* See Table 11.

50. See note 40 *supra*.

(3) Deaths per year (at 15 per 1,000 persons in the population)	150,000
(4) Net increase in persons per year	300,000
(5) Percent net increase in population per year	3.0%

Perhaps 10%, or 200,000 couples might be practicing family planning, and these can be considered highly motivated contraceptors.⁵² If reduction in price leads to doubling of this level of family planning practice, the net annual increase in population might be reduced as follows:

(6) Additional contracepting couples due to reduced price (10% of all couples)	200,000
(7) Estimated live births per year averted as a result of this increase (10% of live births)	45,000
(8) Live births per year after change	405,000
(9) Net increase in persons per year	255,000
(10) Percent net increase in population after change	2.55%

Table 13, based on the method of estimation explained above, shows that modest though not negligible reductions in population growth rates, ranging up to 0.56%, may be achieved in almost all cases. The size of this reduction becomes more important when it is remembered that it is likely to occur in a reasonably short period of time after it is perceived by consumers and that it may be achieved at very low and totally non-recurring cost.⁵³

In addition to the high taxes and duties, there is another kind of legal barrier to reduction of retail cost of contraceptive products. Government controls on margins, ordinarily meant to hold down prices, may also contribute to the relatively high cost of contraceptives. Permissible margins may be unnecessarily high for a product purchased repeatedly, or so low that they may encourage re-sales through multiple levels of wholesaler/retailers before reaching the consumer level. The resultant middleman's margin adds substantially to the price to consumers. Fixed percentage margins also have the disadvantage of encouraging concentration of marketing efforts on the higher

52. A contracepting couple may be considered highly motivated if husband and wife are willing to consistently use an effective method, *e.g.* never miss taking oral pills, use condoms during every act of intercourse.

53. The cost of making price reductions known to the public and of wider distribution would be borne by the private sector and the loss of revenue to the government resulting from elimination of taxes and duties is not significant, *see* note 73 *infra*.

TABLE 13
 PROJECTED IMPACT OF REDUCTION OF RETAIL CONTRACEPTIVE PRICE ON POPULATION GROWTH RATES OF SELECTED DEVELOPING COUNTRIES⁵⁴

Country	Popula- tion (Mil- lions)	Fer- tile Age Fe- males (Mil- lions)	Live Births Per Year (000s)	Deaths Per Year (000s)	Net In- crease in Per- sons Per Year	Addition- al % Con- tracep- ting Due to Lower Price	Births Aver- ted Per Year After Change (000s)	Live Births Per Year After Change (000s)	Net In- crease in Per- sons Per Year	Cur- rent Growth Rate	Growth Rate After Change	Net Change in Growth Rate
Iran	31.1	6.2	1,400	528	872	12.6%	176.0	1,224	696	2.8%	2.24%	0.56%
Thailand	39.9	8.0	1,716	399	1,317	0.0%	None	1,716	1,317	2.3%	2.30%	0.00%
S. Korea	34.5	6.9	1,040	379	661	6.0%	62.4	977	598	2.0%	1.73%	0.27%
Philippines	42.2	8.4	1,900	506	1,394	4.4%	83.6	1,816	1,310	3.3%	3.10%	0.20%
Venezuela	11.9	2.4	488	95	393	3.3%	8.8	479	384	3.3%	3.22%	0.08%
Panama	1.6	0.3	59	14	45	3.5%	2.1	57	43	2.8%	2.68%	0.12%
Jamaica	2.1	0.4	73	14	59	1.8%	2.4	71	57	2.8%	2.66%	0.14%

54. Westinghouse, SUMMARY REPORT, *supra* note 10, and 1973 WORLD POPULATION DATA SHEET (Population Reference Bureau, 1973).

priced products.⁵⁵ Price controls should be instituted only after a realistic appraisal of their probable effects and should seek to link the prospects for a reasonable margin with the sale of contraceptives to more consumers more efficiently.

B. *Restrictions on Distribution Channels and Sales Outlets*

Because oral contraceptives are usually classified as ethical drugs, their sale is in many cases restricted to pharmacies and they can legally be obtained, in theory, only with a physician's prescription. The number of physicians and pharmacies in most developing nations is small relative to the population, and is usually concentrated in the larger cities and towns.⁵⁶ Often, half of the population is "medically indigent," i.e. individuals never see a physician for any reason during their lifetime; even those who do receive medical care have little access to preventive medical services such as family planning. People living in rural or semi-rural areas must either make special long trips to medical centers or else be in effect denied access to contraceptives because transportation to urban areas is irregular or too expensive for frequent trips required for resupply.

Though there is generally little opposition to increasing the available sales outlets for condoms (except in the case of Colombia where sellers want to maintain control of the market), proposals for liberalizing the manufacture, sale and distribution of oral contraceptives have usually met with strong opposition from the medical and pharmaceutical professions. Many physicians argue that most kinds of contraceptives, particularly oral pills, require regular medical supervision in order to monitor the possible serious medical complications. They further contend that no single oral pill formula is appropriate to the physiology of most women, so a physician's examination must precede initiation of use of oral contraceptives.⁵⁷ However, danger from the unsupervised use of oral contraceptives must be compared with the danger of recurrent pregnancy and childbirth.⁵⁸ Pregnancy related fatalities are of much greater magnitude than fatalities related to oral pill usage.⁵⁹ Furthermore, the

55. See P. KOTLER, *MARKET MANAGEMENT: ANALYSIS, PLANNING AND CONTROL* 362-385 (1967).

56. See note 19 *supra*.

57. For discussion of the relative safety and potential long term effects of oral contraceptive use, see Lehfeldt, *Current Status of Oral Contraceptives* in *OBSTETRICS AND GYNECOLOGY ANNUAL* 261 (1973); Bingel & Benoit, *Oral Contraceptives' Therapeutics Versus Adverse Reactions With an Outlook to the Future* in 62 *JOURNAL OF PHARMACEUTICAL SCIENCES* 179-200 (1973); Andrews, *Oral Contraception, A Review of Reported Physiological and Pathological Effects* in 26 *OBSTETRICAL AND GYNECOLOGICAL SURVEY* 477-499 (1971); WORLD HEALTH ORGANIZATION, *METHODS OF FERTILITY REGULATION: ADVANCES IN RESEARCH AND CLINICAL EXPERIENCE* (Technical Report Series No. 473, 1971).

58. Ravenholt, Piotrow & Speidel, *Use of Oral Contraceptives: A Decade of Controversy* in 8 *INT'L. GYNECOLOGY AND OBSTETRICS* 941-956 (1973).

59. The following passage, from Atkinson, Castadot, Cuadros & Rosenfield, *Oral Contraceptives: Considerations of Safety in Nonclinical Distribution* 244-245 in 5 *STUDIES IN FAMILY PLANNING* 8 (1974) makes this point very clearly. Citations are omitted.

"The risks associated with OCs (oral contraceptives) cannot be evaluated without taking into consideration the risks of not practicing contraception or of using other contraceptive methods (cite omitted). The nonpractice of contraception leads to pregnancy, which is a cause of mortality varying from around 25 maternal deaths per 100,000 live births (cite omitted) in those countries providing the best available medical care to most of their population, to 500 per 100,000 in many rural areas of Africa, Asia and Latin America. (cite omitted)

In Table (below), we have compared mortality due to pregnancy and due to method use, by specified method, for the two levels of medical care. The pregnancy rates among OC and IUD users are derived from Tietze (cite omitted) for the United States (2 and 3.5 per 100 woman-years, respectively) and from Sivia's Worldwide Survey of the Postpartum Program (cite omitted) for urban centers of the developing countries (2.6 and 2.2 per 100 woman-years, respectively), and, consequently, these urban use-effectiveness rates might not be representative of the rural areas considered here. The pregnancy rates for "no protection" are derived from Tietze (cite omitted) and take into account the effect of breast feeding on fertility. The rates for condom/diaphragm are from Potts (cite omitted).

The mortality levels associated with OCs and the IUD are based on rates from the United States and Great Britain (cite omitted) and might not be appropriate for other areas. One could assume that the death rates in the developing world are lower among OC users (probable lower incidence of thromboembolic disease) and higher among IUD users (infection less likely to be treated). Although the various rates used in the calculations for this table are approximations only, they seem to provide a reasonable indication of the comparative risks taken by users versus nonusers of contraceptives.

Although there is adequate evidence that oral contraceptives in the United States, Great Britain, and probably other industrialized countries cause a small excess mortality from thromboembolic disease (cite omitted), there is a remarkable scarcity of such evidence from less affluent regions (cite omitted). Part of this might be due to inadequate surveillance and reporting, but some of us who have practiced obstetrics in Africa, Asia and Latin America believe that thromboembolic complications are much less frequent in those areas than in the United States. Initial reports (cite omitted) tend to support these observations. Such a lower incidence rate might be related to different styles of life such as diet, level of activity, lack of smoking, and so on.

In conclusion, the mortality associated with oral contraception is lower than the mortality associated with pregnancy and the less effective methods for each level of health care. The differences are emphasized as the level of health care decreases. The mortality associated with the use of OCs does not seem very different from the mortality associated with the IUD, hence depriving us of clear-cut alternatives in this respect." (Emphasis added.)

CONTRACEPTIVE AND MATERNAL MORTALITY PER 1,000,000 WOMEN
AT RISK BY LEVEL OF HEALTH CARE

Item	No Contraception ^a	Condom/ Diaphragm	IUD	OC
A. Maternal mortality of 250 per 1,000,000				
Pregnancies in any year	600,000	150,000	35,000	20,000
Deaths				
Due to pregnancy	150	38	9	5
Due to method	0	0	10 ^c	30 ^c
Total deaths	150	38	19	35
	No Contraception ^a	Other Methods ^b	IUD	OC
B. Maternal Mortality of 500 per 1,000,000				
Pregnancies in any year	400,000	112,000	22,000	26,000
Deaths				
Due to pregnancy	2,000	560	110	130
Due to method	0	0	10 ^c	30 ^c
Total deaths	2,000	560	120	160

arguments made by medical groups ignore certain key market realities in many developing nations. For example, oral contraceptives, like many other ethical drugs, are generally available over-the-counter in pharmacies in many countries despite legal prohibition on sale without prescription.⁶⁰ Enforcement agencies and pharmacists apparently recognize that enforcing the prescription requirement would generally hurt those who do not have access to the medical system. Removal of these restrictions, which are nonetheless troublesome and partially effective, would only recognize *de jure* what has been widely accepted *de facto*. This could also provide the additional benefit of extending sales of pills to the much broader system of non-pharmaceutical sales outlets and allowing direct advertising aimed at consumers. Of course, each nation must determine on the basis of available data whether the risks and benefits associated with oral contraceptives warrant blanket prohibitions against their sale without prescription or whether some alternate measures may be formulated to insure the public health and safety. Nations have already weighed these factors and decided to eliminate prescription requirements for oral contraceptives (Antigua, Chile, Fiji, Jamaica, Pakistan, the Philippines and South Korea) or to allow para-medical personnel to insert IUDs (Mexico, the Philippines and South Korea).⁶¹

C. *Legal Barriers to Adequate and Regular Supply of Contraceptives*

Effective practice of family planning depends, of course, on the availability of a regular and continuous supply of oral contraceptives or condoms for couples choosing those particular methods, as well as on information for their proper use. In some countries legal regulations and procedures lead to an irregular flow of products, particularly at the import stage.⁶² Customs procedures and foreign exchange regulations may result in port delays which leave retailers out of stock of particular brands or even of particular products for long periods of time.⁶³ Again, these regulations (and the resulting delays) are not specific to contraceptives, but to the customs categories into which contraceptives are classified. If, consistent with government policy, con-

^a Rates for women of reproductive age in fertile unions, with consideration of extent and duration of breast feeding as estimated by Tietze (cite omitted).

^b Other methods include condom (70%), spermicides, diaphragm and a small number of Depo-Provera acceptors (cite omitted).

^c Those figures are approximations and the differences between IUDs and OCs are not of statistical significance.

60. Black, *Oral Contraceptive Prescription Requirements and Commercial Availability in 45 Developing Countries* 250 in 5 STUDIES IN FAMILY PLANNING 8 (1974).

61. C.E. DEAN & P. T. PIOTROW, EIGHTEEN MONTHS OF LEGAL CHANGE 4 (Law and Policy Series E No. 1, 1974).

62. Westinghouse, SUMMARY REPORT 106-135.

63. Id.

contraceptives were dealt with as a special category for customs clearance and currency regulation, the import process would be streamlined and the flow of products expedited.

As with other slow-moving products, retailers hold small inventories of contraceptive products.⁶⁴ Stock-outs of such products are common and are in fact a normal part of day-to-day business operation of small retailers. As many as 20% of the rural couples questioned in five countries (Table 14) said that their source of supply had been out of stock on at least one occasion. This is an especially critical problem because many couples not currently using contraceptives expect to walk to their source of supply and many current users must travel relatively long distances to obtain their supply (Table 14). These stock-outs reflect both the current low sales volume per outlet and also the retailer's inability to obtain credit which would allow each outlet to carry more stock. Should exogenous events (such as reduction in price or a major promotion campaign, for example) lead to a significant increase in demand, some retailers will still be unable to increase their inventory because of lack of credit. Expansion of credit to retailers might be accomplished by such means as tax credits at the retail level (in return for cooperation with other aspects of the government program) as an incentive for stocking a larger than normal inventory of contraceptive products.

D. *Advertising and Information*

Classifying oral contraceptives as ethical drugs also results in prohibitions, either legal (as is the case in Panama)⁶⁶ or based on professional standards (as is the case in Jamaica),⁶⁷ on advertising to the public and restrictions on the role of pharmacists and other para-medical personnel in providing information and advice. Manufacturers cannot or do not post signs to indicate that oral contraceptives are available. The situation with condoms is rather similar, largely because of a tradition of secretiveness involved in their sale. Not surprisingly, improper and ineffective use of contraceptive products resulting from consumer misinformation was widespread in the eight countries surveyed (Table 15). Also, this is an especially appropriate area for change because potential users were favorably disposed toward both mass media advertising and point of purchase display of oral contraceptives and condoms (Table 16). Relaxation of these restrictions should increase the flow of information and availability of products to current consumers, and visibility of products might encourage potential consumers.⁷⁰ The enhanced visibility of

64. *Id.* at 56-65.

66. WESTINGHOUSE POPULATION CENTER, *DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF PANAMA* 23-24 (1974).

67. WESTINGHOUSE POPULATION CENTER, *DISTRIBUTION OF CONTRACEPTIVES IN THE COMMERCIAL SECTOR OF JAMAICA* 22-25 (1974).

70. Simon, *Some Marketing Correct Recommendations for Family Planning Campaigns* 504-507 in 5 *DEMOGRAPHY* 1.

TABLE 14
 PRODUCT "STOCK-OUTS" AND TRAVEL PATTERNS FOR ORAL CONTRACEPTIVES IN EIGHT COUNTRIES, 1972⁶⁵

Country	Percent of Rural Users Ever Experiencing Stock-Out	Percent of Non-Users Who Would Expect To Walk To Source of Supply	Percent of All Oral Pill Users Traveling Less Than 1 Mile for Supply
Turkey	NA	76%	NA
Iran	12%	55%	62%
Thailand	19%	31%	37%
S. Korea	12%	69%	31%
Philippines	20%	34%	17%
Venezuela	NA	39%	NA
Panama	20%	53%	34%
Jamaica	NA	35%	NA

65. Id. at 75.

TABLE 15
 MISUNDERSTANDING OF USE OF CONTRACEPTIVES AMONG CONTRACEPTIVE
 USERS IN SELECTED DEVELOPING NATIONS, 1972⁶⁸

Country	Oral Pill Users <i>Not</i> Understanding That One Pill is to be Used Each Day	Condom Users <i>Not</i> Understanding That a Condom Should be Used at Each Act of Intercourse
Turkey	31%	29%
Iran	11%	16%
Thailand	16%	51%
S. Korea	14%	40%
Philippines	8%	55%
Venezuela	21%	39%
Panama	18%	NA
Jamaica	15%	51%

products might also encourage those who are unaware of contraceptive methods generally to undertake conscious efforts to plan their families.

IV. BARRIERS TO ACTION

The proposed changes in law discussed above are generally consonant with the expressed policies of many countries which have national family planning programs. In addition, they are justifiable on the ground that they provide individuals the opportunity to make voluntary, rational choices regarding family size and spacing, a human right recognized by many nations.⁷¹ Nevertheless, some obstacles may arise if an attempt is made to implement the proposed changes.

Vested commercial interests may also resist changes in the legal system. However, manufacturer, importer and retailer interviews conducted in eight countries⁷² indicated that this is not a critical problem at the moment. Most businessmen in the countries studied seemed more concerned with bringing the birth rate into some balance than with protecting the relatively modest revenue implications for the multiproduct firms now handling contraceptives.

Medical and pharmaceutical organizations concerned with health and safety and other professional organizations may resist measures to make oral contraceptives more readily available to consumers as may various religious and civic organizations.⁷³ The traditional medical aversion to advertising may

68. Westinghouse, SUMMARY REPORT 95-97.

71. See note 3 *supra*.

72. Westinghouse, SUMMARY REPORT 13-66.

73. Dr. Halidan Mahler, Director General of the World Health Organization, commented on this issue in a 1971 interview. "For me there is only one fundamental issue. You have a certain technology, with certain resources, and certain political, social and cultural constraints. Within

TABLE 16
 EXPRESSED ATTITUDE TOWARD USE OF ADVERTISING, OF NON-USERS OF CONTRACEPTIVES
 NOT WANTING MORE CHILDREN AND WILLING TO USE A CONTRACEPTIVE, IN
 SELECTED DEVELOPING NATIONS, 1972⁶⁹

Country	Percent Thinking Use of In-Store Signs is a Good Idea	Percent Thinking Radio and Cinema Ads Are a Good Idea	Reasons Cited for Thinking Signs Are a Good Idea	
			Indicates Availability	Provides General Information
Turkey	NA	NA	NA	NA
Iran	19%	66%	3%	84%
Thailand	49%	57%	69%	—
S. Korea	66%	80%	32%	38%
Philippines	59%	69%	77%	—
Jamaica	84%	87%	73%	10%
Panama	54%	75%	34%	26%
Venezuela	43%	70%	52%	12%

69. See note 40 *supra*.

also retard the wide-scale dissemination of information which may be necessary to cultivate a general level of support for legal reform among both the indifferent and the skeptical. Legal changes must be presented not as a first wedge for an across-the-board incursion into the established medical preserve, but as a special phenomenon which requires unusual measures such as mass advertising and over-the-counter sales of certain ethical drugs.

The existence of price controls and other pricing regulations may complicate effecting changes in prices and margin structures. However, since these price control agencies are generally concerned with maximum prices,⁷⁴ any structural changes which promise generally lower prices should be acceptable. Similarly, reductions in governmental revenues implied by reductions in tariffs or duties on these specific products are generally small⁷⁵ and should not constitute a major barrier provided that the government is serious in implementing its population policies.

Finally, the level of political support of population policies (and specifically the support for measures aimed at encouraging family planning and lowering fertility rates) will be tested by the legislative action required to effect any of the changes suggested here. The time and effort required to secure real support for action (as opposed to basic agreement in principle) will also vary from setting to setting. Open market experiments now in progress should help clarify the scope and degree of the political, medical and commercial problems discussed here and facilitate development of measures to overcome these barriers.⁷⁶

V. A LOOK TO THE FUTURE

It should be apparent from this discussion that means for clear quantitative evaluation of the impact of "primary effect" changes in regulations such as those suggested here, as well as means for evaluation of secondary effects of more general programs are lacking. In fact, one problem faced by population programs is the lack of adequate methodologies to connect the effect of

this setting you have to do the maximum in order to benefit the health care consumer. Therefore I would consider it nonsensical to insist upon using only doctors or other categories of professionally qualified personnel, if you can standardize and simplify your technology to make it safe and applicable through either trained midwives or even people working part-time in health and part-time in other kinds of jobs. I don't think health care will ever be successful at the periphery in many of the developing countries unless other imaginative solutions for delivery are found. This I believe to be the fundamental issue. Our work should not be hampered by any vested interest of the medical profession which still hangs as a cloud over many of the things we do. See *Dr. Mahler: WHO Must Be the Family Planning Coordinator* 12 in 1 PEOPLE 1 (1973).

74. W.J. Keegan, MULTINATIONAL MARKETING MANAGEMENT 267 (1974).

75. Business Management Research Center of Korea University, Research on Prices of Contraceptives and Improvement of Related Tax Systems (1974).

76. See note 40 *supra*.

programs with changes in the birth rate. Absent more research on these issues, estimates of impact must be based on rough calculations like those presented earlier. The significance of any single change is likely to be so modest and the number of factors in the environment so large, that concrete assessment of the impact of a single policy change in terms of birth rate reduction is unlikely. However, it is easy to overlook relatively simple, practical and helpful steps like those suggested here that offer partial solutions in approaching the larger systems problem involved in achieving more ambitious demographic goals. Given the many difficulties that more comprehensive population programs face and will continue to face in terms of both available resources and basic levels of interest of target groups, active search for partial solutions should continue in any case. While the search for simpler and more effective methods of contraception should proceed, it is important to be sensitive to the fact that the relatively minor commitment of resources to activities like removal of legal constraints may be a very effective means of population policy in the short-run and will continue to have some impact over longer periods by assuring broader and more effective distribution of any new contraceptive technologies that might be developed.

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