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RESEARCH ARTICLE OPEN ACCESS

The Malleable Scarcity of Oral Contraceptive Pills

Michelle Brotherton[1,*]

[1]*Philosophy Department, University of Fort Hare, Alice, South Africa*

Abstract:

Introduction: The lack of oral contraceptive pill scarcity is taken into consideration in this article manuscript. Some of the factors are analysed that influence this situation by taking a close look at both historical and contemporary examples of scarcities and shortages.

Methods: Investigations are conducted on whether oral contraceptive pills can even be scarce through an argument by analogy or if politics, legal precedents, societal views, and market politics determine scarcities and shortages.

Results: Given the human rights implications of reproductive health care services and the fundamental difference OCPs can make in the lives of millions of women, claims of shortages and scarcities need to be placed under scrutiny to avoid a violation of rights through unmet needs.

Conclusion: THE malleable scarcity of oral contraceptive pills:"Throughout the history of medicine, thousands of drugs have been developed, but only one has been influential enough to earn the title of simply *the pill*."

Keywords: Reproductive health, Oral contraceptive pills, Reproductive health rights, Human rights, Scarcity, Stockouts.

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*Address correspondence to this author at the Philosophy Department, University of Fort Hare, Alice, South Africa;
E-mail: mishbrotherton@gmail.com

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1. INTRODUCTION

"Family planning is critical – even life-saving. Research shows it plays a major part in reducing the incidence of maternal death globally" [1, 2]. A study in *The Lancet* in 2022 found that pregnancy and childbirth resulted in nearly 200 000 deaths in 2019, and it further concluded that over 162.9 million women have an unmet need for contraceptives [3]. This manuscript is concerned with why this unmet need exists. Particularly, it is concerned with the presumed scarcity of oral contraceptive pills (OCPs)n instances where there is a lack of access to OCPs or a lack of supply of OCPs, the question of *why* needs to be asked. I examine examples of OCP shortages, scarcities, and stockouts and further look at the states' obligations to ensure provision of such. I argue that we are allowing a fundamental need and human right to be treated like a commodity. I argue that it is not enough for states to say that there are not enough resources to make the necessity of contraception available and accessible to those who need it. In arguing this, I challenge the way we view medicine scarcity, shortages, and stockouts.

2. MATERIALS AND METHODS

2.1. Methods

This manuscript is an interdisciplinary inquiry drawing from the legal, medical, bioethics, and political philosophy of disciplines. The article is a synthesis of a qualitative document analysis, a case study, and a discussion on the availability of contraceptives and access thereto.

2.2. Scarcity of Oral Contraceptive Pills

The scarcity of medicine is not a new phenomenon. Nor is scarcity of oral contraceptive pills for women. Currently, in Lebanon, an estimated seventy-five percent of women cannot access OCPs. This drug shortage comes as a result of a multitude of factors, such as the blasting of the port, inflation, the COVID-19 pandemic, the lifting of medicine subsidies, and other issues. (Itani, 2023) Such medicine scarcities pose a public health threat [3, 4]. This has resulted in women having to travel and risk trading on the black market to access OCPs and other contraceptives.

In Bangladesh's Refugee camps, Rohingya girls and women face many hurdles in accessing OCPs [5]. Despite a need for OCPs, there are difficulties and risks in trying to access them, coupled with bias from service providers and community stigma. This is despite the fact that, according to Hudgins:

"Globally, studies have shown that forcibly displaced women and girls face heightened SRV concerns, including increased risks of maternal morbidity, mortality, and sexual and gender-based violence; high risks of sexually transmitted infections, higher risks of unintended pregnancy; and higher risks of unsafe abortion, with its associated complications. Therefore, contraceptive services….[]… are included in the internationally accepted minimum standards for humanitarian health response."

One might be inclined to justify such shortages or lack of access due to the severe and specific circumstances mentioned in these countries. Still, this problem of accessing OCPs is not an isolated one. In the United Kingdom, there is a shortage of hormonal contraceptives [6]. Women's psychological well-being is at risk with the risk of unwanted or unintended pregnancy, and in the UK the link between lack of access to contraceptives and increased abortions has long been recognised, according to Walker. In Australia, some women have somewhat ironically been left waiting over nine months for their OCPs due to product shortages [7]. Alternative options in Australia are not covered by their Pharmaceutical Benefits Scheme and, therefore, are much more expensive, to the point of inaccessibility, per Simons [8].

In Venezuela, there is a severe scarcity of OCPs, something "often unavailable due to chronic supply shortages, and are considered luxury items purchased on clandestine markets." [9] Women are left facing issues of affordability and physical access to OCPs. This has affected such as increasing unsafe abortions and, subsequently, maternal mortality per this study. According to the Association Venezolana para Una Educacion Sexual Alternativa, an organization dedicated to advocating for the rights of women and girls, over 82% of Venezuela's pharmacies reported that they did not have OCPs in 2018 [10]. This situation has only been made worse by inflation and the COVID-19 pandemic, leading to an "era of long lines and black markets," according to Troccoli.

In the United States, where OCPs are used by 14% of women aged 15-49, accessing OCPs has become an increasing issue in light of the overturning of Roe v. Wade [11]. The consequent increase in abortion restrictions has led to more reliance on OCPs. Nicole Huberfeld, co-director of the Boston University Program for Reproductive Justice, stated: "You can't have fewer abortions and not also have more contraception; those things have to go hand in hand." [12] Thus, women in the United States are finding that in spite of their access to abortion being increasingly decreased, their access to OCPs is still limited.

In South Africa, a study found that 40% of all medicine stockouts were that of contraceptives, including OCPs [13]. This is a result of mainly a supply chain issue, resulting in women being unable to access the family planning measures of their choice. As Section 27 researcher Baone Twala told the Sowetan: "Everything else is in place, including laws and policies but in terms of people, contraceptives on the ground is a problem. Somewhere in the administrative process, something is going wrong." [14] This articulates the problem of women and girls in South Africa's lack of access. Although they theoretically and legally have the right to contraception, in practice access is somewhat illusive.

In India, the National Family Planning Health Survey found that there are persistent unmet needs for OCPs [15]. This is despite the fact that "[F]amily planning has been recognised as one of the most cost-effective solutions for achieving gender equality and equity as it empowers women with the knowledge and agency to control their bodies and reproductive choices".

These examples are just a few of the issues faced globally by women and girls seeking access to OCPs (and other contraception). They illustrate the growing unmet need for supply of and access to OCPs. As Coulson *et al*. state, "high unmet need leads to high rates of unintended pregnancies and the links between unmet need for family planning, unintended pregnancies, and unsafe abortions leading to maternal deaths is well established." [16] They go on to say, pertinently, that:

"Universal access to family planning is a human right, central to gender equality and women's empowerment, and a key factor in reducing poverty and achieving the goal of universal health care."

2.3. Evolution of Oral Contraceptive Pills and Influences on Supply and Demand

There has not been a recorded shortage or scarcity of OCPs due to a lack of medication available. From the infancy of OCPs, the ingredients necessary have never been subject to shortages or scarcities. So how exactly have such shortages and scarcities come about and have had such monumental impacts of the lives of women? To understand such scarcities and shortages and discussed above, it is necessary to understand the evolution of OCPs, as they have never been without debate, political interference, marketing effects, or general controversy. These are the things that influence the supply and demand of OCPs, not necessarily the availability of the actual medicine itself.

Margaret Sanger, who was instrumental in the discovery and development of OCPS, coined the term "birth control" in 1914 [17]. However, it was only in the 1960's that the United States Federal Drug Authority (FDA) approved OCPs as a contraceptive. According to the American Experience, by 1967, over 12 and a half million women worldwide were using OCPs. By 1984, this number was estimated to exceed 50 million. The United States attracts focus in terms of the evolution of the OCP as the 'pioneers' of its development were there, and it coincided with the women's movement and various political factors that influenced availability and accessibility worldwide. Thus, it serves as a prime example of how the supply and demand of OCPs are determined by more than just the availability of the medicine itself.

In a 1978 decision by the US Supreme Court, *Carey v. Population Services*, it was held that States do not have the authority to place restrictions on the advertisements, sale, and distribution of contraceptives [18]. This has more recently been affirmed in the Affordable Care Act, which holds that 'preventative health' includes coverage of all FDA-approved contraception. A number of key other legal cases have influenced the politics of OCPs. In 2014, the US Supreme Court, in *Burwell v. Hobby Lobby Stores*, held that employers with religious objections to contraception can refuse to include it in their health insurance plans [19]. In 2017, the Trump administration expanded this religious exemption to include employers with moral objections. Then, in 2019, the US saw a 50 percent decrease in the availability of reproductive healthcare services as a result of the domestic gag rule imposed by the Trump administration. Then, infamously in 2022 the US Supreme Court overturned *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organisation*, holding that the US Constitution does not protect the right to abortion [20]. Especially relevant here is the concurring judgment by Judge Clarence Thomas in which he said that the Court should consider overturning *Griswold v. Connecticut*, essentially arguing that it be re-examined whether people have the right to contraception [21].

These legal and political examples showcase how the supply and demand of OCPS can be influenced by factors other than the availability of medicine. It shows that access to OCPs is market-dependent, and the 'market' is influenced by law, politics, and societal views. According to the IPPF, it is estimated that women with an unmet need for contraception account for 82 percent of all unintended pregnancies [22]. Demand for OCPs is driven by various factors, including the number of women of reproductive age, knowledge and information accessibility regarding birth control, and also attitudes of society. The evolution of OCPs, in the US in particular, provides evidence of how malleable supply and demand are and this is precisely *why* we need to question shortages and scarcities as they can result because of political decisions, societal views, legal proceedings, and many other socio-political factors beyond just the production and availability of the pill. Therefore, shortages and scarcities need to be examined for cause.

3. RESULTS AND DISCUSSION

3.1. Argument through Analogy

To determine the validity of OCP shortages and scarcities, I would like to make an argument through a comparison between painkillers and chairs [23]. This comparison is centered more around the construction or creation of scarcity and the consideration of absolute scarcity *versus* relative scarcity. Absolute scarcity exists when there is only a finite amount of something left in the world, whilst relative scarcity refers to scarcity that results from market dynamics and other influences.[1]

For example, that country *X* does not have any chairs – it is not because there are not enough chairs in the world, as chairs can be made in various ways out of various materials. It may be, however, that no one in country *X* knows how to make a chair or that country *X* has laws or policies preventing anyone in country *X* from making a chair or even importing a chair, despite the fact that country *X* may have the resources available to make chairs or import chairs.

Country *X* may have a need for chairs; there may be a demand for chairs in terms of need; in this instance, the scarcity of chairs is entirely dependent on the structure of the market and political and economic institutions. The lack of chairs is not due to a lack of demand but, therefore, a lack of supply. It is due to the institutional structures that control the supply and demand and serve as the source of the scarcity of chairs.

Now consider painkillers. Painkillers too can be made in various ways out of various materials. Country *X* may have the resources to make or import the painkillers necessary to meet the population's needs but may be barred from doing so by patent laws, regulations, or market structures. Thus, if painkillers are scarce in country *X,* it is not necessarily a result of there not being resources to make or import painkillers to meet the demand. Much like the example of chairs, painkillers can be made in various ways using various materials. Country *X* may know how to make painkillers but may be barred from doing so by patent laws, regulations, or market structures.

As chairs in this example, painkillers are not scarce in the way described as absolute scarcity above. They are scarce relative to the institutional structures in place, affecting their availability and accessibility. In areas where they are deemed scarce, it is not because a finite resource is running out. Just as something could always be used to serve the function of a chair, there is always

[1]This comparison has previously been used in M Brotherton, 2022. "The fiction of scarcity: conceptualising scarcity in terms of global justice" PhD Thesis, available at: https://vital.seals.ac.za/vital/access/manager/Repository/vital:57229?site_name=GlobalView&view=grid&f0=sm_format%3A%221+online+resource+%28233+pages%29%22&f1=sm_subject%3A%22Philosophy%22&sort=sort_ss_sm_creator%5C

something available somewhere to relieve pain. Infinite combinations of ingredients, proportions, and reactions hold somewhat endless possibilities as to the supply of painkillers. Unless one can conceive of chairs being susceptible to absolute scarcity, one cannot concede that medicines are, perhaps with the exception of medicines that contain ingredients that are absolutely scarce. Painkillers thus serve as a good example. People have been relieving pain for centuries before modern medicine. Still today, many people rely on homeopathic or herbal remedies for pain relief. Survivalists, campers, hikers, and indigenous peoples rely on fauna and flora for pain relief. Ingredients and knowledge exist for pain relief to be available to people within the vicinity of those resources.

Chairs cannot become absolutely scarce. There will always be a rock, log, or mound to sit on, and that can serve the purpose of a chair. There will always be something to mould into something suitable for sitting on. It is unimaginable for something serving the purpose of a chair to no longer exist, for chairs to simply run out. Similarly, painkillers – that being things used to relieve pain – cannot cease to exist. Painkillers existing before modern medicine; painkillers exist outside of modern medicine. Their make-up (ingredients) is not limited. As mentioned above, there are somewhat endless possibilities regarding the concoctions and means that could serve the function of painkillers. They are not something, conceptually, which can simply run out. Can the same not be argued for the current status of OCPs? Are they subject to absolute scarcity or are shortages and stock-outs created and manipulated by market dynamics and politics?

This is where it seems counter-intuitive because the news reports that there are stock-outs of medicines or limited supplies of medicines. But this is when one needs to ask why? It does not necessarily follow that the medicines are scarce, at least in the absolute sense as described above. The market determines the supply of medicines in accordance with the demand, which is dictated by patent laws, regulations, and political influence.

If a country does not have the means to purchase painkillers and patent laws prevent it from making its own, can we really say that painkillers are scarce? It is conceivable that enough of painkiller *Z* exists for country *A*, but country *A* simply cannot access painkiller *Z* due to market barriers. This inaccessibility is not the same as scarcity. Conceptually then, just as one can conceive of every person in Mozambique having a chair to sit on, every person in Mozambique *could* receive malaria medication. The lack of malaria medication in Mozambique does not suffice as evidence of scarcity of malaria medication. Malaria medication is synthesized using raw materials which are commonly available. Unless these materials or ingredients become scarce in the absolute sense, then the potential to create malaria medication exists. An absolute scarcity of malaria medication can only occur if a necessary material or ingredient is no longer available or itself absolutely scarce. If malaria medication is scarce, it is likely only relatively scarce in the connection that it is not accessible to those who need it. This could be as a result of the country being unable to make the medication itself, the country being unable to purchase the medication due to a lack of purchasing power, or political barriers impeding access to the medication. Issues pertaining to economics and politics can cause relative scarcity by hindering access to a medication. Yet, just because Mozambique, per this example, does not have access to the medication does not mean that the medication is absolutely scarce. Much like a chair, malaria medication could theoretically be afforded to all if financial, political, institutional, and structural barriers were to be overcome.

This analogy serves to argue that unless the raw materials necessary for OCPs are scarce, there is no justifiable reason for there to be shortages and scarcities thereof, especially if taken seriously as a human right and a human need.

CONCLUSION

There has not yet been a recorded incident of a lack of OCPs due to a lack of the medication existing. Having examined the concept of medicine scarcity and having considered instances such as the US where 'scarcity' of medicine or lack of access of medicine is manipulated by political agendas, societal views, and market politics, we can reexamine the examples from the beginning and question the justifications provided by states for lack of access to OCPs. Can we actually rely on a rhetoric of scarcity from governments when it can be shown that there is no reason (in terms of medicine scarcity) for OCPs to not be accessible? Especially where states recognise reproductive health care services as a human right – what then justifies treating access to OCPs as a mere commodity?

As explained by Dhont, access to OCPs are vital:

"It not only is instrumental in addressing the problem of overpopulation. It has brought millions of women relief from the fear of unwanted pregnancy and has made it possible to avoid innumerable deaths from illegal abortion and childbirth. Moreover, contraception gives women the opportunity to determine the time and number of their pregnancies, allowing them to plan their study and professional career." [24]

This manuscript provides arguements that shortages and scarcities in OCPs are not as a result of a lack of the medication being available but as a result of other factors such as politics, policy, societal views, legal precedents, and other factors that influence supply and demand beyond the mere availability of the medicine. For something which is considered a human right, that of reproductive health care, we should not accept the provision of OCPs to be treated as a market commodity subject to these forces of supply and demand. If taken seriously as a human right, that should supersede influences beyond the actual availability of the medicine. Examining the causes and reasons for alleged scarcities and shortages is thus vital to properly address the unmet needs of millions of women.

DECLARATION

Part of this article has previously been published in a Ph.D thesis by M Brotherton "The Fiction of Scarcity: Conceptualising Scarcity in terms of Global Justice" Available: https://vital.seals.ac.za/vital/access/manager/PdfViewer/vital:57229/SOURCE1?viewPdfInternal=1

AUTHORS' CONTRIBUTION

The author confirms sole responsibility for the following: study conception and design, data collection, analysis and interpretation of results, and manuscript preparation.

LIST OF ABBREVIATIONS

OCP	=	Oral Contraceptive Pills
US	=	United States

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

HUMAN AND ANIMAL RIGHTS

Not applicable.

CONSENT FOR PUBLICATION

Not applicable.

AVAILABILITY OF DATA AND MATERIALS

The data and supportive information is available within the article.

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CONFLICT OF INTEREST

The author declares no conflict of interest financial or otherwise.

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