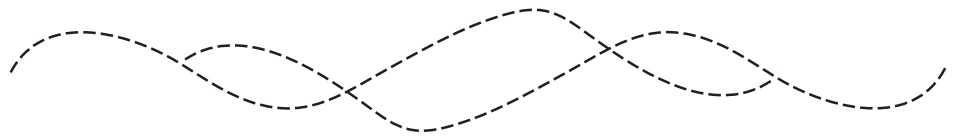


Reviving Reproductive Safety

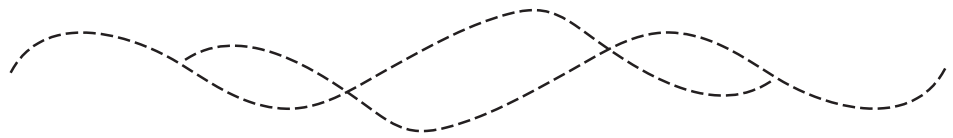
Series No. 1

A *different* TAKES
publication

Examining
Reproductive
Technologies



Linking
Women's Health
and Social Justice



Redefining Choice

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Design by Moira Clingman

Reviving Reproductive Safety: Introduction to Series I

by Betsy Hartmann and Amy Oliver, co-editors, *DifferenTakes*

The 1960s saw the birth of women's health movements in the United States and around the world as feminists organized to transform hierarchal male-dominated medical models, challenge the growing power of the pharmaceutical industry, demand reproductive rights, and fight both anti-abortion and population control forces that target women's bodies. Although these movements varied in their priorities, they shared in common a concern for women's health, safety, bodily integrity and autonomy. They were not afraid to take on powerful vested interests — from pharmaceutical firms to national governments to international agencies — and to expose the connections between them. For example, women's health activists mounted campaigns against risky contraceptives like Depo Provera, Norplant and the Dalkon Shield IUD, revealing the collusion between the drug industry and population control interests whose prime concern was reducing population growth rather than meeting women's needs for safe, voluntary contraception. Women's health movements won many important victories and changed the political landscape of women's health and population policy nationally and internationally.¹

Today many of these movements remain active, rejuvenated by a new generation of leadership. In the U.S. women of color organizations in particular have brought fresh energy and vision to the women's health and reproductive rights movements, broadening the agenda to include fundamental issues of economic, social, racial and gender justice.²

Without romanticizing the past or diminishing the present, however, we believe it is important to revive issues of reproductive safety that are no longer as center stage as they were in the early decades of the women's health movement. A constellation of powerful forces operates to minimize and obscure safety concerns around reproductive technologies, or to render them so politically controversial that women's health activists are wary of taking them up for fear of playing into the hands of the Right. This constellation of forces includes:

- The weakening of drug regulatory agencies like the U.S. Food and Drug Administration (FDA) as part of the neoliberal assault on the public welfare functions of the state;
- A corresponding increase in the power of pharmaceutical corporations and their less than impartial sponsorship of many drug safety trials;
- The pharmaceutical hard-sell, as drugs are widely promoted through television and other media as the technical fix for individual and social problems;
- The intense pressure on women to conform to impossible ideals of both physical beauty and economic efficiency;
- The penetration of anti-abortion forces into government regulatory and research institutions such as the FDA;
- The related binary struggle over 'science' between the ideologically-motivated anti-abortion movement on the one hand and liberal defenders of technological progress on the other which leaves little space for open and informed debate over the pros and cons of new technologies;
- Narrow constructions of 'choice' that equate more contraceptive and reproductive options with women's empowerment, failing to distinguish between safe and unsafe technologies and to address the economic and social barriers that limit women's advancement;

- The lack of access in many places to safe, legal and affordable abortion services vital to real reproductive and contraceptive choice;
- The persistence of population control and other repressive social policies that target women's bodies and penalize them for having children;
- The new eugenics that promotes unregulated and potentially risky and discriminatory genetic technologies with the promise of a perfect future – for those who can afford it.

A
constellation of
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technologies...

The authors of the following *DifferenTakes* issue papers do not shy away from an analysis of these powerful forces. Their contributions are intended to spark discussion and debate about reproductive safety. Although they address different issues, the authors share in common a deep commitment to women's health activism and the belief that central to that project is the need to carefully weigh the risks and benefits of any new technology or policy to women's health, rights and autonomy. In the process, they ask the hard questions and develop and advance a feminist ethics vital to the struggle for reproductive and social justice.

Their contributions are, in order of appearance:

A Decade after Cairo: Women's Health in a Free Market Economy by Sarah Sexton at the UK-based Corner House and Sumati Nair and Preeti Kirbat of the Women's Global Network for Reproductive Rights, Amsterdam.

Reproductive Health and the FDA: Buffeted by Political Battles by Amy Allina, Program Director of the National Women's Health Network in Washington, DC.

Ten Years after Cairo: The Resurgence of Coercive Population Control in India by Rajani Bhatia of the Committee on Women, Population and the Environment.

Depo Provera: Old Concerns, New Risks by Amy Oliver, coordinator of the Population and Development Program at Hampshire College and reproductive rights activist and researcher Diana Dukhanova.

Egg Donation for IVF and Stem Cell Research: Time to Weigh the Risks to Women's Health by Judy Norsigian, co-founder, Boston Women's Health Book Collective and co-author, *Our Bodies, Ourselves*.

Quinacrine Sterilization in India: Women's Health and Medical Ethics Still at Risk by Indian journalist and women's and peace movement activist Rajashri Dasgupta.

Beyond the Hype: What You Should Know about the Seasonale Birth Control Pill by reproductive rights activist and researcher Amelia Bucek.

Ten Reasons Why Prisons are Bad for Reproductive Freedom by Eesha Pandit, associate director of programs for the Civil Liberties and Public Policy Program at Hampshire College.

The Politics of Abortion and Reproductive Justice: Strategies for a Stronger Movement by Marlene Gerber Fried, director of the Civil Liberties and Public Policy Program at Hampshire College and co-author of *Undivided Rights: Women of Color Organizing for Reproductive Justice*.

This publication is being released on the occasion of the 10th International Women and Health Meeting, September 21-25, 2005, in New Delhi, India. Activists from around the world are gathering there to build and sustain an international movement that places women's health, rights and autonomy ahead of unregulated science, harmful reproductive technologies, and corporate interests; and that effectively connects the struggles for reproductive rights and social justice.

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- 1 See, for example, Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990* (New Brunswick: Rutgers University Press, 2002).
- 2 Jael Silliman, Marlene Gerber Fried, Loretta Ross and Elena R. Gutiérrez, *Undivided Rights: Women of Color Organize for Reproductive Justice* (Boston: South End Press, 2004).

A Decade After Cairo: Women's Health in a Free Market Economy

by Sumati Nair, Preeti Kirbat and Sarah Sexton

The Program of Action that came out of the 1994 UN International Conference on Population and Development (ICPD) held in Cairo was the first and most comprehensive international policy document to promote the concepts of reproductive rights and reproductive health.

Its major recommendation — that population programs should provide integrated reproductive health services rather than just family planning — reflects the organizing and lobbying of women's health groups around the world, and the Program has undoubtedly been a useful lobbying and advocacy tool for women's health activists internationally.

One decade later, however, maternal mortality worldwide remains high. Some 600,000 women die each year, 95 per cent of them in sub Saharan Africa and Asia. Eighteen million are left disabled or chronically ill because of largely preventable complications during pregnancy or childbirth. These figures indicate that many women do not have access to essential and emergency obstetric care, let alone access to more comprehensive reproductive health services.

Indeed, more generally:

- i) Health services in many countries are in terminal decline;
- ii) The underlying conditions that determine women's health and their ability to make decisions about their childbearing are deteriorating;
- iii) Fundamentalisms opposing women's rights are on the rise; and

iv) Malthusian thinking that attributes social and environmental problems to the number of children to whom women give birth is as ingrained as ever in development institutions, donor agencies and government departments.

These four trends can be attributed in large measure to the implementation of neo-liberal economic policies over the past two decades, first by means of structural adjustment programs and more recently by international trade agreements. Such policies have helped to prevent the more progressive aspects of the Cairo Program of Action from being implemented.

More critically, however, the Program of Action, and the political organizing that accompanied it, did not challenge this neo-liberal framework sufficiently. In fact, it endorsed it in several respects.

A Few Health Services for the Few

Ten years ago, many lobbyists calling for population programs to provide comprehensive reproductive health services seemed not to notice that influential policy makers were advocating cuts in public health services, the introduction of "user fees" for the public services that remained, and incentives for the "free market" in the health care sector. These developments have had important implications for reproductive health politics.

Much of the Program of Action simply followed the prescriptions outlined in the World Bank's 1993 World Development Report, *Investing in Health*, which openly advocated one limited and under-

funded health care system for the poor (“essential clinical services”), and another high-tech one for those who can or will pay.

The Program’s free-market and neo-liberal approach to implementation undermined its groundbreaking principles and goals of gender equality, women’s empowerment, and reproductive and sexual health. Governments may now subsidize family planning as part of the essential clinical services they provide, but do not pay for doctors, nurses or midwives.

Several studies from Ghana, Swaziland, Zaire and Uganda suggest that the introduction of user fees for public health services is often followed by dramatic drops in women’s use of health care services, an accompanying rise in maternal and infant mortality rates, and a drop in the use of services to treat sexually transmitted diseases.

The Malaysian women’s group, Arrow, concludes that “government and civil society actors trying to implement the Cairo recommendations are working at odds with donors and governments striving to cut health costs.”

Many women’s groups are now well aware that the processes of “health sector reform” are affecting women’s access to health services. Yet calling upon policy makers to integrate reproductive health services into what remains of national health systems leaves unchallenged the interests and forces directing current health sector reforms and their connections with global financial and trade interests.

Neo-Liberalism’s Impacts on Health

Neo-liberal economic policies have affected not just women’s access to health services but also the

determinants of their health more generally. A large proportion of maternal and infant deaths in India, for instance, are attributable to undernutrition, anemia, and infectious and communicable diseases, which are in turn attributable to poverty and a lack of food, not to a lack of contraceptives.

Women’s reproductive rights cannot be achieved unless other fundamental rights — to food, work, freedom of movement and education, for instance — are met. This means that the impact of socio-economic policies on women’s lives has to inform any politics of reproductive rights.

By the time of the 1994 ICPD, the effects of the structural adjustment programs introduced in the 1980s and 1990s were evident. Lifting price controls, freezing or lowering wages, devaluing local currencies, reducing subsidies on basic essentials and encouraging countries to produce food and goods for export rather than domestic consumption all made ordinary people less able to obtain food, transport, education or health care.

In the decade since the Cairo ICPD conference, the agreements of the World Trade Organization (WTO), together with a multitude of bilateral, regional and multilateral free trade agreements, have been implemented to varying degrees throughout the world. If the World Bank has become the most influential institution in terms of health policy and health systems, the WTO has arguably become the most important in its impact on the conditions for health.

Many of these trade agreements require countries to allow competition in health care, water, education and energy services, opening up the way for the commercialization and privatization of public services. The privatization of water supply has become a key trade issue. Because of their responsibilities in the household, women tend to have a higher dependency on access to clean sanitation and drinking water. Recent outbreaks of cholera in South Africa and Latin America have been linked to the privatization of the local water supply.

In countries where average wages dropped and unemployment increased, more women and children entered the paid workforce to increase household incomes. Many of the new jobs created in export



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industries, however, were unskilled and low-waged. Many women became more exposed to machine-related accidents, dust, noise, poor ventilation, exposure to toxic chemicals and sexual abuse, all of which can affect reproductive health, leading to miscarriages and poor fetal health.

Many women left their homes in huge numbers to find work as nannies, domestic help or sex workers. In many countries, women turned to prostitution, making them more vulnerable to sexually transmitted diseases. Many commentators now link the increasing commodification of sexuality, trafficking in women and girls, and prostitution with the neo-liberal economic agenda, as women and girls have fewer and fewer options to earn livelihoods. All of these processes facilitate the spread of HIV and AIDS, thus undermining women's reproductive health and rights still further.

Despite its groundbreaking advances, the Program of Action failed to address macroeconomic inequities and the inability of prevailing neo-liberal, market-oriented approaches to deliver reproductive and sexual health for the vast majority — the commercial sector is just not interested in delivering services to those who can't afford to pay for them.

Reproductive health and rights — and indeed health in general — requires broad, multisectoral approaches rather than single interventions. In practice, however, reproductive health is still translated narrowly as family planning, although now with HIV/AIDS treatment and prevention tacked on.

Resurgent Fundamentalisms

One reason that many women's health groups paid less attention towards assuring the structural and macroeconomic conditions for women to exercise their rights was because they were aiming instead to counter the impacts of religious fundamentalisms on women's rights and self-determination. But a decade later, both economic and religious fundamentalist and traditionalist interests have gained ground in both North and South.

As neo-liberalism has impoverished and excluded more and more people, so it has generated more and more support for religious fundamentalisms, which are thus strengthened in their goals of subordinating women. Women's health groups are struggling today not only to ensure the provision of integrated reproductive health services but even to retain some of the Program of Action's progressive language and concepts. The United States, for instance, has called for many of the key concepts and all language referring to reproductive health services, reproductive rights and sexual health to be removed altogether. The Women's International Coalition for Economic Justice link the attempted dismantling of the reproductive rights agenda to today's intertwined fundamentalisms — the "fundamentalism" of the market, and ethnic and religious fundamentalisms.

Population thinking continues to underlie mainstream development and economic policies...

Malthusian Thinking

A final trend that has blocked women from exercising their reproductive rights is the persistence of Malthusian or population thinking within a range of development institutions and policies, echoing the neo-Malthusian subtext that runs through much of the Program of Action.

No matter how progressive or feminist-sounding population policies and institutions may have become, population theory and practice are still deeply entrenched within many government, academic, NGO, and even women's organizational, circles. They have deep and pervasive effects upon women's lives and health in other areas besides population policies.

Population thinking continues to underlie mainstream development and economic policies, for instance — policies that have made more people surplus to economic requirements. Immigrants, the elderly and the disabled are now added to women, the poor, indigenous peoples and people of color that Malthusianism has traditionally targeted.

Claims that burgeoning numbers of immigrants steal jobs, are parasites on state welfare, and destroy the

environment of countries such as the US, Britain or Australia derive in large part from Malthusian thinking — even though the word “population” itself may seldom be used. Western countries proclaim themselves “full up” (even as the number of children being born drops to below “replacement level”) and argue that they are unable to admit migrants at the same time as they support wars, development projects and climate change that create ever-larger enforced migrations from the South. The belief that these people are “too many” or “overpopulation” has bolstered public antagonism, racism and fear in many places, has fed renewed calls for population control and harsh measures against migrants — and has supported attacks on women’s rights.

The challenge today is not just to make demands for reproductive rights and social justice outside of a population framework, but also to challenge the very thinking that underpins many health, welfare, employment, immigration and education policies, to name a few.

Conclusion

Groups seeking to implement reproductive and sexual rights for women have to confront macroeconomic, fundamentalist and neo-Malthusian agendas that perpetuate gender, race and class inequalities and that impede the implementation of those rights for the vast majority.

Some women’s groups may still find some space within the Cairo framework to negotiate for higher-

quality contraceptive, abortion and health services and increased access to economic and educational resources. But when the international women’s health movement accepts the population framework, it ends up endorsing a narrow technocratic agenda rather than broader policies of social and economic transformation.

The real political space will remain in alliance with progressive development agencies, social justice environmentalists, and anti-racism organizers. New Zealand lawyer Jane Kelsey points out that “If the architects of structural adjustment are pooling their experiences . . . to help them impose their agenda on the rest of the world, those who want to stop them should do the same.” Kelsey admonishes activists to “take economics seriously” because:

“There is no boundary between economic, indigenous, social, foreign, environmental or other policies. Those who focus on narrow sectoral concerns and ignore the pervasive economic agenda will lose their own battles and weaken the collective ability to resist.”¹

Kelsey concludes that activists need to “rethink identity and alliances — combine a critical analysis of economic, political, cultural and social models of the past with a forward-thinking vision of what a socially just future might look like.”²

This is the task before the international women’s health movement.

This paper is an edited extract of “A Decade After Cairo: Women’s Health in a Free Market Economy” by Sumati Nair and Preeti Kirbat of Women’s Global Network for Reproductive Rights (WGNRR) and Sarah Sexton of The Corner House, CornerHouse Briefing 31, www.thecornerhouse.org.uk; www.wgnrr.org

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different TAKES

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Reproductive Health and the FDA: Buffeted by Political Battles

By Amy Allina

Since its inception, the Food and Drug Administration (FDA), the U.S. government's main watchdog agency over the pharmaceutical industry, has been subject to political pressures that undermine its mission to ensure drug safety and protect consumer health. In the last several years, these pressures have intensified as the FDA is buffeted by the Bush administration's right-wing agenda and an ever more powerful pharmaceutical industry. More often than not, women's reproductive health and safety are caught in the crossfire of these political and economic agendas.

The Religious Right and the Battle over Emergency Contraception

In 2002, the Bush administration set off a powerful reaction when it tried to install W. David Hager as chair of the reproductive health drugs advisory committee responsible for advising the FDA on questions relating to contraception and abortion. The outrage of women around the country — expressed by more than 10,000 protest email messages to the FDA — led to a close public scrutiny of Hager's record. Hager had been the lead spokesperson for the Christian Medical Association's petition for a ban on mifepristone,¹ the drug approved by the FDA for abortion. He had spoken publicly of his reluctance to prescribe contraception to patients who are not married.² And as headlines across the country proclaimed, he was co-author of a book recommending prayer as treatment for PMS.³

In the face of this storm of public opposition, the Bush administration backed off from the original plan of putting Hager in charge of the committee, but they did make him a member. And they provided him with like-minded colleagues, appointing Joseph Stanford (who has written that he is unwilling to prescribe contraception even to married patients because of his belief that any

interference between sexuality and fertility is detrimental to marriage⁴) and Susan Crockett (a board member of the American Association of Pro-Life Obstetricians and Gynecologists) to the committee as well.

Reproductive rights advocates and FDA watchers saw these appointments as a sign of the Bush administration's allegiance to the religious right and pointed out that they set the stage for a fight over the pending FDA decision on whether to make emergency contraception (EC) available over-the-counter. Following that discouraging development, feminist activists and reproductive health advocates cheered the triumph of science a year later when the committee voted unanimously that emergency contraception was safe for use in an over-the-counter setting. In the face of overwhelming scientific evidence, even the three staunch opponents of reproductive rights on the committee had to acknowledge that this after-the-fact contraceptive method could be used safely without a prescription requirement. Among the doctors, scientists and activists who had been working for years to expand women's access to EC, most had expected far worse from the committee.

The victory was short-lived, however. Despite the overwhelming recommendation from FDA's science advisors, opponents of contraception prevailed and the FDA denied the EC over-the-counter application.*

Scientists and medical experts joined reproductive rights advocates in criticizing that decision, pointing out that by bowing to anti-choice political pressure, the FDA has denied women access to a safe and effective contraceptive and has undermined its own credibility as a scientific agency around the world. An editorial in the *New England Journal of Medicine* lamented the loss of FDA's "enviable

international reputation” and pointed out that the decision was “likely to mean that both physicians and patients will wonder whether future drug-approval decisions are based on the evidence with regard to efficacy and safety or, rather, on political considerations.”⁵

Mission in Flux

The EC controversy was not a typical, everyday occurrence at FDA. The FDA usually operates behind-the-scenes, unnoticed by most people — even those concerned about health. Yet, despite being out of the public eye, the FDA is still under constant pressure from political forces of a different kind than the very public battles that take place over reproductive rights. The standard battle at the agency is between the interests of the companies that make the drugs and devices it regulates and consumer advocates concerned about the safety of those products.

Since the FDA was first created early in the twentieth century, there have been struggles between businesses, determined to fight off government interference, and consumers and their advocates, working to establish a role for the federal government in protecting the public health.⁶ At its start the FDA was made up of a handful of scientists who worked in an obscure bureau of the Department of Agriculture; as the scope of drugs and medical devices in the world has expanded, the FDA has grown as well, now responsible for regulating over a trillion dollars worth of food, drugs and medical devices, more than a fifth of the U.S. economy.

This growth has taken place in spite of industry resistance. It has taken fierce fights between consumer advocates and industry, and all too often, national and international tragedies to expand the

scope of FDA regulation. Sadly, many of the events that have persuaded Congress of the need for better regulation of drugs and medical devices have specifically involved damage to the life and health of women. Only after thalidomide, given to pregnant women to reduce morning sickness, was found to have caused nerve damage in the women who took it and sometimes fatal birth defects in their children, did Congress mandate that FDA must review evidence of a drug’s safety and efficacy before a company could begin to sell it. And pre-market review of medical devices came even later. In the United States alone, 17 women died and thousands more had emergency hysterectomies to save their lives as a result of using the unsafe Dalkon Shield IUD before the FDA was given the authority to require those reviews.

In the last decade, however, the trend has gone in the opposite direction. When conservative lawmakers won control of Congress in 1994, they went to work on a broad reform agenda that reflected the wish lists of industries from financial services to pharmaceuticals. The FDA Modernization Act of 1997 reshaped the agency in response to the drug industry’s long-held desires. The new law speeded up drug approvals, scaling back safety requirements, and even redefined the agency’s mission statement to commit it to working in consultation with “manufacturers, importers, packers, distributors, and retailers of regulated products.”⁷

Recent news about drug safety problems with widely prescribed pain relievers, however, has led to a growing public understanding that FDA’s ability to protect the public has been eroded. Public outrage has already translated into Congressional interest, and these developments may lead to drug safety reform legislation to restore some of FDA’s capacity to ensure drug safety.

The False Choice Between Speed and Safety

Over the years as these trends have evolved, drug companies have not always been alone in criticizing FDA for its slow approval process. Patient activists have sometimes made common cause with industry, pushing for faster drug approvals even at the expense of rigorous safety testing. Early AIDS activists, in particular, urged FDA to dispense with stringent safety requirements to give dying patients access to new treatment drugs. Later, as more AIDS



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drugs became available, many of these same activists responded to the changed circumstances and urged the FDA to reprioritize the need for evidence of long-term effectiveness and safety in its consideration of AIDS drugs.

Women's health advocates similarly urged faster approval for the female condom and other barrier methods of contraception that hold the potential to protect women from HIV infection and other sexually transmitted diseases. The question of how to balance safety concerns with the urgent need for a product will again be at center stage when FDA eventually considers approval of microbicides now in development — topically applied products that help prevent the transmission of HIV and other infections.

Drug companies and device manufacturers have watched these developments carefully and learned from them. Industry-funded patient groups now often play a very public role in companies' plans for obtaining FDA approval; in some cases these patient groups have been found to be wholly created by the companies whose products they are demanding access to. But activists who are accountable to real-life patients suffering from illness are learning as well. They have learned to reject the false choice between faster approval and safer products. The demand for efficient consideration of urgently needed products does not have to result in the elimination of safeguards for the public health.

Addressing Safety Concerns and Overcoming Division

When it comes to contraception, the political battles sometimes converge, subjecting these critical women's health products to the complicated tensions of the safety/access balance as well as the bruising assaults of the anti-choice, anti-family planning right-wing. In the past, this convergence has created division within the reproductive health community, as was seen with Depo Provera, the contraceptive injection, and Norplant, the contraceptive implant. Women's health advocates who asked the FDA not to approve a contraceptive because of safety concerns have been seen by family planning advocates as unwitting accomplices to anti-choice efforts to block access to products that improve women's ability to control fertility. Family planning advocates who have urged approval of new contraceptive products in spite of unanswered questions about safety have been seen by consumer health advocates as unwitting accomplices to an

industry agenda that promotes fast approval without adequate safeguards for women's health.

These controversies (as well as the fact that the Baby Boomers, who drive so many marketing choices in the United States, need less and less contraception as they age) have sometimes led major companies to shy away from contraceptive products, except in cases where they expect very high levels of profitability to counterbalance their concerns about political controversy. Both mifepristone and EC fell into this category, failing to attract the interest of the big pharmaceutical companies and only advancing to FDA approval with the support of smaller companies committed to providing women access to these products.



It is interesting to note that in the case of both mifepristone and EC, the companies involved worked closely with the reproductive rights and women's health communities to make sure that women's

safety concerns were seriously addressed. This cooperative approach headed off the potential for internal controversy and created a united front of women's advocates to face the anti-choice opposition which was thus effectively marginalized.

Lack of Credibility Undermines FDA's Ability to Protect Women's Health

Last fall, a new development in the regulation of Depo Provera proved the truth of the *New England Journal of Medicine* editorial warning that FDA's motivation for future decisions would be called into question.

Women's health advocates have raised concerns about the safety of Depo Provera for decades. Over time, research has laid to rest some but not all of the questions about the effects of this drug. One uncertainty that had remained was about Depo's effect on the strength of the bones of women using it; some preliminary research indicated that women using Depo experienced a loss of bone.⁸ Health advocates have continually called for better information on this and other possible risks of long-term use of the method. The kind of cooperative approach that created unity among women's advocates on EC and mifepristone has not yet

evolved with respect to Depo Provera. Meanwhile, the FDA — its credibility weakened by the Bush administration’s appointment of unqualified candidates like David Hager and by denying women improved access to safe and effective EC — announced labeling changes for Depo Provera that revealed the fault lines in the women’s community.

Based on new data, submitted by the company that makes Depo, the FDA has instructed the company to add information to the drug label about bone loss and to recommend that clinicians limit use of Depo to two consecutive years. This new information is being conveyed in the form of a black box warning on the label — FDA’s most severe label warning, commonly although not exclusively, used for life-threatening conditions. Many women’s health

advocates have been pleased to see the FDA requiring that the bone loss information be provided to women.⁹ But at the same time, the agency’s recent history of manipulating and suppressing scientific data for political ends and the Bush administration’s track record of attacks on family planning cannot help but raise questions about what is really behind this label change. Is it a genuine effort to protect women’s health by sharing new scientific evidence? Or is it a politically motivated attack on contraception, using science as a smokescreen for an anti-choice agenda? Just as the editorial warned, FDA’s distorted decision on EC has undermined the agency’s credibility and led even those who support its role as a protector of the public health to question the motivations behind these actions.

Amy Allina is Program Director of the National Women’s Health Network, a national organization that is committed to ensuring that women have self-determination in all aspects of their reproductive and sexual health. Prior to joining the NWHN in 1999, she worked on women’s health policy issues at the consulting firm of Bass and Howes and as the Political Organizer for the Maryland affiliate of NARAL. She serves on the board of directors of the Reproductive Health Technologies Project and the Alan Guttmacher Institute.

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* While this is being written, a revised application to make EC available over-the-counter is still pending and may eventually be approved, but it’s been seriously weakened by a plan to restrict over-the-counter access to women 16 and older, setting up a two-tiered system of access based on age and denying improved access to younger women.

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Ten Years After Cairo: The Resurgence of Coercive Population Control in India

By Rajani Bhatia

In 1994 at the U.N. International Conference on Population and Development (ICPD) in Cairo, world leaders reached a new consensus on population. Although the ICPD Program of Action (POA) legitimizes demographic goals set by national governments, it recommends policy approaches based on the promotion of reproductive health, informed free choice, and gender equity. The document specifically rejects the use of coercion in family planning programs and discourages the use of social and economic incentives and disincentives to reduce fertility.

However, today after commemorations of the tenth anniversary of the ICPD have taken place around the world, population control is still with us. While the negative effects of China's one-child policy have received much attention, recent two-child norm policies in India have also had devastating consequences for women and the poor. It is important that women's health and reproductive rights activists remain vigilant about the continuing impact of population control.

During the last 15 years, population control in India has moved away from a tightly connected system of policies imposed by the central government mainly involving pressure on the poor to be sterilized.¹ Instead, individual states are devising their own schemes to enforce a two-child norm. Designed to deter parents of two children from having a third, these policies employ disturbing new incentives and disincentives that trample on the rights and health of the country's people. Disincentive penalties prohibit parents of more than two children from holding posts in local village councils or seeking government employment and deny or circumscribe access to public provision of education, health insurance and other welfare

benefits. Working in the reverse, new forms of incentives give preferential access to anti-poverty and employment schemes to individuals who accept sterilization after two children.² Emerging studies show how these population control policies have increased socio-economic and political disparities as well as gender-based violence in the country.

Oddly, most of the two-child norm policies came about either concurrent to or just after the national government of India made significant policy changes consistent with the ICPD Program of Action. First, a Target Free Approach (TFA) was adopted in April 1996, which officially removed targets related to contraceptive acceptance.³ In February 2000 the government announced a new National Population Policy (NPP 2000) that upheld the principles of voluntarism and informed consent in reproductive health care provision. However, many of the new strategies never had a chance to get off paper and on the ground. Health Watch, a watchdog coalition formed to monitor the government's commitments made in Cairo, conducted surveys in nine states and found the new approach poorly implemented.⁴ In those areas where the TFA was tried, many officials doubted its merits and too quickly interpreted the subsequent fall in sterilization rates as system failure.⁵

When India's population crossed the one billion mark on May 11, 2000, alarmism around the need to reduce population further undid what little progress had been made toward upholding ICPD and NPP principles in state health policies. M.K. Raut, a government official from Chattisgarh state, for example, expressed this common sentiment, "We can't wait forever. The empowerment route advocated by the Cairo declaration is a long

process and we would have added another billion by then...Yes, it is coercion. But with a billion-plus people, family size is no longer a personal matter.”⁶ The current national government led by the newly elected Congress Party has thus far taken no action to pressure states into adhering to NPP 2000 principles. As recently reported by the *Washington Post*, officials of the Indian Ministry of Health and Family Welfare describe population issues as an area now mandated by states without central regulation.⁷

Among the most controversial disincentives are electoral laws that since 1992 have sprung up in eight states. These debar anyone with more than two children from holding office in local government bodies or village councils known as *panchayats*. As a result over 4000 *panchayat* members have been forced to vacate their posts upon having a third child.⁸ State officials say they devised electoral disincentive laws in order to force village council members to act as role models in encouraging smaller families.⁹

In July 2003 the Supreme Court of India gave a national stamp of approval to the state two-child norm policies by upholding the constitutionality of the electoral disincentive law of Haryana state. In its ruling the Supreme Court stated, “Disqualification on the right to contest an election for having more than two children does not contravene any fundamental right, not does it cross the limits of reasonability. Rather, it is a disqualification conceptually devised in the national interest.”¹⁰ Emphasizing India’s “burgeoning population” as a national problem causing everything from congestion in urban areas to shortfalls in food grains and reduced per capita income, the Supreme Court further observed, “Complacency in controlling population in the

name of democracy is too heavy a price to pay, allowing the nation to drift towards disaster.”¹¹ Critics of the two-child norm and the Supreme Court decision have likened current policies to the 1970s Emergency Period in India’s political history remembered for massive forced sterilizations and suspension of democratic rights.¹²

A study conducted by the Bhopal-based NGO, Mahila Chetna Manch, between July 2001 and March 2002 clearly reveals how state policies have adversely impacted local communities and their village councils. Commissioned by the Ministry of Health and Family Welfare with support from the U.N. Fund for Population Activities (UNFPA), the study covered the states of Andhra Pradesh, Maharashtra, Madhya Pradesh, Orissa and Rajasthan. It found that 75 percent of those disqualified from their *panchayat* posts for having a third child belonged to economically and socially disadvantaged groups known as Scheduled Castes and Tribes. People resorted to a variety of means in order to evade the law including forced abortion, desertion of pregnant wives, divorce, extra-marital affairs, denial of paternity, hiding babies or children (for example by not allowing them to attend school), child abandonment, tampering of birth and immunization records, and giving away of children in adoption. The laws also resulted in a marked rise in the number of prenatal sex determination tests and abortion of female fetuses. In the case of a male fetus, most mothers were pressured into having a third child with the consequence of losing her own or her husband’s post in the *panchayat*.¹³

Meanwhile, the traditional system of incentives has not disappeared entirely. In the state of Andhra Pradesh, for example, Health Watch documented the use of gold chains to entice women to get sterilized after having two children.¹⁴ States have also employed a range of new incentives to allow individuals accepting sterilization preferential access to subsidized housing, food, government jobs and the like. In addition, some states have implemented group or community incentive schemes that give preferential access to development grants for housing, sanitation, school buildings, etc., based on collective family planning performance. As in the past, Madhya Pradesh, Andhra Pradesh and Maharashtra provide performance awards to service providers who meet family planning targets.¹⁵



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Most shocking is a guns-for-sterilization scheme put into place in three districts of Uttar Pradesh. The policy mirrors past incentives for family planning “motivators,” but is directed at harnessing the exploitive power of rich, land-owning farmers. Bringing in two people for sterilization gets you a single-barrel shotgun; five people a revolver license. The London *Guardian* recently reported a case of five poor farmers who in July 2004 were lured by a rich farmer’s offer of work and then forcibly sterilized.¹⁶

Some states employ population policies to address social issues such as low age at marriage, son preference and lack of male responsibility in contraception – but unfortunately by punitive or preferential means. Uttar Pradesh, Rajasthan and Madhya Pradesh, for example, deny individuals married before the legal age of 18 access to government jobs, thereby further disempowering women forced against their will to marry early.¹⁷ Similarly ill-conceived is a policy in Andhra Pradesh that awards three couples selected by a “lucky lotto” dip 10,000 rupees. In order to qualify for the lotto, couples must either adopt a permanent method of family planning after having one child or two girl children or by adopting vasectomy after having one or two children.¹⁸

Neo-liberal economic and deregulation policies of the past ten to fifteen years have also had a negative effect. Resource allocations to the health sector have fallen at both federal and state levels. The research of Health Watch revealed that many women in India do not have easy access to basic health care or even minimum reproductive health care services. The context of population control has become decentralized as a host of different actors including state and local government bodies, NGOs, corporations, and lending sources for micro-businesses implement separate strategies to instill a two-child norm.

Another recent development in Indian population rhetoric is the influence of Hindu right wing alarmism that posits a Hindu majority threatened by a rapidly growing Muslim population. While announcing the new state population policy in Uttar Pradesh in 2000, the Hindu Nationalist Chief Minister, R.P. Gupta, spoke unobtrusively, “There are groups and communities which feel that if they go on increasing their number they will capture power

one day. Such a way of thinking has to be disincentivised.”¹⁹

Women in India have raised their voices against the latest resurgence of coercive population control. On March 6, 2003, a group of women representatives from local government bodies in different states spoke out at the National Human Rights Commission. They denounced the two-child norm policies as both anti-women and anti-poor.²⁰ Immediately following the Supreme Court ruling to uphold the two-child norm policy in Haryana, the All India Democratic Women’s Association released a statement condemning the decision and demanding that the national parliament take action to force states to adhere to Cairo and NPP principles.²¹

On the other hand, many mainstream women’s and population organizations in the West have been slow in responding. Their efforts in recent years have mainly focused on defending the Cairo POA against conservative anti-abortion forces and reinstating their government’s monetary commitments made at the conference. The accomplishment of the Cairo declaration with its gender progressive content seems to have blinded many to the continuing reality of population control abuses.

While the POA is worthy of support, much more must happen to counter trenchant population control ideology and abuse internationally. The UNFPA and the Population Council in India have openly condemned two-child norm policies.²² Women’s groups internationally must also take action. The U.S. Agency for International Development, for example, ought to be confronted for its silence, as it has influenced the formulation of some state population policies in India, including in Andhra Pradesh and Uttar Pradesh.²³ The September 2005 International Women and Health Meeting in Delhi will provide an opportunity for women around the world to join their sisters in India in opposing population control and building action steps to stop abusive policies. Let this not be a missed opportunity for solidarity.

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Depo-Provera: Old Concerns, New Risks

By Amy Oliver and Diana Dukhanova

The Summer 2000 issue of *DifferentTakes* provided an introductory glance at the injectable contraceptive Depo-Provera (or DMPA), and why many women's health advocates are concerned with its use and misuse around the world.¹ Approved for use in the U.S. in 1992, Depo has only become more controversial as its image as a hassle-free contraceptive clashes with the reality of possible side effects such as irregular bleeding, weakness, depression, weight gain, nausea, loss of libido, darkening of skin, abdominal pain, headaches and hair loss.² Side effects can be so numerous and severe that over 70% of American women who have ever used Depo discontinued their use within the first year.³ Injected into the arm or buttock, Depo's effects last for three months and its effectiveness rate is an impressive 99.7%.⁴ But with alarming new risks added to these worrisome side effects, the contraceptive deserves closer scrutiny.

Depo-Provera Receives "Black-Box" Warning

The Food and Drug Administration (FDA) recently mandated that Depo carry the "black box" warning label, the agency's most severe warning. Based on new data from Pfizer, Depo's manufacturer, the new label will inform users of recent findings that Depo causes a loss in bone mineral density that may not be completely reversible. The warning also suggests that Depo use should be limited to two years unless other forms of birth control are insufficient, and in this case women should be evaluated while taking the drug long-term.

These findings have special relevance to young women who are in the critical period of bone growth. Studies are conflicting as to whether or not bone loss can be completely recovered once use of the drug is discontinued.⁵ Clearly, the FDA black box label poses a red flag that more research is needed on Depo's

long-term effects on women's bone loss and future risk of osteoporosis.

Increasing Risks of STI's and HIV/AIDS

Other recent studies show that Depo-Provera users are at an additional risk of contracting Sexually Transmitted Infections (STI's). A joint study funded by the National Institute of Child Health and Human Development (NICHD) and the U.S. Agency for International Development (USAID) recently found a strong correlation between Depo use and a woman's chances of contracting chlamydia and gonorrhea. The study, published in the journal *Sexually Transmitted Diseases*, followed over 800 women in Baltimore, MD, who had the choice of using Depo-Provera, oral contraceptives, or a non-hormonal contraceptive. The study found no correlation between taking oral contraceptives and contracting the infections, and did not conclude why Depo users were more likely than women using other hormonal contraceptives to contract these STI's, indicating further research is needed on the subject.⁶

The findings clearly have important implications for women's reproductive health and call into question the widespread promotion of Depo-Provera in family planning programs in the U.S. and overseas. Yet there is already an attempt by some agencies to downplay them. Family Health International's (FHI) August 2004 report on the findings states that "while of concern...this new research does not call for changes in the provision or use of DMPA."⁷ The report goes on to assert that women in monogamous relationships are at no additional risk of infection, and that the results of the study "are of little concern for DMPA users who use condoms consistently and correctly, since such condom use only rarely fails to provide protection..."⁸ The fact that the report virtually ignores such significant findings is alarming. The results clearly state that the *use of Depo-Provera only*, not hormonal contraceptives in general,

increases the risk three-fold of contracting chlamydia and gonorrhea.⁹ In lieu of an in-depth look at the implications of these findings, FHI quickly puts the responsibility on correct and consistent condom use and monogamous relationships to prevent the spread of STI's.

Encouraging condom use is of course important, but as a consumer choosing a safe, reliable method of birth control in addition to condoms, one might think twice about choosing Depo given that condoms can fail or one's partner might be unwilling to use them. Moreover, monogamous, heterosexual women who are at risk for contracting STI's because of their partner's promiscuity most likely believe (or would like to believe) that their partner is faithful. The point at which a woman finds out her partner isn't faithful is far too late to decide to switch birth control methods, particularly if she just received her three-month shot. Meanwhile, she could have been putting herself at an additional risk of contracting STI's from her partner simply *because she used Depo*.

New studies show conflicting evidence of whether Depo-Provera increases the risk of contracting HIV, transmitting it to others, and increasing the rate at which the virus progresses once in the body. A study published in January 2004 in *The Journal of Infectious Diseases* found a correlation between taking hormonal contraceptives (both injectable and oral) and acquiring HIV.¹⁰ The study further concluded that the use of Depo at the time of HIV transmittal hastened the rate of disease progression.¹¹ In terms of contracting HIV, skeptics point out that the research yielding these results used sex workers in Kenya, who would have more frequent exposure to HIV than the average person.¹² Only a handful of prospective studies have addressed injectable hormonal contraceptives in particular and their effect on HIV, and findings are mixed.¹³ Some found no correlation between Depo use and HIV, and suggest further research is needed. The National Institute for Child Health and Human Development (NICHD) is currently conducting a larger study

inclusive of subjects who are at a lower risk of HIV infection, and results are expected some time this year.

Depo Hype

Although Depo's manufacturer was mandated to add the "black-box" label concerning bone loss, it seems less concerned with adequately informing women of other new risks. While promoting their product as ultra-convenient and period-free, Depo's current distributor, Pfizer, claims "There is no proof from clinical studies that shows Depo-Provera increases your risk of acquiring a sexually transmitted disease, or STD."¹⁴ This claim was found on the official Depo-Provera website *seven months* after the findings were released (and reported in popular U.S. news sources)¹⁵ concerning women's increased risk of contracting STI's. While Pfizer does remind women that Depo does not protect from STI's and HIV/AIDS, it thus far ignores this recent finding.

In informational materials (mainly targeting college-age women) put out by Depo's former distributor, Pharmacia, sweeping statements are made that "while most sexually active young women use condoms to protect themselves against sexually transmitted diseases, they don't often think to protect themselves against pregnancy as well."¹⁶ Pharmacia's materials go on to claim that the condom's failure rate is as high as 14%, compared to Depo's 99.7% effectiveness.¹⁷ The materials neglect to mention that condoms, used with withdrawal, can be up to 98% effective, as reported by Planned Parenthood.¹⁸

With the rate of HIV infection rising to pandemic levels among the youth population — half of all HIV infections in the U.S. occur in people under 25¹⁹ — promoting a birth control method to youth that downplays condoms as ineffective will only contribute to the crisis. In light of the recent findings that Depo increases the risks of contracting STI's and possibly HIV, it is critical that women receive accurate information regarding the risks of solely relying on hormonal contraceptives.

At What Risk?

Because of the particular circumstances in which Depo-Provera is used in the U.S. and abroad, new risks associated with Depo should not be taken lightly. Long-acting contraceptives such as Depo and Norplant (a contraceptive placed under the upper arm) have a history of being coercively targeted at poor women and women of color, often without informed consent, despite the current promotion of Depo as a white, college woman's contraceptive.²⁰ Anecdotal evidence shows that Depo is



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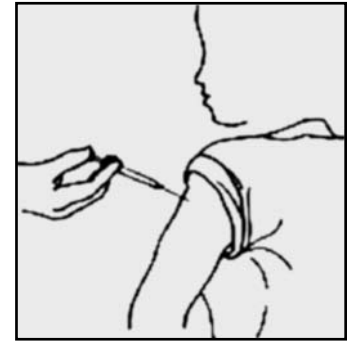
disproportionately promoted to women on welfare as a population control measure,²¹ and there is a pressing need for more research in this area. New risks associated with bone loss, contracting STI's and possibly HIV pose great concern for women who are already less likely to have access to basic services such as healthcare.

With many questions left unanswered, widespread research is needed on the safety of Depo-Provera. A study conducted in India in 2003 explored women's experiences with obtaining and using Depo (banned in 2002 from India's Family Welfare Program after much pressure from women's groups). The study profiled a sample of 50 women, most between the ages of 21 and 30, who received Depo from a public hospital. Goals were to measure how informed the choice was to take the drug, women's knowledge of risks and benefits, medical screening tactics, personal health risk factors, and physical setting of medical facilities. The study found some alarming results: over half of the women were given no other contraceptive options besides Depo, 42 out of 50 were not informed of the probable side effects, and more than half received no screening.²² The study made women's first-hand experiences a central focus of the research, an approach severely needed in the U.S.

Depo has for years served as both a subtle and blatant tool for population control in developing countries despite the fact that risks are aggravated in places where medical monitoring is difficult or impossible.²³ Under apartheid in South Africa, Depo was typically given to women without adequate screening and health services, which were virtually inaccessible to rural populations. Many black South African women were coerced into using Depo and were sometimes forced to use it in order to keep their jobs.²⁴ Although this does not mean Depo is always misused in developing countries, its vast history of abuse by population control programs and potential for further misuse (particularly in areas of high HIV risk such as South Africa) call into question its ultimate safety for women.

Despite recent concerns about a link between Depo-Provera and HIV/AIDS, there is little evidence that new risks will be taken seriously by those who consider reducing Third World birth rates a higher priority than women's health. In a report on the recent findings concerning Depo and HIV risk, Timothy Wilkin, M.D., M.P.H., (Instructor of Medicine at Cornell University and writer for a popular website on AIDS research), states "It is difficult to say what this means for women's reproductive health. Because women in developing

countries such as Kenya are much more at risk for dying during childbirth...it is unclear whether this increase in HIV infection is more important than the risk of unwanted pregnancies."²⁵



While it is true that because of poor living conditions and lack of prenatal care, a woman's chance of dying during childbirth is generally higher in developing than in developed countries, it is a cruel trade-off to pit the risks of an unwanted pregnancy and childbirth against using Depo (with possible increased risk of contracting HIV) as a woman's only two options. If we are really concerned with reducing death rates related to childbirth, we instead should focus on improving overall standards of living and prenatal care for women in Kenya and elsewhere. Further, the risk of contracting HIV can greatly be reduced by increased condom use and there are other contraceptives women can use besides Depo. Indeed, given present concerns about Depo causing increased risk of acquiring STI's and possibly HIV/AIDS, it is questionable whether Depo should be used at all in vulnerable populations. We may be witnessing the beginning of a major public health crisis.

A Broader Vision for Contraceptive Choice

Despite the new FDA black box warning about bone loss, evidence of increased risk of contracting STI's among Depo users, and concern that Depo may be linked to increased HIV infection, Depo-Provera continues to be used by many of the most vulnerable populations in the world. Seen at first as a hassle-free contraceptive that would answer women's prayers, new findings raise serious questions of the usefulness of this drug as a safe option for women. While many advocates for reproductive choice argue that more contraceptive options automatically empower women, we must raise the question of how important a choice is if the safety of the method is in serious doubt. A broader movement for reproductive health looks beyond a narrow definition of choice to the assurance that available options are safe as well as effective. Moreover, women need to be completely informed of the array of contraceptive options available to them, and the risks associated with their use.

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Egg Donation for IVF and Stem Cell Research: Time to Weigh the Risks to Women's Health

By Judy Norsigian

Last year, Barbara Seaman's article, "Is This Any Way to Have a Baby?" in *O (Oprah) Magazine* (February 2004) caused quite a stir among infertility experts as well as women dealing with infertility. It explored women's experiences with fertility drugs and underscored the paucity of long term safety data as well as the serious, occasionally irreversible problems experienced by some women using these drugs. In response, members of the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) posted an unusual rebuttal at the ASRM website (www.asrm.org), and the controversies continue.

Because there is now significant debate about embryo stem cell research, and because one type of embryo stem cell research ("somatic cell nuclear transfer" or SCNT) requires women volunteers to undergo egg extraction to produce eggs for research purposes, there is renewed attention to the larger question of risks to women's health from egg extraction procedures. These procedures are the same whether performed for reproductive purposes — as is the case in an infertility clinic where women undergo "in vitro fertilization" (IVF) procedures — or performed for research purposes, as is now being proposed in a number of states pursuing embryo cloning as part of a larger plan to expand stem cell research.

What are the risks of multiple egg extraction? The drug most often used to shut down a woman's ovaries (before stimulating them with other drugs to produce multiple follicles) is Lupron™ (leuprolide acetate), which has caused a range of problems reported to the Food and Drug Administration (FDA), including rash, vasodilation (dilation of blood vessels causing a "hot flash"), paresthesia (sensation of burning), tingling, pruritis (itching), headache and migraine, dizziness, urticaria (hives),

alopecia (hair loss), arthralgia (severe joint pain, not inflammatory in character), dyspnea (difficulty breathing), chest pain, nausea, depression, emotional instability, loss of libido (sex drive), amblyopia (dimness of vision), syncope (fainting), asthenia (weakness), asthenia gravis hypophyseogena (severe weakness due to loss of pituitary function), amnesia (disturbance in memory), hypertension (high arterial blood pressure), tachycardia (rapid beating of the heart), muscular pain, bone pain, nausea/vomiting, asthma, abdominal pain, insomnia, swelling of hands, general edema, chronic enlargement of the thyroid, liver function abnormality, vision abnormality, anxiety, myasthenia (muscle weakness), and vertigo. Although approved for several specific uses,¹ Lupron is NOT approved for use in procedures for multiple egg extraction — something not well understood by many women. (It is legal to use a drug for a non-approved use, as long as it is on the market for at least one *approved* use, and Lupron is just one of many drugs used "off-label" in this fashion. But proper studies justifying this use for egg extraction have never been formally submitted to the FDA).

The drugs used to "hyperstimulate" the ovaries also have negative effects, most notably a condition called Ovarian Hyperstimulation Syndrome (OHSS). Serious cases of this syndrome involve the development of many cysts and enlargement of the ovaries, along with massive fluid build-up in the body. As noted in an article about OHSS, "the reported prevalence of the severe form of OHSS is small, ranging from .5 to 5%. Nevertheless, as this is an iatrogenic complication of a non-vital treatment with a potentially fatal outcome, the syndrome remains a serious problem for specialists dealing with infertility."² Also, as noted by Dr. Suzanne Parisian, a former Chief Medical Officer at the FDA: "OHSS carries an increased risk of clotting

disorders, kidney damage, and ovarian twisting. Ovarian stimulation in general has been associated with serious life threatening pulmonary conditions in FDA trials including thromboembolic events, pulmonary embolism, pulmonary infarction, cerebral vascular accident (stroke) and arterial occlusion with loss of a limb and death.”³

So why is multiple egg extraction the norm in IVF clinics? With such risks involved, why don't specialists just try to extract the single egg that women normally release each month? If only one egg is “harvested” using so-called “natural” cycling, there is a good possibility that it will not be successfully fertilized, or if fertilized, it may not develop into an embryo that could be successfully implanted into a woman's uterus, thus requiring repeated surgical procedures to extract more eggs. Extracting multiple eggs obviously increases the likelihood of success with each IVF procedure.

The same reasoning can be applied to the research context, as it would be better to have more eggs with which to conduct research rather than fewer eggs. But given the early stages of embryo stem cell research, with only very hypothetical benefits at hand, it may be far wiser to protect women from the risks of multiple egg extraction solely for SCNT research purposes and to permit only surgical extraction of the usually single egg produced each month. Others argue that whatever the risks are — known and unknown — a woman should have the choice nonetheless to take these risks, especially if she has a strong personal investment in seeing certain therapies developed, even if they are only a distant promise.

Those who oversee the ethical conduct of research, especially members of Institutional Review Boards (IRBs), are supposed to think carefully about the matter of “risk/benefit” ratio when making decisions about whether to approve a research protocol. Embryo cloning research (SCNT) poses

significant challenges in this regard. One IRB for Advanced Cell Technology in Massachusetts did approve a protocol for somatic cell nuclear transfer several years ago and included in the informed consent document the following language: “Severe lung and blood clot events have resulted in death.”⁴ They clearly decided that it was ethical to ask women to take such a risk, though others might argue just the opposite.

Reading the stories of young women who agreed to be multiple egg donors for IVF clinics and ended up with tragic consequences should give us all reason to think carefully about whether these risks are justifiable in the research context. Many advocates believe that such risk-taking would not be ethical, partly because true informed consent is not possible in the absence of better data regarding Lupron in particular.⁵

One of the more serious issues needing far greater attention is the absence of any good quality long term safety data on the infertility drugs commonly used. There are hundreds if not thousands of anecdotal reports, where complications were NOT short-lived. As noted in a three-part series in the *Boston Herald*:

“Seven of the women interviewed for this story say they suffered memory loss and bone aches while on Lupron, and that the problems continue years after stopping the drug. Some say seizures and serious vision problems that started while on Lupron also haven't gone away.

One woman, Linda Abend in southern New Jersey, started a National Lupron Victims Network after her 34-year-old sister was hospitalized with seizures while taking Lupron in 1991 for a benign fibroid. Abend says her sister continues to suffer daily seizures, plus debilitating bone and muscle pain eight years later. And Abend said she has heard from more than 1,000 people nationwide — mostly women — who also report serious side effects that continue after stopping Lupron.

The FDA says it has not tracked claims of such long-term effects....”⁶

In a report submitted by TAP Pharmaceuticals to the FDA in April 1998, researchers wrote that they were “concerned” because more than one-third of the women they studied who took Lupron did not “demonstrate either partial reversibility” or “a trend toward return” of bone mass in the six months after they stopped taking the drug. Further, the researchers noted some women lost as much as 7.3



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percent of their bone density during treatment — more than twice the amount the drug’s packaging lists in its warnings. The researchers concluded, “A more complete assessment of the effects of Lupron on (bone density) can only be made with longer term follow-up of these patients.”⁷

Some women’s health advocates argue that it is premature to conduct SCNT, especially when it involves multiple egg extraction, because the substantial risks involved are not offset by any clear benefit. In the case of IVF, the best infertility clinics can now offer 30-40% success rates, so that women undergoing multiple egg extraction — whether to achieve a pregnancy themselves, or to be an egg donor for another woman — do know that there is a clear potential benefit, and one that is of inestimable value: a baby.

The risk/benefit ratio is vastly different in the case of SCNT, where the possible benefits of such research are quite hypothetical at this stage. It is far from clear that SCNT will lead to any viable therapies, and much of what we need to learn in this realm of research can result from studying embryo stem cells derived from “conventional” embryos that would otherwise be discarded by couples who are no longer pursuing IVF at an infertility clinic. (Thousands of such embryos are now available for embryo stem cell research being conducted around the country.) It is conceivable that, over time, when embryo stem cell research has demonstrated that viable therapies are possible, a stronger case can be made for pursuing SCNT. (SCNT theoretically will make it possible to develop therapies that will be immuno-compatible, thus avoiding the problem of tissue rejection, which is more likely to occur with stem cell therapies that have a different genetic make-up.)

Although SCNT does provide an opportunity to study the progression of certain rarer diseases, some of this research can be done with embryos that were rejected during the process of preimplantation genetic diagnosis (PGD). Again, these are embryos that will not be used for reproduction purposes, because problems were detected, and thus would likely be discarded if not used for research.

Some women’s health advocates urge that multiple egg extraction for research cloning purposes not be pursued at this time, and that any eggs for such

research be obtained only via “natural cycling” — where a woman would not use fertility drugs but simply have the (typically) one follicle per month that she releases surgically collected. Given that South Korean researchers had to extract 242 eggs from 16 women to create one clonal embryo from which they developed a line of embryo stem cells to study further, there will certainly be pressures to accelerate the collection of eggs through more widespread use of multiple egg extraction procedures. Ads for egg donors are already commonplace on many college campuses, where young women are motivated to undergo egg extraction for much-needed income (\$4-7,000 in most cases) as well as for altruistic reasons. Both of these motivations could influence thousands more young women and economically disadvantaged women to undergo risky egg extraction procedures solely for research, and under circumstances where the benefits are far less clear and mostly still hypothetical. This will be another arena where we will see the mantra of “reproductive choice” once again co-opted and falsely applied.

Given that there may be new techniques developed soon that would obviate the need for multiple egg extraction, there is even more justification for a cautious approach. As noted in the *New York Times*, a technique called “in vitro maturation,” or I.V.M., may make it possible to obtain multiple eggs without using hormone injections. “Doctors have found that a few days before ovulation, as many as 30 to 50 egg follicles have begun to mature. Normally, only one will fully ripen for ovulation, and the rest are lost. But if the eggs are removed before ovulation, many of them can be matured in the laboratory.”⁸

The push for SCNT (also called research cloning or “therapeutic” cloning) will be strong in the coming years. Because the most vocal critics of this research are from the anti-abortion community, many pro-choice advocates are reluctant to get involved with this debate for fear of lending support to a larger anti-choice agenda. Although there are those who have deliberately confused this issue, sometimes conflating embryo cloning research with ALL embryo stem cell research, it is important to keep the two separate and to insist that health concerns for women don’t take a back seat.



Judy Norsigian is a co-author of Our Bodies, Ourselves and co-founder of the Boston Women's Health Book Collective, now called Our Bodies Ourselves. She serves as the organization's Executive Director and is involved with numerous women's health initiatives nationally and internationally.

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- 1 For example, the treatment of endometriosis and fibroid-associated anemia.
- 2 Delvigne, Annick and Rozenberg, Serge. "Epidemiology and prevention of ovarian hyperstimulation syndrome (OHSS): a review" *Human Reproduction Update*, vol. 8, no. 6, 2002, pp 559-577.
- 3 From Dr. Parisian's February 2005 memo now posted at www.ourbodiesourselves.org
- 4 Other language from this document, titled "Consent to Participate in a Study Involving Egg Donation for Stem Cell Research":

Complications associated with being an egg donor include unpredictable response to the hormones provided to you, surgical complications during the egg collection, and unknown long-term side effects from the hormones. If any of these complications arise the reproductive biologists involved in this research may choose, at their discretion, to terminate your continued participation in this research.

Risks and side effects associated with hormones (gonadotropins, hCG and GnRH agonists).

The gonadotropins will be used in order to stimulate your ovaries. Adverse reactions reported in women treated with gonadotropins include ovarian hyperstimulation. This is a condition in which the ovaries continue to enlarge even after the eggs have been collected. In addition to enlarged ovaries, fluid begins to be retained in the abdomen and becomes very difficult to control, resulting in fluid imbalance. Rare, but serious, consequences of this imbalance include lung and circulation problems such as collapse of a lung, acute respiratory distress syndrome, blood clot which may lead to inflammation of the veins, obstruction of blood vessels in the lungs, damage to the lung tissues, stroke, obstruction of an artery resulting in the loss of limb(s); blood in the abdominal cavity; kidney damage; large ovaries; increased heart rate; shortness of breath; rapid breathing; flu-like symptoms of fever, chills, musculoskeletal aches, joint pain, nausea, headache and tiredness; breast tenderness; and skin reactions such as dry skin, blood rash, hair loss and hives. Severe lung and blood clot events have resulted in death.

The following adverse reactions have been reported in patients receiving human chorionic gonadotropin therapy: headache, irritability, restlessness, depression, fatigue, edema, and pain at the injection site.

Adverse reactions regarding GnRH agonists include anemia; changes in various heart problems; high blood pressure; fluid accumulation in the limbs; formation of blood clots which potentially could be dislodged from the involved vein or artery causing damage to vital organs such as lungs, heart or brain; intestinal problems such as decreased appetite, constipation; nausea and vomiting, diarrhea, difficulty in swallowing; intestinal bleeding, intestinal ulcers and polyps; thyroid enlargement; breast tenderness; hot flashes; bone, muscle and joint pain; anxiety; depression; blurred vision; mood swings; nervousness; numbness; taste changes; memory problems; lightheadedness; blackouts; and headaches.

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- 6 Lazar, Kay "Wonder drug for men alleged to cause harm in women," *Boston Herald*, August 22, 23, 24, 1999.
- 7 Ibid.
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Quinacrine Sterilization in India: Women's Health and Medical Ethics Still at Risk

By Rajashri Dasgupta

Women's groups in India are only too aware that the "real battles" are fought outside the court room. In 1998, when the Supreme Court of India banned quinacrine sterilization (QS) because its long-term effects on women are unknown and are potentially harmful, activists knew they had to continue the struggle outside the courts. Their fears proved true when a group of medical practitioners violated the ban on the use of the drug for female sterilization.

A study conducted in 2003 found that five years after the ban, medical practitioners in India were still using quinacrine to sterilize women.¹ None of the women interviewed knew that QS was an unauthorized method, with potential health hazards. Most of the women who underwent QS said that the provider never asked them to sign or give their thumb-print on any consent form or other document. The few who did sign forms said that they were not aware why they were asked to do so. "It calls into question any claim that informed consent was given by these women, thus violating their human rights," stated Shree Mulay, Director, Centre for Research and Teaching on Women, McGill University, Canada, who led the team of researchers based in Kolkata, the capital city of West Bengal, the Indian state bordering Bangladesh.²

QS is a non-surgical, permanent method of sterilization by the synthetic anti-malarial chemical quinacrine. When quinacrine pellets are inserted into the uterus through an intra-uterine device, they dissolve, form scars and block the fallopian tube to prevent fertilization.

In 1997, women's health advocates around the world were alarmed to discover that large-scale clinical trials had been conducted with QS on over 100,000 women in 25 countries. An ardent proponent of QS, Dr. Ashi Sarin, claimed in a telephone interview that at least one-fifth of the QS cases in the world were done in 26 centers in India before the ban. Sarin herself has conducted 134 QS procedures among 'high-risk' women and found it to be effective. "In most countries like India the trials were covert. We are concerned that women are being targets of unethical drug trials," said Mohan Rao of the Public Health faculty of Jawaharlal Nehru University (JNU) in Delhi.

It was this concern that led to intense campaigns by women's groups in several parts of the country. Protest demonstrations were held in front of clinics of doctors practicing QS in the cities of Delhi and Kolkata. Saheli, a prominent women's rights group, published an in-depth study that countered the arguments put forward by QS advocates and media reports questioned the government's failures in regulating and monitoring illegal drug trials. To further strengthen the growing movement, the faculty of Public Health at JNU joined hands with the All India Democratic Women's Association to file a public interest litigation that finally led to the Supreme Court ban on QS.

Two years later in a workshop in Kolkata, a study with a feminist perspective was developed to document women's experiences of QS, determine if there are any deleterious effects, investigate whether QS is being used after the ban and find

out whether women were aware that QS was an experimental method. The workshop participants were women's health advocates, academics and media personnel, many of whom had been involved in the movement against QS in India, Bangladesh, the USA and Canada; they supported the study team with ideas and advice during the entire research period.

Given limited resources, a larger population-based study was not possible. Instead the study in West Bengal would conduct in-depth interviews with 32 women in one region who had undergone quinacrine sterilization, followed by medical examination offered to those who wanted one. An equal number of women who had undergone surgical sterilization (SS) were selected using parity parameters such as socio-economic status, current age, age during the sterilization procedure, and reproductive history at the time of the study.

In 2003, the study was released in Kolkata with the support of women's activists and the Women's Commission of West Bengal, a statutory body. It found the striking difference between the QS and SS women was that the former had several cases of cervical erosion and inflammation, requiring long-term follow up. Thirteen of the 32 QS women "bled on touch" during internal examination, and the cervixes of 13 were diagnosed as "clinically unhealthy" and "ulcerated," and had "growth," therefore requiring further microscopic investigations, according to Dr Sanjeev Mukherjee, a Kolkata-based gynecologist who conducted the medical examination.

In the last decade worldwide unethical QS trials received a series of setbacks. In 1998, the U.S. Food and Drug Administration (FDA) asked the two Americans, Dr. Elton Kessel and Stephen Mumford, the spirit behind the trials, to halt immediately the distribution, import, manufacture and export of quinacrine pellets for female sterilization. Earlier in 1994, the World Health Organization (WHO) had cautioned researchers to stop all human trials until laboratory and animal testing was complete, the first essential steps in the development of any new drug. But it was the Indian ban that was an "enormous setback" for QS worldwide, said Dr. Mumford, as it "undermined the efforts of individuals in numerous other governments to have their own governments undertake national clinical trials."

QS is promoted in countries like India by a network of doctors (like Sarin) in urban areas, who in turn train rural practitioners and supply them with pellets. In West Bengal, gynecologist Biral Mullick claimed to have done 10,000 QS procedures; he trained hundreds of rural practitioners and set up the Indian Rural Medical Association (IRMA) that claims a membership of 40,000. The rural practitioners have a smattering knowledge of allopathic drugs and combine it with traditional medicine and homeopathy. "The doctors are my friends and I only teach them the technical know-how and provide them with pellets," admitted Kessel when he was in Kolkata in 1998 to convince doctors to appeal to the Indian government to rescind the ban. "I do not do anything illegal, I do not do trials in your country."

What drives Kessel, founder of the International Federation for Family Health, and Mumford, director of the US-based Center for Research on Population and Security (CRPS), is their life-long devotion to fighting population growth in developing countries and increased immigration to developed countries. They promote QS as the answer to maternal deaths in poor countries while simultaneously promoting the need for sterilization by playing on upper-class fears of the "population problem."



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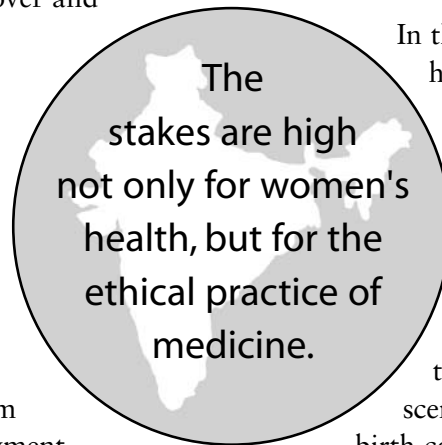
“The explosion of numbers will come from the immigrants and their offspring and will dominate our lives. There will be chaos and anarchy. It’s even more serious than the nuclear threat,” said Kessel. “The threat of immigrants invading and taking over is real, they are swarming all over and draining the resources. Look at the chaos in India’s eastern region with thousands coming in from Bangladesh and in the USA, Mexicans and Caribbeans are pouring in. No civilized government can allow this.”

By exploiting fear of the “population explosion,” Mumford and Kessel shift attention away from pressing issues of hunger, unemployment and rising costs of health care and education, according to economist Navsharan Singh, who co-authored the West Bengal study. Like national governments and the international population lobby, the duo do not take into account the impoverished lifestyles and gender inequality that rob most women of their choice on issues of marriage or repeated pregnancies.

The West Bengal study, for the first time, documented the actual experiences of women who have undergone QS. Apart from the health impact, it probes deeply the socio-economic context in which women are choosing to be sterilized and the issue of easy availability of QS from private medical practitioners in the context of deteriorating public health services. Rural medical practitioners who provide QS were interviewed to understand their informal networks and to provide a contrast to the information given by the women.

A major factor that influenced women’s decision-making was that the rural medical practitioners who provide QS are locals and trusted members of the community. Moreover, they have a personal relationship with the women and their families since over the years they have treated them for various ailments. As one woman sterilized with quinacrine put it, “He (the provider) guaranteed that there would be no side-effects. And his medicines really work. He has treated me many

times; I have faith in him.” In contrast, surgical sterilizations are done in impersonal camps by unknown doctors with hundreds of women sterilized on one day with makeshift facilities and little counseling.



In the absence of adequate public health services, particularly in rural areas, the easy availability and accessibility of these providers make the community dependent on them. The IRMA of unregistered ‘doctors’ also provide essential services like abortion and thus endear themselves to women. In such a scenario, women who are desperate for birth control need little convincing to try QS after hearing positive things about these ‘doctors’ from relatives or neighbors who have undergone the procedure.

According to women’s rights activist Laxmi Murthy, “The non-governmental organizations (NGOs) like IRMA providing QS tend to be better-behaved and have better services than the government-run clinics. So when NGOs use these banned procedures, people unfortunately tend to trust them more than the government, which they are more suspicious of. Since government services are almost non-existent especially in villages, NGOs fill the gap and are welcomed.”

The use of banned drugs and procedures in India is possible because of weak regulations and lack of monitoring and enforcement. Two years ago, members of IRMA conducted trials on 700 women in Bengal by inserting crushed erythromycin tablets through an intra-uterine device to sterilize them. Last year, doctors experimented with chord blood on HIV/AIDS patients without their consent or following research protocols. “It’s the lure of fame, foreign travel and the glamour of seminars that encourage doctors to pursue these so-called trials,” said gynecologist Mukherjee.

Health and women’s rights networks have used various opportunities to raise awareness about the campaign against quinacrine sterilization in India.

They have suggested to the state drug controller that medical professional bodies should be informed repeatedly and warned against its use. Following the public hue and cry, the rampant use of QS seems to have weakened among qualified doctors in the cities.

However, some doctors have appealed to the Drug Controller of India to rescind the QS ban. Last year Dr. Sarin filed a legal petition in the Punjab High Court to lift the ban on quinacrine. For the last six years, said Mumford, Dr. Kessel and he have “personally” talked to perhaps 20,000 American clinicians about QS, including physicians, nurse practitioners and nurse midwives. Since without FDA approval, there is little chance of QS being approved by any governments, least of all India, the International Federation for Family Health and CRPS have encouraged FDA-approved trials initiated by Dr Jack Lippes in the U.S. “We are now preparing to apply to the FDA for approval to undertake a much larger national trial,” said Mumford.

If so, the struggle against QS is far from over. In India, the QS ban, the study to document the experiences of QS women, and the coalition of health activists and academics are a step forward in the campaign. However, while women continue to be sterilized with quinacrine, thousands of QS women are left without health follow-up, medical practitioners conducting the unapproved trials go scot-free and governments remain indifferent.

With the unholy alliance of right wing groups keen to stop the ‘invasion’ of third world immigrants and a group of dubious medical practitioners quick-fixing medical ethics, only a sustained campaign with a stronger and wider network of international solidarity backed by more feminist research can highlight how quinacrine sterilization exploits and harms women. The stakes are high not only for women’s health, but for the ethical practice of medicine. QS threatens to be another infamous chapter in an ongoing saga of unethical medical experimentation on human beings.

Rajashri Dasgupta is a journalist with a special interest in issues relating to gender, health, development and politics. She is active in the women’s and peace movements.

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- 2 The interviews quoted in the text were conducted by the author either on phone or through email. Interview with Elton Kessel was conducted personally in November 1998 when he was in Kolkata to attend a medical conference. In March 2005 Dr Mumford replied to the set of questions I sent to April Mayberry referred to by Dr. A. Sarin. He said she was out of the office traveling.

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Beyond the Hype: What You Should Know About the Seasonale Birth Control Pill

By Amelia Bucek

Since the first birth control pill was released to the American public in 1960, oral contraception has evolved considerably. Within today's burgeoning and increasingly specialized pharmaceutical industry there are dozens of varieties of birth control pills available. Many of these are advertised as offering more than just fertility control.¹ Dubbed "designer contraceptives," these pills cater to specific issues completely detached from contraception. Whether the allure is convenience, acne treatment, or a reduction in water retention, focus on the gimmick attached to the pill overshadows all other concerns associated with the contraceptive. The niche marketing of these pills translates to an expanded customer base and increased profits for contraceptive manufacturers. The deregulation of prescription advertisements in 1997, which allows pharmaceutical companies to advertise alternative uses for the pill directly to consumers, hastened this practice. Media attention to designer contraceptives has also facilitated this growing market. One of the most celebrated and criticized pharmaceuticals in this field is Seasonale.

What is Seasonale?

Seasonale is an extended cycle oral contraceptive pill, which differs from the standard pill in its method of prescription. Oral contraceptives are customarily dispensed in 28-day packs containing 21 active pills with hormones and 7 placebo sugar pills. The break in hormone intake for one week every month causes the body to think ovulation has occurred, resulting in the shedding of the uterine lining. This outcome is technically called a withdrawal bleed, but is also known as a period since it mimics the monthly occurrence of menstruation. Seasonale promises to limit this bleeding to just four times a year. Women prescribed Seasonale take active pills for 84 consecutive days, followed by 7 days of placebo. Periods are

thereby reduced from an average of 13 a year to 4, creating the specialized purpose of Seasonale: menstrual suppression.

Selling Doctors on Seasonale

After testing Seasonale on 1400 women in 47 cities nationwide, the FDA approved the pill in September 2003.² In its initial marketing of the product, Barr Pharmaceuticals aggressively targeted physicians. Questionable mingling of reproductive health education and manufacturer profits was evident in audio conferences sold for \$99 a piece to educate healthcare providers on extended use contraception. These corporate-sponsored listening sessions could also be used as credit toward professional nursing requirements.³ In early 2004, Barr unleashed a 250-person sales team that sought out 28,000 physicians (20 times the number of women they tested for the safety of their product) throughout the U.S. in order to spread the word on Seasonale.⁴ This profit-driven approach proved to be quite successful. In February 2004, 5000 prescriptions for Seasonale were written each week and by March sales totaled \$17.7 million. Seasonale had become the fourth top selling oral contraceptive.⁵ Only eight months after its release, over 120,000 prescriptions had been written, with 7,000 being added weekly.⁶ After significant buzz had been created throughout the medical community and spread to the patient population, Barr launched a \$50 million ad campaign in June 2004.⁷

Advertising Seasonale to Consumers: PMS, Liberation, and Health

The Seasonale campaign included television spots, two-page ads in magazines as diverse as *Vogue* and *US News and World Report*, as well as a trendy website all promoting the Seasonale mantra, "Fewer Periods. More Possibilities."⁸ The overall theme of the ads is

that it is fun and attractive to get fewer periods a year and the decision to suppress menses is easy and obvious. One television commercial pictures a woman in a bright white space, wearing a red polka dot dress, responding happily to a voice-over informing her that it is now possible to limit her monthly periods to just four a year. She then proceeds to spin around as all but four of the polka dots (representing menstruation) fly off her dress. Thus, menstruation is deemed as frivolous as a fashion decision. Some versions of this ad feature multiple women, all dressed in white, who pick up the red dots and throw them around like Frisbees. The ads try to equate Seasonale with a crisp and clean sense of carefree fun.

The marketing and media coverage of Seasonale paints a very negative picture of menstruation, which serves to further imply that the pill is a constructive addition to a woman's life. In research sponsored by Barr on women's attitudes toward their periods, the company claimed that more than half of the women surveyed felt "messy, fat and unattractive" during their periods. However, as the National Women's Health Network (NWHN) points out, this data was misconstrued. In actuality, only one third of the women reported menstruation made them feel unattractive and Barr neglected to disclose the 68% of respondents who experience a positive sense of health during menses.⁹

Such faulty reporting on the negative effects of menstruation is eerily similar to the wave of media attention given to premenstrual syndrome in the 1980s. In fact, PMS is widely cited as a reason to take Seasonale, and as was the case in the late 20th century, the alleged problems caused by menstruation are often overblown and quite dubious. For example, one *Boston Globe* piece on extended cycle pills was titled, "No Chocolate Cravings / No PMS or Bloating / No Fatigue or Moodiness / What if Having Your Period Was a Choice?"¹⁰ Readers are led to presume that all menstruating women experience these symptoms and

that even chocolate cravings necessitate pharmaceutical treatment. Journalists writing about Seasonale also claim that the menstrual cycle causes women to miss professional, social, or family-oriented events,¹¹ keeps them from participating in summer activities,¹² and makes them ineffective leaders.¹³

Even more troubling is the way these damaging, broadly applied stereotypes are used to depict menstrual suppression as the road to feminist liberation. Candace Bushnell, creator of the HBO series *Sex and the City* and Seasonale's celebrity spokeswoman, summed up this idea by saying, "When you think about what women can accomplish with 13 periods a year, think about what we can accomplish with only four. We have come a long way, but we've only just begun."¹⁴ By alluding to the feminist movement in her speech, Bushnell places menstruation as an obstacle on par with institutional forms of sexism that hinder women's possible achievements. Instead of offering a critique of the social structures that impede women's progress, the blame is turned inward and placed on the menstruating body. She implies that if only women could stop menstruating, they could achieve so much more. Barr Laboratories also hired a doctor to attend a media briefing on Seasonale to make similar claims, asserting that the drug could improve high school girls' test scores.¹⁵ Although there is no proof of the accuracy of this statement, the message is clear: if women want to excel in school, employment, and life in general, they should limit their periods.

An interesting component of the 'feminist' argument for Seasonale is the hypothesized role of menstrual suppression in maintaining women's health. There is a school of thought, led by Dr. Elsimar Coutinho and Dr. Sheldon Segal, authors of *Is Menstruation Obsolete?* (1999), that firmly believes women are becoming ill due to regular menstruation.¹⁶ Simply put, the rationale is that historically, Western women's main function in society was to procreate. Consequently, they were pregnant or breast-feeding, in other words not menstruating, for the majority of their reproductive lives. The conclusion is then drawn that the woman who experiences infrequent menstrual cycles is more natural and healthy than the woman whose menstrual cycle occurs monthly. Regular menstruation is deemed unnatural and a threat to women's wellbeing.

Menstrual suppression is offered as a compromise to fix this biologically unnatural turn of events. It is hailed as a "radical rescuing [of] the ovaries and endometrium from modernity."¹⁷ This approach simultaneously argues that women's bodies were



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designed for a life of serial pregnancy, and not much else, as it also alleges that if women try to exceed these roles, their reproductive health will falter. Thus, the only way to be a successful modern woman and retain your health is to suppress your menstrual cycle. In a *New Yorker* article, Malcolm Pike of the University of Southern California illustrates this rationale by claiming that:

*The modern way of living represents extraordinary change in female biology. Women are going out and becoming lawyers, doctors, presidents of countries...the world is not the world it was. And some of the risks that go with the benefits of a woman getting educated and not getting pregnant all the time are breast cancer and ovarian cancer, and we need to deal with it.*¹⁸

Although women's health advocates firmly deny any reduction in cancer risk due to menstrual suppression,¹⁹ Seasonale is offered as a means of returning women to a more biologically natural state of infrequent menses that will allow them to lead healthier, more enriching lives. However, such assumptions about women's nature are far from empowering. They frame the female body that does not participate in compulsive procreation as pathological, and rely on the notion that women's bodies are most healthy when symbolizing a social function focused on reproduction. Therefore, even though Seasonale is marketed as an aid to women's empowerment, it also frames women's liberation as biologically unnatural and unhealthy.

10 Health Concerns You Should Be Aware of Before Taking Seasonale

While proponents of menstrual suppression advocate on behalf of Seasonale for its health benefits, there are several health issues related to the pill that paint a far less optimistic picture of extended cycle contraception.

- Seasonale does not protect against STDs. The focus on the designer purpose of menstrual suppression relegates Seasonale's role in fertility control to the back burner, rendering promotion of safe sex while taking Seasonale all but forgotten.
- The extended cycle regimen of Seasonale exposes women to a 23% increase in annual hormone intake. This may translate to an increased risk of side effects already attributed to the birth control pill, such as stroke and heart attack.²⁰

- There has been no long-term research undertaken to study the effects of extended cycle oral contraception. Physicians and journalists attempt to downplay this fact by referencing women who have skipped the placebo pills to manipulate their periods for years.²¹ However, personal experimentation is no substitute for scientific study and has no effect on the safety of this practice.



- The research conducted to test Seasonale was only conducted on women over the age of 18. Even though 1.2 million girls aged 15-19 currently use oral contraceptives, the effects of an extended cycle pill are unknown for this age group.²²
- Seasonale was only tested on women who had previously been using 28-day oral contraceptives. No research on the effects of Seasonale has been performed on women who have never used birth control pills before.²³
- Significant breakthrough bleeding can occur between scheduled periods while taking Seasonale. In December of 2004, the FDA took action and officially admonished Barr for excluding information about the possibility of substantial breakthrough bleeding in their advertisements in order to make Seasonale appear safer.²⁴
- Abnormal changes in menstrual flow are often early warning signs of other physiological problems. Suppression of this function can mask symptoms and delay attention to a variety of disorders.
- The expected loss of monthly menstruation would also remove a common marker of pregnancy. Women who become pregnant while taking Seasonale may not become aware of their condition until much later than the average woman, thereby reducing their options for abortion.
- Promotion of menstrual suppression may cause or promote a negative view of the menstruating body. The National Women's Health Network warns that if menstrual suppression is aggressively advertised as the preferred and natural way for the female body to function, young girls especially will acquire a negative body image.²⁵

- Positive physical effects linked to monthly menstruation such as lowered risk of heart disease, bone health, sexual desire, increased immunity, and a cyclic reduction in blood pressure, would be lessened with the use of an extended cycle pill.²⁶

Conclusion

Despite the health concerns and the media manipulations associated with menstrual suppression, an extended cycle oral contraceptive may be the right choice for some women. Those who experience

extremely painful periods or women who have conditions exacerbated by the onset of monthly menstruation might find Seasonale to be the relief they have been looking for. Others may simply prefer to bleed less frequently for their own personal reasons. Regardless of the impetus to use Seasonale, it is pertinent that both physicians and manufacturers ensure that women have access to all of the health information necessary to make an informed decision. Women also deserve new contraceptive methods that are developed in an environment that places their needs and safety above the profit margins of pharmaceutical giants.

Amelia Bucek recently graduated from Hampshire College. Her senior thesis evaluated the media reaction to Seasonale as the latest installment in a long history of defining, and redefining, women's nature through menstruation.

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Ten Reasons Why Prisons are Bad for Reproductive Freedom

by Eesha Pandit

The nightly news is riddled with gruesome tales of increasing crime in our communities. Daily, battles are fought and lost in the 'war on crime' and the 'war on drugs,' both of which are pseudonyms for the criminalization of poverty. Are our communities stronger and healthier as we become increasingly dependent on systems of incarceration to solve social problems? The answer is an emphatic no. Further, prisons and the criminal justice system at large have specific consequences for women's reproductive freedom. Here are 10 reasons why women's health and reproductive rights advocates should think critically about prisons, their impact on women and their role in our society.

1. Prisons devastate families and communities.

The U.S. has the largest number of people in prison in the world, and women are the fastest growing prison population. Since 1980, the number of women incarcerated has risen by almost 500%.¹ Family ties and relationships are inordinately strained when a mother is incarcerated. About 78% of women in prison have children, but they are often incarcerated in federal prisons out of state or in state prisons in remote towns.² Less than half of these women are able to see their children and families. Furthermore, incarcerated women are at a high risk of losing their children. According to the Adoption and Safe Families Act of 1997, a woman loses her parental rights to a child who has been in foster care for 15 of the previous 22 months. Thus, a great majority of women who must place their children in foster care during their incarceration will lose them.³

Such facts raise larger questions about what effects prisons have on the social fabric of our communities. Prisons impact children, partners, wives, mothers and community members. Women often bear the burden of

supporting households in which a partner is incarcerated. Children of inmates are at risk of educational failure, joblessness, addiction and delinquency. Much of this devastation is caused by the so-called 'war on drugs' and mandatory minimum sentencing. The drug war does not promote and protect family values, as many would have us believe.⁴ Between 1986 and 1996, the number of women in prison for drug law violations increased by 421 percent.⁵ The vast majority⁶ of women are incarcerated for relatively minor, non-violent crimes. Instead of incarceration, these women need access to drug treatment, education and decent jobs.

2. Prisons pose a particular threat to women of color and poor women.

Women of color are the fastest growing prison population in the country today⁷ and most come from underprivileged and under-resourced environments. Almost half of all women in prison report that they have been sexually assaulted during their lifetime.⁸ Victims of sexual assault are more likely to be forced into homelessness and poverty, which often precede drug use, prostitution and committing economic crimes. Women of color and poor women are least likely to have access to the necessary treatment and counseling for sexual abuse. Instead of receiving such care, they are incarcerated and treated as criminals and not victims of a system that has failed to protect their rights.⁹

Once these women serve their sentences they are further denied access to the public services and support that they need to prevent themselves from winding up in prison yet again. Anyone who has been convicted of a drug-related felony is prohibited from receiving cash or food stamps and living in public housing.¹⁰ Thus, many women ex-prisoners are unable to provide for themselves and their children, continuing the cycle of punishing women not for crimes they commit, but for their poverty.

3. Prisons perpetuate the criminalization of sexuality.

Discrimination and oppression in society at large make certain communities more vulnerable to state violence. LGBTQ people often face increased violence from law enforcement officials, which jeopardizes their reproductive and sexual health. Until very recently, it was criminal for LGBTQ people to engage in sexual activity. Such legislation stems from the state's desire to control sexual activity in certain communities. Sex itself is not criminal — unless you are poor, LGBTQ, and/or a person of color. Likewise, sexual abuse by prison guards is often attributed to the hypersexuality of female prisoners, particularly women of color. The demonization of (female and queer) sexual deviance is commonplace in our culture, and because of our reliance on prisons, this translates into increasing numbers of women and LGBTQ people in prison.¹¹

4. Prisons are detrimental to women's overall health.

Women in prison are subject to some of the worst health services known to exist. The recent exposé in the *New York Times* regarding the now infamous Prison Health Services Company only scratches at the service of human rights abuses perpetuated against prisoners in the United States.¹² This violence affects the lives of women in very specific ways that often fly below the radar of mainstream prison reform activists.

Women are often denied very basic health care rights while in prison. Women in the California prison system are denied access to necessary medical diets, basic hygiene products like soap, shampoo and toothpaste, as well as essential medication.¹³ Women suffering from treatable diseases and mental illnesses are often denied medical treatment and access to health care and gynecological and reproductive services.¹⁴ Often such negligence causes exacerbation of their illnesses and leads to unnecessary, expensive and dangerous medical

procedures that could have been avoided with proper and preventative care. In extreme, but not entirely uncommon cases, this form of medical neglect results in death.

5. Prisons restrict reproductive choice.

Prisons function in several ways to prevent women from exercising control over their reproduction. The extreme medical neglect in the criminal justice system jeopardizes women's right to make their own reproductive choices by endangering their health and fertility. Often, the failure to screen for and treat sexually transmitted infections and cervical cancer leads to infertility and preventable hysterectomies.¹⁵

Further, detention centers, jails and prisons often interfere with a woman's right to an abortion. They require women to bear the cost of the abortion as well as security and transportation to a clinic. Often, a court order is required before women are taken to a clinic, causing such a long delay that the abortion is no longer possible when the necessary permissions are granted.¹⁶

Women who are pregnant at the time of their detention face a lack of adequate and available prenatal care. They report difficulty in accessing health care services and obstetricians. They are denied prenatal vitamins and the appropriate diet and work assignments. If they suffer from a drug addiction, they are denied the requisite medication to prevent unnecessary miscarriages and stillbirths.¹⁷

6. Women in prison face sexual abuse.

Women in prison face the threat of sexual violence on a daily basis. Seventy percent of guards who are responsible for monitoring women prisoners are men. These guards are responsible for supervising women prisoners throughout the day, including in the showers and bathrooms. A very high degree of rape, sexual assault, groping during body searches, and extortion occurs. To prevent women from reporting their abusers and to punish those who may have spoken out, guards use threats of physical assault and sentence extension and deny women visitation by their children and family members.¹⁸

7. Prisons negatively affect pregnancy and motherhood.

Law enforcement officials, judges and elected officials nationwide have sought to punish women for their actions during pregnancy, which may affect the fetus they are carrying. Women can be charged with child



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abuse, fetal homicide or drug trafficking if they test positive for drugs during pregnancy. Often women are tested for drugs without their knowledge. While in prison, the active endangerment or neglect of a pregnant woman can result in the termination of her pregnancy. Often the women themselves are held accountable and further punished for these outcomes.¹⁸ Women and children's advocates agree that women should engage in healthy behaviors that promote the birth of healthy children, yet they realize that a woman's substance abuse problem involves complex factors that must be resolved with treatment and social services, not incarceration. Thus, prisons violate a woman's privacy rights, criminalize a medical and social problem and offer nothing to help women have healthy babies.²⁰

Furthermore, irrational security measures dehumanize and endanger women during childbirth. In most states, it is standard practice to shackle all prisoners during transportation to medical facilities and during the medical visit. Pregnant women are routinely shackled during active labor and after they give birth; they are often restrained while they are giving birth as well. Illinois is the only state whose legislature has banned this practice.²¹

8. Prisons foster and perpetuate the injustices inherent in the criminal justice system.

With more than two million people behind bars, the U.S. has become the world leader in incarceration. Although women are currently less than 10% of the prison population, since 1995 women have been entering prison at a faster rate than men. Given such an alarming trend, it is crucial to understand the changing role of prisons in the larger criminal justice system to understand the challenges a system of mass incarceration poses to reproductive freedom.

Prisons and jails render women's reproductive rights expendable, even though the courts define these rights as essential. Women of color and poor women are increasingly vulnerable to such violation of their rights because access to resources and freedom from discrimination are key factors in obtaining reproductive autonomy. The criminal justice system's reliance on incarceration points to a broader contention between women and the state. State authority takes diverse and shifting forms that pose very difficult challenges to women trying to exercise control over their reproduction.²²

Resources

Amnesty International Women's Human Rights Program
www.amnestyusa.org/women/womeninprison

Critical Resistance: Beyond the Prison Industrial Complex • www.criticalresistance.org

Drug Policy Alliance
<http://www.drugpolicy.org/drugwar/>

Incite! Women of Color Against Violence
www.incite-national.org

Human Rights Watch Prison Project
<http://www.hrw.org/prisons/>

Justice NOW • www.jnow.org

The National Center on Institutions and Alternatives
www.ncianet.org/ncia

Prison Activist Resource Center
www.prisonactivist.org

Prison Legal News • www.prisonlegalnews.org

Prison Moratorium Project • www.nomoreprisons.org

The Sentencing Project • www.sentencingproject.org

9. Prisons do not make us safer.

Currently, activists that address the issue of state violence work in isolation from those that address domestic and sexual violence. Women of color and poor women who suffer disproportionately from both state and interpersonal violence are marginalized as a result.²³ The mainstream anti-violence movement has sought to protect women from domestic violence and battering by advocating for more involvement of police agencies. For communities of color and immigrant communities, this strategy is at times wholly ineffective because these communities face disproportionately a threat of violence in the home from the very same law enforcement authorities that are charged with their protection. In situations like these, home raids can take place at any time on tenuous legal grounds and women are left no recourse in the face of violence from both batterers and law enforcement officials.²⁴ Clearly, we need to re-evaluate the role of prisons and mass incarceration in our society. If prisons are not serving

the purpose of protecting the members of our society from violence and instead are jeopardizing women's rights and health, then the burden falls on each of us to challenge the injustices perpetuated by this system.

10. There are alternatives to prisons.

Many believe that we need new approaches and strategies to deal with violence in our communities. In order to come up with workable solutions, the first step is to let go of our desire to discover one single alternative system of punishment that would play the same role as the current prison and jail system. The

prison system is deeply entrenched in the social, cultural, and economic practices of the United States. We need to explore community based responses to violence that don't rely on the criminal justice system. Many ask: what about violent offenders? We need to call into question our analysis of violence as individual acts perpetrated solely by individual people, to the exclusion of examining it as a phenomenon symptomatic of larger structures of power and oppression. These are starting points. From here we can move forward to create structures that not only end violence, but advance freedom and human rights.

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The Politics of Abortion and Reproductive Justice: Strategies for a Stronger Movement

by Marlene Gerber Fried

The current battle over the nomination of John Roberts to the Supreme Court illustrates the continued centrality of the abortion issue in U.S. politics. On one side is the anti-abortion movement, dedicated to making abortion illegal and relying on George Bush to appoint Supreme Court justices dedicated to this goal. On the other side advocates for reproductive rights continue to fight to preserve legal abortion as a fundamental right necessary for women's equality and health.

Worldwide, unsafe and illegal abortion remains a major public health problem as well as a fundamental woman's human rights issue. There are an estimated 46 million abortions each year.¹ Induced abortion is one of the most commonly performed medical interventions.² When legal and performed by trained providers, it is also one of the safest medical procedures. Despite this, the mortality and complication rates from unsafe abortion remain high because of restrictive laws and regulations and inadequate, inaccessible services.

While making abortion legal is necessary to its safety, liberalizing laws is not in itself sufficient to guarantee that all women have access to safe and legal abortion. For example, in India where abortion has been legal since 1971, many women still undergo illegal abortions because of inadequate or unaffordable services and a lack of knowledge about legal abortion.³ Access is a problem in Western countries too. In the United States, abortion was legalized in 1973, but many women lack access because of restrictive legislation which especially burdens poor and young women, an inability to pay, the uneven geographic concentration of services, and the shortage of providers.⁴ Throughout the world, the most vulnerable women in a society are the ones who are the most harmed by the lack of access to safe, legal abortion.

In addition to changing laws, ensuring abortion access for all women requires closing the gap between legality and access, a goal that requires widespread societal and institutional change. The way abortion is viewed in society at large must also be addressed. Anti-abortion forces are well aware of this. Their actions are aimed both at preventing women from having abortions and at molding public opinion, stigmatizing abortion and women who have them.

In the U.S., the effort to defend and expand abortion and reproductive rights has been impeded not only by the successes of the opposition, but also by divisions among advocates of abortion rights. In this paper I will explore these issues and suggest that the movement adopt a reproductive justice approach.

Restricting Reproductive and Sexual Rights: The Bush Agenda

Although abortion was rarely mentioned by any of the candidates during the 2004 presidential election in the U.S., it has been in the forefront of Bush's agenda since he took office in 2000. His appointments to high level cabinet and agency positions and nominations for federal judgeships include people who oppose abortion and contraception. In addition to doing what he can through appointees, budget appropriations, and executive orders, Bush has assured opponents of abortion that he will continue to sign all of the restrictive laws that Congress passes. His track record speaks for itself. He signed legislation banning so-called partial birth abortion,⁵ which President Clinton had vetoed and which had already been declared unconstitutional by the Supreme Court. The fact that it has now been enjoined by three federal courts does not seem to be a deterrent to Bush. What is most important is that he show himself to be faithful to an anti-abortion agenda and to the Christian fundamentalists that were so crucial to his re-election.

Opponents of abortion are hopeful that if Bush is able to make enough new appointments to the Supreme Court, the federal constitutional right to abortion secured by the *Roe v Wade* decision could be rescinded.⁶ The resignation of Sandra Day O'Connor, who was part of a narrow majority in favor of abortion rights, has provided Bush with his first opportunity to change the court. If *Roe* were overturned, abortion would be treated as it was before 1973, with each state making its own laws. The Center for Reproductive Rights estimates that 30 states would criminalize abortion and 20 would legalize, although the restrictions would vary.⁷ Access to abortion would be further curtailed and as with all the other erosions in abortion rights, the most vulnerable women would be the most harmed. While there is considerable disagreement about whether this will be a Bush strategy, this frightening possibility is a cause for alarm. Many abortion rights advocates are thinking about how to ensure that women will get their needs met should this come about.

As a result of anti-abortion efforts, abortion and other reproductive rights have been seriously compromised, especially for the most vulnerable women in the U.S. and throughout the world — those who are poor and young, with women of color everywhere bearing a disproportionate burden. Internationally, the global gag rule remains in place, undermining services and the health of millions of people worldwide. The gag rule prohibits foreign NGOs that receive funding from US Agency for International Development and/or the Department of State⁸ related to family planning from addressing abortion, either through advocacy, referrals or provision of services. NGOs that refuse to comply have lost funds needed to run health clinics and provide other sexual and reproductive health services such as contraception and education about HIV/AIDS and other sexually transmitted infections.

The Bush administration pushes its anti-abortion agenda at every international meeting on women's rights and health. At the recent session of the UN Commission on the Status of Women in March 2005, a meeting to review the 1995 Fourth World Conference on Women, the U.S. delegation tried to amend the Beijing Platform to exclude abortion and "clarify" that the document does not create any new international human rights. After the amendment was opposed by more than 150 NGOs, the U.S. withdrew it, claiming that it was not backing down, only that the amendment was unnecessary.

While there is unanimity among feminists about the need to oppose the Bush agenda, there are also deep divisions about the overall political framework within which abortion rights are to be supported. While the ever-present threats from anti-abortion forces make it difficult even to discuss these issues, failure to address them ultimately weakens our movement and undermines the possibility of effective resistance.

Critique of Choice

The movement that fought for the legalization of abortion in the U.S. de-mobilized after it was achieved. Later in the same decade, the movement that emerged in response to the newly formed anti-abortion movement was a defensive one. The momentum seemed to have shifted to the opposition as the religious Right gained more power. Abortion rights supporters decided to use the language of choice and privacy as their framework. They thought this would have wider appeal and that it would broaden their base of support, encompassing even those who were conservative on issues of social and economic welfare.⁹ This approach was temporarily successful, insofar as it split those on the Right. However, it undercut demands for public funding of abortion and other aspects of access that had characterized the earlier struggle for abortion rights.¹⁰

Framing abortion rights in terms of a woman's right to choose is problematic on other counts as well. Because "choice" appeals to those who have options, but is relatively meaningless to those who do not, it is politically divisive. In a capitalist context, the idea of choice invokes the marketplace — things that are for sale can be chosen. This neo-liberal notion locates rights within an individual and obscures the social context and conditions needed in order for someone to have and exercise rights.¹¹ The fact that race and class inevitably circumscribe one's choices is ignored.



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Together with a failure to oppose population control, making abortion a matter of choice reinforced the disparity between the predominantly white and middle class women who were seen as the champions of abortion rights, and the low income women and women of color worldwide who bear the brunt of restrictions.

Not only is “choice” inadequate to express the full range of needs and conditions which must be met if women are to be able to make their own reproductive decisions, it is also a weak ethical framework, especially when counter-posed to “life.” The attempt to cast supporters of reproductive choice as anti-life should be resisted by raising the life issue on the abortion rights side. This means bringing the full reality of women’s lives to the discussion.

Choice has also been used to silence concerns about women’s health and potential coercion in the area of new reproductive technologies, including contraception. For example, Norplant was the first new contraceptive to be introduced in the U.S. in 25 years. It was met with relatively uncritical approval by mainstream women’s groups who saw it as expanding women’s contraceptive options. Depo-Provera too has been seen as providing women with greater choice. The mainstream feared that criticisms of these contraceptive methods raised by women’s health advocates in other countries and women of color in the U.S. would play into the hands of opponents of abortion and contraception, thus undermining women’s right to choose. As a result, contraceptive safety concerns were too readily dismissed and even discouraged.

Currently, stem cell research is in the same position. The Right and the anti-abortion movement are ideologically opposed to it. In 2001, President Bush outlawed federal funding for all but a very limited category of such research. However, many Republicans, even some who oppose abortion, do not agree with Bush’s position on stem cell research. Democrats successfully use this as a “wedge” of their own to divide the Republicans. Proponents of stem cell research have portrayed the opponents as religious ideologues who would prevent science from finding cures for diseases.

In this highly politicized context, the positions are too narrowly drawn. One can either side with science by

supporting stem cell research, or be anti-science by opposing it. There is no room for concerns about the potential risks to women’s health. One women’s health group, the Pro-Choice Alliance, is arguing for another approach. While they support most stem cell research, they are also raising important objections to embryo cloning. Specifically, they are worried about the risk to women’s health from the multiple egg extraction that embryo cloning necessitates. They argue that because of incomplete knowledge about the risks to women’s health, women cannot give informed consent. They advocate a series of measures designed to protect women’s health. These include requirements that researchers adopt the safest and most ethical approaches to collecting eggs; a neutral party whose sole purpose is to protect the safety and rights of women review existing data before undertaking multiple egg extraction; and every woman who provides eggs for research have her own physician, independent of the researchers.¹² The Pro-Choice Alliance wants to create a more balanced public discussion, one in which women’s health does not have to take a back seat for fear that opponents of abortion will win the day. Thus far they have not been successful in securing their policy objectives. They are, however, raising awareness and opening the space to be both supportive of abortion rights and critical of technologies that pose potential health threats.

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Organizing for Reproductive Justice

Historically, women of color have organized for reproductive and sexual rights outside of the choice framework. They have created their own organizations and coalitions, and have redefined reproductive rights in ways that emphasize the needs of their communities. Overarching socio-economic inequalities and racism shape these communities and the lives of women in them. They have disproportionate rates of poverty, lack of access to health care services and information, high incidences of violence, and poorer health outcomes in all areas. Examples include the fact that a majority of new HIV cases in the U.S. are among African American and Latina women; Native women experience very high rates of reproductive tract infections; Latinas have proportionately higher rates of cervical cancer; and Asian American women are the only group to experience a rise in overall cancer mortality. Consequently, their definitions of reproductive justice focus on achieving the broad set of conditions necessary for reproductive and sexual

freedom. Human rights and economic justice become part of this analysis, not separable from reproductive rights. Their definitions provide an expansive understanding of reproductive freedom, which integrates the race, class, gender and cultural aspects of their lives. Because of the histories of population control, the right to have children and families is core to their activism.

The reproductive justice approach is in sharp contrast to the narrowness of mainstream pro-choice politics. It is a holistic formulation, which links communities and issues and therefore has a greater potential to draw new constituencies to the reproductive freedom struggle. This is especially important now in the aftermath of the Bush victory. As in the past, when the Right has gained power, the mainstream reaction from the Democrats is to become more conservative. Several leaders of the Democratic Party have called for making

the party more hospitable to opponents of abortion. Senator Hilary Clinton's version of this approach is to describe abortion as "tragic."¹³ We should know better. Abortion rights are important both symbolically and practically since the availability of safe abortion has a direct impact on women's lives everywhere. A woman's bodily autonomy and integrity are at the core of self-determination and liberty.

Removing women's rights and sexuality from the abortion struggle and pursuing a narrow agenda have not been winning strategies in the long run. They have perpetuated racial and class divisions in the movement, weakening the ability to resist threats from the anti-abortion movement and to move forward to secure rights never achieved. I therefore hope that reproductive justice will become *the* central frame for reproductive rights, not only because this is the right thing to do, but also because it is the only way to win.

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1 "Safe Abortion: Technical and Policy Guidance for Health Systems," World Health Organization, 2003, p.10.

2 "Abortion Facts," www.womenonwaves.org, last visited: June 28, 2004.

3 "Abortion in Context: United States and Worldwide," Issues in Brief, 1999 Series. No.1, p.32, Alan Guttmacher Institute.

4 For more information see: "Justice Demands Abortion Funding," National Network of Abortion Funds, www.nnaf.org, April 2004; "Revisiting Public Funding of Abortion for Poor Women," The Guttmacher Report on Public Policy, April 2000.

5 The term "partial birth abortion" is purely political. It does not refer to any one procedure or gestational period, and it is not recognized by any medical authority. If found constitutional, the ban would compromise women's access to the safest abortion procedures. *Our Bodies, Ourselves*, Simon & Schuster, New York, 2005, pp 410-411.

6 Abortion was legalized in the U.S. in 1973 with *Roe v. Wade*, a decision of the U.S. Supreme Court, *Roe v. Wade*, 410 U.S. 113 (1973).

7 "What if Roe Fell? The State by State Consequences of Overturning *Roe v. Wade*," Center for Reproductive Rights, September 2004.

8 The State Department was added in 2003.

9 Silliman et al, *Undivided Rights: Women of Color Organize for Reproductive Justice*, South End Press, Boston, 2004, p30.

10 Ibid.

11 Silliman, Jael and Anannya Bhattacharjee, *Policing the National Body: Race, Gender and Criminalization*, South End Press, Boston, 2002.

12 "Unregulated Stem Cell Research May Put Women's Health At Risk," Center for Genetics and Society, http://www.genetics-and-society.org/resources/cgs/20050307_cirm.

13 Saletan, William, "Safe, Legal, and Never," <http://slate.msn.com/id/2112712>, last visited 1/26/05.



**population &
development**

The Population and Development Program, based at Hampshire College, brings a global feminist perspective to the study and investigation of population and environmental issues and challenges traditional views of overpopulation and immigration as primary causes of environmental degradation, political instability, and poverty. <http://popdev.hampshire.edu>



Population in Perspective

Population in Perspective provides resources for educators interested in a broad range of perspectives on global population issues, including an innovative curriculum and professional development workshop for middle school, high school, college and community educators, and a variety of population-related resources available at: www.populationinperspective.org.

Reviving Reproductive Safety

Reviving Reproductive Safety is a series of publications and activist tools that critically examines the health risks and ethical concerns surrounding contraceptives like Depo-Provera and Quinacrine and new reproductive technologies.

DifferenTakes

An investigative series of issue papers providing alternative information and critical analysis on a wide range of reproductive rights and population concerns.

Publications

Militarized Zones, published with CWPE and AFSC, explores the link between war-making and racism, the criminalization of immigrants, the demonization of Arabs and Muslims, the portrayal of young people as a threat to the future, restrictions on reproductive freedom, and more.



**civil liberties &
public policy**

The Civil Liberties and Public Policy Program, based at Hampshire College, is a reproductive rights organization that trains, educates, and inspires new leaders, organizers, and supporters nationwide. CLPP is expanding the reach and impact of the reproductive rights movement by connecting reproductive rights to social justice issues. <http://clpp.hampshire.edu>



Annual Reproductive Rights Conference

April 7-9, 2006

CLPP's annual April conference for students and community activists connects young people to reproductive rights organizations and campaigns locally, nationally, and internationally and provides them with information, analysis, and "how-to" organizing to bring back to their own campuses and communities.

National Day of Action

October 20, 2005

National Day of Action is organized every October by young people in their communities. It inspires grassroots activities that support struggles for reproductive and sexual freedoms, racial and economic justice, and calls for an end to violence.

New Leadership Networking Initiative

NLNI is a training and leadership building network for a diversity of young reproductive rights activists.

Reproductive Rights Activists Services Corps

RRASC is a summer internship project that places Five College students from the Amherst, Massachusetts area with reproductive rights and related social change organizations.