CONTRACEPTIVE CONTROVERSIES: CHOICE OR CONTROL?

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CERTIFICATE

This dissertation entitled, **"CONTRACEPTIVE CONTROVERSIES: CHOICE OR CONTROL?"** is submitted in partial fulfillment of the requirements for the award of the degree of Master of Philosophy, of Jawaharlal Nehru University. This dissertation has not been submitted for any other degree of this University or any other University and is my original work

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To Amma and Papa.....

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List of Abbreviations

ACOG-	American College of Obstetricians and Gynaecologists
ABCL-	American Birth Control League
AES-	American Eugenics Society
AIDS-	Acquired Immune Deficiency Syndrome
BMD-	Bone Mineral Density
BCFA-	Birth Control Federation of America
CBD-	Community Based Distribution
CDER-	Centre for Drug Evaluation and Research
CIOMS-	Council for International Organizations of Medical Sciences
CRLP-	Centre for Reproductive Law and Policy
CCP-	Centre for Communication Programs
DMPA-	Depot Medroxyprogesterone Acetate
EC-	Emergency Contraceptive
FALAH-	Family Advancement for Life and Health
FDA-	Food and Drug Administration
FHI-	Family Health International
FINNRAGE-	Feminist International Network of Resistance to Reproductive and Genetic Engineering
FSH-	Follicle-stimulating hormone
HRP-	Human Reproduction Programme
HIV-	Human Immunodeficiency Virus
ICEC-	International Consortium for Emergency Contraception

ICMR-	Indian Council of Medical Research
ICPD-	International Conference on Population and Development
IEC-	Information, Education and Communication
IMF-	International Monetary Fund
INGO-	International Non Governmental Organisation
INFO-	Information & Knowledge for Optimal Health
IPPF-	International Planned Parenthood Foundation
IRB-	Institutional Review Board
IUD-	Intra Uterine Device
IWHC-	International Women's Health Coalition
LH-	Luteinizing hormone
MOH-	Ministry of Health
MOPW-	Ministry of Population Welfare
NARAL-	National Abortion Rights Action League
NEP-	New Economic Policies
Net En-	Norethisterone Enanthate
NGO-	Non-Governmental Organization
NIEO-	New International Economic Order
NIS-	Newly Independent States
NORAD-	The Norwegian Agency for International Development
NOW-	National Organization for Women
NWHC-	National Women's Health Coalition
PATH-	Program for Appropriate Technology in Health

PCC-	Population Crisis Committee
PID-	Pelvic Inflammatory Diseases
PSI-	Population Service International
PGSI-	Pew Global Stewardship Initiative
PPFA-	Planned Parenthood Federation of America
SAPs-	Structural Adjustment Policies
SIDA-	Swedish International Development Cooperation Agency
SSA-	Sub-Saharan Africa
SSSB-	Society for the Study of Social Biology
UBINIG-	Unnayan Bikalper Nitinirdharoni Gobeshona.
UNDP-	United Nation Development Programme.
UNFPA-	United Nations Population Fund
USAID-	United States Agency for International Development
WB-	World Bank
WCHR-	World Conference on Human Rights
WHO-	World Health Organisation
WHO/HRP-	World Health Organization Special Programme of Research

INTRODUCTION

INTRODUCTION

Reproductive technologies of some sort or another, of various levels of sophistication and efficacy, have been developed in all human societies to prevent or facilitate conception. Michelle Stanworth[1] has divided these technologies into four groups. The first is associated with fertility control - preventing conception, frustrating implantation of an embryo, or terminating pregnancy. The second group of reproductive technologies is concerned with the 'management' of labour and childbirth. The third is concerned with improving the health and genetic characteristics of foetuses and of the new born child - the production of 'the perfect child'. And the last group focuses on conceptive technologies through directing attention to techniques that help to overcome and bypass infertility.

These technological innovations have been continuing over centuries with most advancement occurring in the second half of the twentieth century.[2] These technologies have not been developed, introduced or used in vacuum,[3] but have involved many powerful actors and institutions. These have also profoundly involved and politicised issues concerning race, gender, sexuality, reproduction, parenthood and the family because of the social control imposed upon it.[4] Above all they have also been shaped by the politics of colonialism and imperialism as they determine who controls access to the world's resources.

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[1] Stanworth, Michelle, "Reproductive Technologies and the Deconstruction of Motherhood" in Michelle Stanworth(ed) .1987. *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge, Polity Press.Ch.1

[2] Franklin, Sarah and Robbie Davis-Floyd.2001.Reproductive Technologies, *International Encyclopedia of Women*, New York, Routledge.

[3] Stanworth, Michelle.1987. *op cit*

[4] Ollila, Eeva .1999. *.Norplant in the Context of Population and Drug Policies.* Finland, STAKES National Research and Development Centre for Welfare and Health.

Reproductive technologies and controversies have always gone together. This dissertation focuses on the first in the above classification of reproductive technology, namely preventing conception through contraception.

Through this work, an effort is made to trace the controversies around selected contraceptives in different countries with an aim to unwrap the politics of contraception and also ideas and discourses embedded in it.

The term contraception is used to refer broadly to "all scientific methods of fertility regulation, thus including technologies for menstrual regulation and abortifacients."[5]

The different methods of contraceptives evolved over the decades include:

1. Barrier methods: such as condoms, diaphragms and cervical caps designed to prevent pregnancy.

2. Intrauterine devices (IUDs): small devices that are inserted into the uterus by a health care provider to prevent conception.

3. Hormone based birth control: formulations that are used in different forms like pills, injections, skin patches, vaginal rings and implants which release hormones into a woman's body that interfere with fertility by preventing ovulation.

4. Sterilization: a surgical technique leaving a male or female unable to reproduce and usually cannot be reversed.[6]

Humankind has constantly felt the need to enjoy sex without the fear of unwanted pregnancy or without the fear of contracting diseases. Historically, there were many barrier methods devised for contraceptive purposes. Condoms were one of the earliest devices that were invented using the sheep's gut, but this was mostly used to prevent diseases rather than pregnancy. This rubber barrier method that men could use over the years got associated with promiscuity, sex and diseases and so never came to be used for

[5] Gupta.J.A.2000.*New Reproductive Technologies, Women's Health and Autonomy-Freedom or Autonomy?*, New Delhi, Sage Publications. pp 331(notes)

[6] Contraception: As available on :www.nichd.nih.gov- Accessed on 13th January,2010

contraceptive purposes.[7] Coitus interruptus was the most frequently used method of contraception since time immemorial, but in the 19th century this method came under attack corresponding to the growth of a contraceptive manufacturing industry. The 20th century saw tremendous scientific development in the field of contraceptives and their increased use.[8] Methods to control fertility have positively impacted the lives of many women by giving them the ability to make decisions about whether and when to have a child. But as Betsy Hartmann puts it, "development of contraceptive technology has not been neutral but embodied by the values of their creators".[9] It was one of the biggest industries that initially depended on word-of-mouth advertising and then was vigorously marketed through the print and visual media. Andrea Tone through her work has shown that controlling women's fertility and ethical considerations within this technology have centred on commercialisation and achieving profits.[10]

Women over decades have struggled against this control over their lives. It was understood that if women are to have autonomy over their lives and maximise their health, they must be able to determine the nature of their reproductive lives.[11] As these technologies are shaped as products of the society they are part of, they represent the politics and influences of the times they were developed in. This politics and influences have rarely allowed the control of their reproductive lives to be in the hands of women. Rosalind Pollack Petchesky argues that if women make their own reproductive choices they do not make them just as they please; they do not make them under conditions which

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[7] Greer, Germaine.1984.Sex *and Destiny-The Politics of Human Fertility*, London, Secker and Warburg.

[8] *ibid*

[9] Hartmann, Betsy .1995. *Reproductive Rights and Wrongs: The Global Politics of Population Control*, Boston, South End Press. pp 173

[10] Tone, Andrea.2006. "From Naughty Goods to Nicole Miller: Medicine and the Marketing of American Contraceptives"; *Culture, Medicine and Psychiatry.* 30: 249–267.

[11] Doyal, Lesley.1995.*What Makes Women Sick: Gender and the Political Economy of Health*, New Brunswick, Rutgers University Press.

they themselves create but under social conditions and constraints which they, as mere individuals, are powerless to change.[12]

Reproductive technology to control fertility has had a historical linkage with the issue of "overpopulation" and neo-Malthusian understanding of the population resource. It has been argued that socio-economic status, political climate, and role of women in societies are neglected when contraceptives usually developed in the West are imposed, adapted or dumped into the developing countries.[13] They have never been free of controversies because of the difficulty in obtaining social sanction from family, religion, and state.[14] The struggle to be able to use contraceptives has been a long one and has involved many pressure groups.

Basically these debates of contraception can be narrowed under broader aspects of 'harm reduction' and 'rights perspective'. In the harm reduction perspective, sex is inherently risky and can lead to various negative reproductive health outcomes, including unintended pregnancy, pregnancy related morbidity, sexually transmitted infections and abortion. Expanded access to contraceptive or abstinence is needed to limit these public health "problems". In contrast, the 'rights perspective' frames the issue around the right to engage in sex, right to make autonomous decisions about sexual and reproductive health, women's right to full and equal social status and the obligations of governments to respect, protect, and enforce these rights.[15] But placing the controversies *only* within these two perspectives does not elicit an appropriate picture of these controversies. These controversies are intertwined within each other, bringing out a complex structure of power which will be discussed below.

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[12] Petchesky R P .1980. "Reproductive Freedom: Beyond "A Woman's Right to Choose";*Signs*,5 (4): 661-685

[13] Saheli .2006.*25 years of Continuity and Change*, New Delhi, A Saheli Publication.

[14] Doyal, Lesley.1995.*op cit*

[15] Wynn, L.L.et.al. 2007. "Harm Reduction or Women's Rights? Debating Access to Emergency Contraceptive Pills in Canada and the United States", *Studies in Family Planning,* 38 (4):253

Neo-Malthusians, Population and Contraception

Rev. Thomas Malthus who wrote "Population when unchecked increases in geometric proportions. Subsistence only in an arithmetic proportion"[16] popularised the idea that poor are responsible for their own misery since they breed proportionately more than the food that can be provided for them, or employment created. Malthus therefore called for moral restraint to control population. He was convinced that since the poor were unable to exercise moral restraint their numbers would be checked by what he called "positive checks", namely calamities, natural disasters, famines and droughts. Malthus was opposed to abortion and deliberate birth control on moral grounds. It is within this logic that he opposed relief under the Elizabethan Poor Laws as he was of the view that welfare would not only increase their misery but drain resources from the rest of the society as well. But as Betsy Hartmann puts it[17], Malthus was wrong on two basic counts – first, the ability of the population to stabilise itself and not because of positive checks by nature, but by improving living standards and bringing about other social changes which alter the need for many children. The second mistake was underestimating a society's capacity to clothe and feed a growing population.

The late nineteenth century saw the birth of a new avatar of Malthusianism, namely neo-Malthusianism.[18] Malthusians and neo-Malthusians shared the same understanding that identified population growth as the root cause to all problems and control of fertility as the major solution to all social problems. They differed on the manner of dealing with the problem, with neo-Malthusians favouring artificial contraception.[19] While Malthusians were concerned with the poor of their own countries, the neo-Malthusians looked across the seas at the poor in developing countries. In other words, their concerns were global

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[16] Rao, Mohan.2004.*From Population Control to Reproductive Health- Malthusian Arithmetic*, India, Sage Publications Pvt.Ltd.

[17] Hartmann, Betsy .1995. *op cit*

[18] Rao, Mohan .2004.*op cit*

[19] Bandarage, Asoka.1997.*Women, Population and Global Crisis: A Political Economic Analysis*, London and New Jersey, Zed Books.

while Malthus had called for moral restraint; neo-Malthusians depended on 'contraceptive revolution' to stop the breeding of the third world.[20]

In the post Second World War period, neo-Malthusian institutions were established that contributed in a large way to the spread of contraceptive technology through intervention in family planning programmes of different countries. Soon governments in both the First and Third World were involved in population control programmes at the behest of these agencies. Academic institutions in the First World provided scholarships and research grants to students from the third world to conduct research on the "population problem" in their respective countries. Neo-Malthusian views on fertility control and population stabilisation were increasingly accepted by the environmental movement and the feminist movement in the North. In the South also, the governments and the non-governmental organisations (NGOs) support neo-Malthusian views on the population question. The widespread acceptance of neo-Malthusian ideas must be understood in the context of increasing global inequalities and the economic and political power that contours this.

Eugenics, Pure Race and Reproductive Technology

Malthusian ideas were also central to another nineteenth century movement, namely that of eugenics, a movement that was aimed at improving the racial stock of nations. In the judgement in the famous Buck vs. Bell case by Justice Oliver Wendell Holmes Jr opined:

> "We have seen more than once that the public welfare may call upon the best citizens of their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for the world if instead of waiting to execute degenerate offspring for crime or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing in their kind The principle that sustains compulsory vaccination is broad enough to cut the Fallopian tubes...three generations of imbeciles are enough"[21]

This was the first judicial victory for eugenics like Dr.Bell who performed the surgery on Carrie Buck, an inmate of the infirmary at the Virginia Colony for Epileptics and Feeble

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[20] *ibid*

[21] Bruinius, Harry.2006.*Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity*, New York, Alfred A. Knopf,Vintage Books.pp no 21

minded in 1927.[22] For the first time, medical interventions on women's body were legally recognised in the larger interest of the society to attain a society with 'perfect children' and through them a 'perfect society'. But science of eugenics has a long history which will be touched upon in the following section.

Francis Galton first propagated the idea of improving the human condition through selective reproduction based on the famous publication by his cousin Charles Darwin *The Descent of Man* in 1871. Charles Darwin's theory of competitive struggle, natural selection and survival of fittest, greatly inspired Francis Galton who adapted the theory of evolution to humans. Galton, a self confessed connoisseur of beauty, used his interest in scientific measurements, numbers and statistics to establish a vision of a pure society. He called this the science of Eugenics, derived from the Greek word '*eugenes*' which meant good in stock.[23] The science of eugenics was of course established at a time when there was no understanding of genes or inheritance. However it provided a "science" to those who believed that intelligence and beauty were inherited and that these were characteristics of the rich. Mixed up with anthropology and colonialism, eugenics soon provided a veneer for racism as it was argued that the White races were superior to others because of genetic characteristics. The ruling classes in the West initially, and later in the colonised countries also, believed that manipulating the process of natural selection would give rise to a perfect society. They believed that discouraging the physically and mentally unfit from breeding and encouraging the 'best and brightest' with good hereditary qualities to procreate more, would create a society free of all socio-economic problems.[24] Thus 'breeding of poor women' was to be forcefully prevented through scientific methods. For example, in the early 20th century, the eugenics movement promoted policies that restricted reproduction of society's most marginalized

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[22] *ibid*

[23] *ibid*

[24] Priyaranjan.2007, "Setting the Agenda for Neo-Eugenics: An Exploration", Unpublished, MPhil Dissertation submitted to Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

communities, and adopted access to birth control to achieve these eugenic ends.[25] Sterilisation was the most common method in the first half of the 20th century to achieve the eugenics goal. Mostly women from working class backgrounds were sterilised most often against their wish. This use of scientific technology also led to the medicalisation of contraception. Finally, when eugenics was discredited at the end of the Second World War due to the egregious excesses of Hitler's regime, eugenic associations decided to support population control institutions.[26]

Right Wing Groups, Religion and Birth Control Services

Right wing groups have been another dominant influence on controversies around contraceptives. Opposition to contraceptive services and women's right to birth control has not only come from religious groups such as the Catholics and some sections of Muslims, but also from non-religious conservative forces.[27] The Roman Catholic Church has exerted considerable power and influence over the politics of contraception globally, fiercely opposing all methods of artificial birth control and abortion. Control over women and their sexuality are central to all fundamentalisms, Hindu, Muslim and Christian.[28] Right wing fundamentalists believe that access to contraceptives and abortion facilities will make women promiscuous and lead to immoral behaviour. This not only threatens patriarchy, but the patriarchal basis of the family as an institution. Protestant fundamentalist groups have been crucial in shaping policies in the United States especially with reference to abortion, but more generally with women's access to contraception. The Vatican has exerted immense pressure on states by using their special status as a Non-member State Permanent Observer at the United Nations.[29] They have argued powerfully at many international conferences on population over the years. The

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[25] A New Vision for Advancing an Understanding of Reproductive Health, Reproductive Rights and Reproductive Justice: Available on http://www.sistersong.net/documents/ACRJ_Reproductive_Justice_Paper.pdf: As Accessed on 10th December,2009

[26] Rao, Mohan .2004.*op cit*

[27] Gupta.J.A .2000. *op cit*

[28] Lynn P Freedman.1996. "The Challenge of Fundamentalism";*Reproductive Health Matters*,8.

[29] Bandarage, Asoka .1997. *op cit*

USA with an anti-women's reproductive rights platform set the agenda at the 1984 Mexico Conference while International Conference on Population and Development (ICPD) and ICPD+5 have seen the softening of stances by the international population lobby so as to please the Vatican and the US conservative beliefs. Indeed, the Holy See often uses the language of the Left, the developing countries and feminists, arguing that population control detracts from more fundamental causes of poverty and might represent biological imperialism by the West.

Malthusians, Eugenicists and the Right wing find a common base in capitalism as an ideology.[30]Capitalism sees the body as a unit of production while medicalisation expanded as a continuous process through the emergence of medical profession.[31] The critique of medicalisation was initially done by Marxist and liberal humanist perspectives that formed the basis of the emergence of social movements in the sixties and seventies.[32] Social problems and social life were 'medicalised' creating a 'diseased' society.[33] Ivan Illich, one of the strongest critics of medicalisation, argued that scientific medicine rather than enhancing health of the people creates a morbid society in which principal economic activity is through obtaining social control of the population by the medical system.[34]He also states that it is not only the medical profession that creates a dependency but also the pharmaceutical market which has invaded the homes of the people through intense promotion.[35]One of the central contentions of the Foucauldian perspective is that there is dispersed nature of power within the medical context, such that society is medicalised in a profound way. The functions of the state and other institutions serve to monitor and administer the bodies of citizens in an effort to regulate and maintain social order as well as promote good health and productivity. At the same time, the state is also responsible

[30] *ibid*

[31] Costa, Tonia.et.al .2007. "Naturalization and Medicalisation of the Female Body: Social Control through Reproduction"*; Interface*,3.

[32] Lupton, Deborah. "Foucault and the Medicalisation Critique". Petersen, Alan and Robin Bunton (eds).1997.*Foucault Health and Medicine.* London and New York, Routledge.Ch.5

[33] *ibid*

[34] Illich, Ivan.1975.*Medical Nemesis--The Expropriation. of Health*, London, Calders and Boyer.

[35] *ibid*

for the reproduction of medical domination and other actors too exert their power to keep this domination intact.[36] However, that knowledge is intricately linked to power is evidenced by the fact that knowledge of medicine and technology is differentially dispersed among different social groups in the society leading to differential access among them.

Feminists have argued that hegemony of the medical profession has been responsible for ordering and standardizing issues concerning the female body. Medicalisation of women's lives has been through new reproductive technologies which have focussed on the 'biological vulnerability' of women, making each part of her body diseased and thus creating a 'life cycle' of women which need medical attention. This mode of medicalisation defines problems of women as part of scientific medical knowledge rather than within the context of their religious, moral, political, cultural or social lives.[37] The medico-scientific approach leads women to fear their own bodies.[38] This fear leads to the increased use of medical services and exploitation of their bodies.

International Organisations, Politics of Funding and Contraception

International donor organisations have greatly influenced population control initiatives in the developing world. They have been instrumental in institutionalising birth control. These organisations started providing population assistance in the late Cold War period of the 1950s and 1960s.

These donor organisations can be classified into three broad groups:

- Bilateral Agencies such as the United States Agency for International Development (USAID), the Swedish International Development Agency (SIDA) and The Norwegian Agency for International Development (NORAD) and others.

[36] Lupton, Deborah. "Foucault and the Medicalisation Critique". Petersen, Alan and Robin Bunton (eds).1997. *op cit*

[37]Medicalisation: Available on: www.ucel.ac.uk/shield/docs/rlo_spec**medical**sation.doc- Accessed on 13th April,2010

[38] Karkal, Malini. "Reproductive Rights and Reproductive Health of Women". In: J.P.Singh (ed).1998. *Studies in Social Demography*, New Delhi,M.D.Publication Pvt Ltd, ch.12.

- Private funded organisations such as the International Planned Parenthood Foundation (IPPF), The Population Council, and the Pathfinder Foundation and Compton Foundation
- Multilateral Agencies such as the United Nations Population Fund (UNFPA) and the World Bank.

Dominant among other global institutions that promoted population control were the US government, the World Bank, and United Nations system. Huge amounts of money were given by private foundations and the US government for population research, programme design and implementation. Through their influence population control became a powerful sect within the US as well as within global academic and policy planning circles.[39] These organisations have partnered with governments of different countries to spread information and availability to cover the 'unmet need' for contraceptives as part of the family planning initiatives

Feminist Movements, Autonomy and Contraception

Gender and sexuality have been the central issues around which the feminist movement has evolved, raising diverse issues of equal rights in areas such as sexual division of labour, sexism in law, abortion, birth control, sterilization abuse, domestic battery, rape, incest, discrimination against sexual minority groups, sexual harassment, prostitution, female sexual slavery, pornography etc.[40] In all these areas, feminist efforts confront and change women's lives concretely and experientially. Taken together, they produce a feminist political theory centering on gender and sexuality: its social determination, daily construction, birth to death expression, and ultimately male control.[41] New reproductive technologies have helped to promote an idea of freedom and control over ones sexuality. This idea of individual freedom was supported by the White western liberal feminist movement. Feminists of Colour and some Third World feminists have questioned this

[39] Bandarage, Asoka .1997. *op cit*

[40] MacKinnon, Catharine .1982. *op cit*

[41] *ibid*

concept of reproductive right and choice determining their lives. They have argued that the concept of right is individualistic in nature and inapplicable to conditions of their lives that include oppression by colonialism and imperialism; in other words that the freedom for women of the First World has been on the back of unfreedom for women of the Third.[42]Reproductive rights in domains such as birth control and midwifery have been a primary area of debate for a woman's control over her own body.[43]

Liberal feminists claim that gender differences are not based in biology, and therefore that woman and men are equal in all arenas as their common humanity supersedes their procreative differentiation. Equality before law has been one of their major demands. They have claimed reproductive rights as a necessary precondition for self determination and autonomy.[44] Liberal theory works on the general principle that women must be able to control their own bodies and procreative capacities to compete with men in the labour market.[45]Liberal feminists oppose unnecessary state intervention in matters related to their body, and attempts to prevent or prohibit is taken as a violation of rights to their privacy and autonomy. It has been argued that liberal feminism holds an uncritical acceptance of male norms, where it is assumed that the ultimate goal of women is to be like men and to seek success within the structures and rules laid down rather than attempt to change them.[46] Liberal feminists maintain a distinction between the public and private life.[47] These feminists also have come to accept the neo-Malthusian position that population growth in Third World countries is responsible for poverty in these countries,

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[42]Chapter 1, Human Rights, Women's Rights, and Reproductive Freedom: The Evolution of Ideas-Presented at the AdaptingtoChangeCoreCourse.1999.-Avaliable on http://info.worldbank.org/etools/docs/library/48442/m1s5dixon.pdf: As accessed on 12th May 2010

[43] Feminism and Women's Right: As Available on http://www.cato.org/pubs/articles/feminism-women-rights.pdf: As Accessed on 12th April, 2010.

[44] Lorber, Judith. The Variety of Feminisms and their Contribution to Gender Equality-Available on http://www-a.ibit.uni-oldenburg.de/bisdoc_redirect/publikationen/bisverlag/unireden/ur97/kap1.pdf:As accessed on 14th May,2010

[45] Petchesky R P .1980. "Reproductive Freedom: Beyond "A Woman's Right to Choose";*Signs,*5 (4): 661-685

[46] Bryason, Valerie .1999. *Feminist Debates: Issues of Theory and Politics Practice*, London, MacMillan Press Ltd.

[47] *ibid*

ignoring the role of colonialism and imperialism. Thus they emphasise access to contraception; in doing so they reduce 'women's rights' to 'reproductive rights' which in turn get equated with population policies.[48] Liberal feminists have been critiqued based on the argument that it is not possible to look at gender in isolation without analysing the structures that shape choice; indeed that the concept of choice might itself be a red herring.[49]

Socialist Feminists believe in collective class interest rather than individual rights as the primary focus of political concern. They insist on economic and social rights and freedom from exploitation while prioritising the interest of the working class.[50] They believe in reproductive rights of women and insist that women make their own choices, reproductive and otherwise. Reproductive rights remain integrated within the idea of social rights and responsibilities. Socialist feminists believe that it is immaterial to talk about legal rights without improving the economic and social conditions of women to acquire these rights. [51]

Marxist Feminist thought derives from Marxism, wherein development lies in understanding human society and history from a class perspective. Technology is given importance along with economy. Women's problems are understood as a by-product of economic activity and class struggle. It has been analysed that socio-economic status of women and their historical contexts result in their subordinate position. This idea of situating subordination within the social and economic context has, however, been critiqued by other feminists as it accepts capitalism as more fundamental a problem than patriarchy. But situating a split between the two dynamic forces of capitalism and patriarchy by focussing all the problems historically with capitalism has also not been

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[48] Bandarage, Asoka .1997. *op cit*

[49] Bryason, Valerie .1999. *op cit*

[50] *ibid*

[51] Arathi P M.2006. "Aborting Gender Justice: Legislating Abortion "Unpublished MPhil Dissertation submitted to Centre for Social Medicine and Community Health , Jawaharlal Nehru University, New Delhi.

accepted by many feminists as it is argued that these dual forces cannot exist separately.[52] Many Marxist feminists emphasise on the social dimension of reproduction. The term 'social reproduction' has foundations in the classic concept of Marxism.[53,54] This conceptualisation is based on the belief that sexual relationships, fertility control and family are part of the material basis of society rather than its product.[55]Marxist feminists believe in the benefits of methods to control fertility and reproductive technology which allow women to enjoy freedom and feel liberated. It is argued that development in contraceptives and reproductive technologies will end women's alienation if provided within the context of economic and social change, and can transform into a conscious and freely chosen human activity.[56,57]

It is argued by both socialist and Marxist feminists that family is a source of women's oppression and exploitation, as women are expected to contribute to production while retaining their domestic duties.[58] They believe that the welfare services provided by the states such as maternity benefits and child care services are paternalistic, substituting public patriarchy for private patriarchy. They argue that male-dominated government policies put the state's interests before those of women, hence, when the state requires women to have more children or less children they use technology as a tool for the same.[59]

Radical Feminists based their theory and action on the slogan 'personal is political'.[60] They believe that all women share common experiences of suppression at the hands of men. The theoretical analysis of male power based on the concept of 'patriarchy' is the

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[52] Bryason, Valerie.1999. *op cit*

[53] *ibid*

[54] Petchesky R P .1980. *op cit*

[55] Bryason, Valerie.1999. *op cit*

[56] *ibid*

[57] Arathi PM .2006. *op cit*

[58] *ibid*

[59] Lorber,Judith.The Variety of Feminisms and their Contribution to Gender Equality-Available on http://www-a.ibit.uni-oldenburg.de/bisdoc_redirect/publikationen/bisverlag/unireden/ur97/kap1.pdf:As Accessed on 14th May,2010

[60] Bryason, Valerie .1999. *op cit*

foundation of radical feminism.[61] This state is situated within the social system of male domination and female subordination to such an extent that it is accepted to be 'natural'. This is maintained through a process of socialisation. Radical feminists believe that women's oppression is deep rooted within her personal life, and this has led to campaigns to confront personal life styles.[62] Radical feminists have identified technology as a source of control and violence. For them control of reproduction is a means of patriarchal control. Reproductive rights which are hailed by the liberal feminists are critiqued by radical feminists stating that the former are individualistic in their arguments because they do not consider the oppression of women within the patriarchal society through these technological controls. Women are naturally trapped in the childbearing function. They believe that men are intent on capturing and controlling women's reproductive capacities. Male doctors, scientists and entrepreneurs have gained access to what was once exclusively women's world of conception, gestation and childrearing through new reproductive technologies. Men gain control of the reproductive capacities and vast economic wealth from the commercialization of reproductive research which exploits women's bodies.[63]Therefore radical feminists believe that liberation of women depends on their being freed from this trap. Radical feminists do not believe in the liberative quality of new reproductive technologies. However radical feminists have been critiqued, in that they focus on universal gender oppression and neglect ethnic and social class differences among women and that they downplay other sources of oppression. By pitting women against men, radical feminism alienates women of Colour and working-class women, and indeed most feminists from the Third World who feel torn between their feminist politics and their ethnic and class contexts.[64]

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[61] *ibid*

[62] *ibid*

[63] Condit, Deirdre.1994." Writing Reproduction: Reproductive Technologies and Motherhood Examined";*Policy Sciences*,27(2-3):287-294

[64]Lorber,Judith.The Variety of Feminisms and their Contribution to Gender Equality-Available on http://www-a.ibit.uni-oldenburg.de/bisdoc_redirect/publikationen/bisverlag/unireden/ur97/kap1.pdf:As accessed on 14th May,2010

Disabled Feminists have fought against biological determinism and support women to make decisions about their bodies, sexuality and childbearing. They believe that the women's movement has failed to address the issues of reproductive rights keeping in mind the perspectives of disabled women. Disabled women have been denied sex education, contraception, discouraged from childbearing, forced to undergo abortions or sterilisations and have lost custody of their children.[65] Disabled feminists have fought against the 'politics of eugenics' which underlies repression of sexuality and reproduction through coercive use of contraception and sterilsation.[66] All too frequently, they are also pitted against other feminists because of their attitude to abortion since many disabled feminists believe that all abortion is neo-eugenic in nature.

Black Feminists believe that they do not face oppression purely due to their gender, instead they experience oppression in many forms due to their long history of slavery and colonization. They argue that western imperialism has institutionalised racism, xenophobia, heterosexism, and class oppression in this society, so that policies supposedly designed to serve all women often function to perpetuate injustice for women of colour.[67] They have called for a greater analysis of oppression in discussions of reproduction and birth control than has hitherto been the case; indeed arguing that these discussions have been often framed by White women who have gained from the oppression of Blacks in general. Angela Davis, for example, argued that the hard-won right to abortion for White women was in fact won on the backs of Blacks and other women of Colour, subjected to decades of sterilisation abuse.[68] They have stated that the reproductive rights framework which has been the flagship of the feminist movement is not all inclusive as they focus largely on individual rights and solutions, rather than structural societal changes and intersecting forms of oppression, including race and

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[65] Kallianes, Virginia and Phyllis Rubenfeld. 1997. "Disabled Women and Reproductive Rights"; *Disability and Society*, 12(2).

[66] *ibid*

[67] A New Vision For Advancing Our Movement-For Reproductive Health, Reproductive Rights and Reproductive Justice : Available on http://www.tides.org/fileadmin/pdfs/ReproductiveJusticeResources.pdf-As accessed on 10th April,2010

[68] Davis, Angela.1981.*Women, Race and Class*, New York,Vintage Books.

colour. As Angela Davis states "Reproductive Rights agenda has been shaped by dynamics of class and race".[69]

Framework of the Dissertation

The present dissertation is an attempt to place arguments of choice and control through analysing controversies of contraceptives. Through this dissertation, there is an effort to examine the role of different actors and groups that have influenced the growth of contraceptives within the perspectives mentioned above. This study sees 'choice' as a political concept that has greatly influenced the kind of contraceptives that have been available to women. An effort has been made to bring out the usage of the language of choice and the different meanings attributed by different actors.

Throughout the dissertation, focus is given to systemically used contraceptives with hormone based formulations and its two different forms:

- Long acting hormonal contraceptives-injectable and implants
- Emergency contraceptives.

Long acting Hormonal Contraceptives are provider controlled contraceptives that afford protection from conception for longer periods. There are two basic forms of long acting hormonal contraceptives. One is in an injectable form that offers protection for three months and another in the form of implants that offers protection for three to five years.

Emergency Contraceptives are used after an act of unprotected intercourse and are usually accomplished after self administration within 72-125 hours.

These contraceptives have been selected for review depending on the nature of usage as well as provision – long acting contraceptives need provisioning through medical expertise and emergency contraceptives can be self administered by women.

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[69] Silliman, Jael et.al.2004. *Undivided Rights-Women of Color Organize for Reproductive Justice.* Massachusetts, South End Press. pp.11

All these contraceptives have been in the eye of a storm for a variety of reasons that will be examined.

Methodology

This dissertation is based on review of both primary and secondary literature. The primary literature is disseminated in websites of organisations and groups that hold and propagate views of these contraceptives. Secondary literature includes information from published academic works.

Method of Literature Collection

Literature for the review was accessed through library search, print and web based search of articles and books published mainly in the area of reproductive health, population issues, contraceptives and birth control movement.

Chapterization for this Dissertation

The dissertation begins with the definition of reproductive technology and contraceptive technology and further examines the perspectives that influence the controversies around contraceptive technology. Introduction also covers the approach and methodology employed by the study.

This introduction is followed by three chapters:

Chapter one titled *A History of Contraceptives and their Controversies* examines, in short, the history of contraception while simultaneously tracing the emergence of controversies that accentuated or opposed the growth of these contraceptives from 19th century onwards. In this chapter largely the birth control movement that has evolved in America has been traced. This is because birth control movement within America has greatly influenced the birth control movement and policies world over.

Chapter two titled *The Continuing Controversies with Long-Acting Contraceptives* reviews the controversies surrounding long acting contraceptives. These contraceptives have evolved over a period of time and have been involved in controversies from the beginning. There has been an attempt made to present the history of long acting contraceptives around three major issues of safety, efficacy and ethics which have been the major focus of the controversies. While presenting these controversies examples from different countries are given to explain them in detail.

Chapter three titled *The 'Emergency' of Emergency Contraception* assesses the controversies based on the role of religion, anti-choice groups and the women's group.

Chapter one attempts to trace the controversies while bringing out the historically context to place the arguments of 'choice' and 'control'. Chapters two and three while probing into the history of long acting contraceptive and emergency contraceptives attempt to place the consequences of historically emerged controversies within the ambit of how it has influenced women's health world over.

The dissertation in the conclusion summarises the controversies that influence 'choice'. This chapter brings out arguments asserting that there is a need to go beyond the rhetoric of choice.

CHAPTER ONE

A HISTORY OF CONTRACEPTION AND OF THEIR CONTROVERSIES

It has been fifty years to the introduction of the 'pill' that ushered in the 'sexual revolution'.[1] But the history of contraception goes beyond these fifty years; it is as old as human civilisation itself. The desire to control conception has been a universal social phenomenon in all cultures.[2]

Women from different continents, for hundreds of generations, have used a variety of fruits and plants to control their fertilisation.[3] But there remained a gap between the desire for control and effective prevention; hence methods of abortion and infanticide were the most commonly used methods to limit the number of children.[4,5,6] Ideologies that entirely banned birth control came into existence after the development of agricultural societies. This was accompanied by the accumulation of private property, which in turn, made large families an asset.[7]

1.1- Emergence of the Birth Control Movement in the Nineteenth Century

The earliest methods of contraception, albeit natural, included coitus interruptus, coitus reservatus and outercourse. These, along with abstinence, and what came to be called the "rhythm method" were practiced to avoid pregnancy. One of the earliest invention of contraceptives devices were linen sheaths by Gabriele Fallopio known as prophylactics.[8] Condoms are modelled after these linen sheaths; they were only used

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[1] Allyn, David.2001. *Make Love, not War: The Sexual Revolution: An Unfettered History*, New York, Routledge.

[2] Himes, Norman.1936.*Medical History of Contraception*. New York, Gamut Press, Inc.

[3] A History of Birth Control Methods Report.2006.Available on http://www.plannedparenthood.org/- As Accessed on 13th June,2010

[4] Himes, Norman.1936. *op cit*

[5] Cirillo Vincent.1974. "Birth Control in Nineteenth-Century America: A View from Three Contemporaries"; *The Yale Journal of Biology and Medicine* ,47: 260-267

[6] Gordon, Linda.2007.*The Moral Property of Women: A History of Birth Control Politics in America,* USA, University of Illinois Press.

[7] *ibid*

[8] Greer, Germaine.1984.*op cit*

to avoid diseases and hence got associated with promiscuity and sex. As stated by Germaine Greer, no man could imagine using armour against his wife.[9]

It was in the nineteenth century that contraceptives gained visibility and popularity. As Linda Gordon states, "Although, birth control is old the movement for the right to control reproduction is young."[10] The spread of contraceptive practices in nineteenth century France, England and the USA can be attributed to the emergence of the birth control movement. The eighteenth and nineteenth century growth of population, consequent to the decline of the death rate, led, after a period to the decline of the birth rate. The beginnings of the birth control movement, then, can be traced to England that had undergone industrialisation the earliest.

By the beginning of 1830s contraceptives was part of what Foucault calls public 'discourse'.[11] This was the consequence of the economic development through industrialisation resulting in increased migration and urbanisation. This was followed by the withdrawal of children – and women – from several occupations and thus the decreasing contribution by children to the household economy. The desire to have smaller families was accompanied by the growth of a fairly large contraceptive manufacturing industry in the second half of the nineteenth century selling an array of contraceptive devices.[12,13] There was also increased information on birth control in the form of pamphlets and publications. But open discussions regarding sex or the anatomy of women and men were considered immoral.

By the 1860s, contraception gained popularity – albeit largely among the middle classes - and focus shifted from 'morals to the market' because of the economic benefits of the sale of contraceptive devices.[14] But the ban on birth control was not easily subverted because of the presence of ideologies regarding sex, gender and

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[9] *ibid.* p.no.130

[10] Gordon, Linda.2007.p.no.7.

[11] Brodie, Janet Farrell.1994. *Contraception and Abortion in the 19th Century*, USA, Cornell University Press.

[12] Gordon, Linda.2007.*op cit*

[13] Greer, Germaine.1984.*Sex and Destiny*: *The Politics of Human Fertility*, London, Secker and Warburg.

[14] Brodie, Janet Farrell.1994. *op cit*

motherhood.[15] Religions like Islam, Christianity and Judaism were opposed to the use of contraceptives. All three religions condemned some aspects of the control of reproduction for various reasons. These included the belief that children were the gifts of God; that women's control over reproduction would threaten the sanctity of the family and the role of the husband and father; and that sexual pleasure among women would lead to their wantonness.[16] These ideas were especially true of Christianity which became more explicitly against women after contraception came to be publicly discussed. Hence it can be said that 'control' over birth control is as old as the birth control movement itself

Nineteenth century ideas about the social and economic desirability of birth control[17]have been informed by many ideas, actors and institutions from the eugenics movement, the Malthusians, health advocates, the feminist movement and, finally, the contraceptive market. A web of complex political structures surfaces when one traces the history of the emergence and socialisation of contraception.

Prior to 1860 contraception was considered a many thinkers and scholars talked about contraception in private but were hesitant to be public about it as it was a considered 'private matter'[18] There did not even exist a proper term with which one could refer to control of fertility in the nineteenth century. Controversies around birth control were one of early cultural attempts to redefine and reshape the 'private into public'.

There persisted a Malthusian fear of the reproduction of the lower classes among the earliest propagandists of birth control. Four such thinkers in the USA and UK who greatly influenced the birth control movement in the nineteenth century - over the period between 1823-1850 - were Francis Place, Richard Carlile, Robert Dale Owen and Dr. Charles Knowlton. [19] Although their support for birth control was embedded within the Malthusian framework, they rejected the idea of 'moral restraint'

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[15] Gordon, Linda.2007.*op cit*

[16] *ibid*

[17] Himes, Norman.1936.*op cit*,pp.211

[18] *ibid*

[19] *ibid*

propagated by Malthus as impractical.[20] Their focus was on technology that could help prevent conception.

Francis Place was the earliest amongst these thinkers to talk about contraception publicly. He promoted contraceptives among the working classes and the less privileged through handbills and publications.[21]He initially wrote of coitus interruptus as an appropriate method, subsequently shifting focus to sponges and tampons dipped in various acids or salt to kill sperm.[22] Place based his support in favour of contraception on an economic argument that limiting the population of labourers and thereby creating a demand for labour would increase their wages and standard of living. He believed that their standard of living would decrease if the working class continued to breed excessively. In his publication *Illustrations and Proofs of Population* (London, 1822), Place stated: "It is time that those who really understood the cause of a redundant, unhappy, miserable and considerably vicious population, and the means of preventing this redundancy, should clearly, freely, openly and fearlessly point out the means."[23]

Richard Carlile was one of Place's closest disciples who also believed in contraception and propagated it through his pamphlets, one of which was entitled '*What is love*'. His arguments were however slightly different. He propagated contraception to achieve freedom from conception so as to have the freedom to enjoy sex.[24]

Robert D. Owen who returned to England from the USA was greatly impressed by the work of Francis Place and Robert Carlile. He took the pamphlets prepared by Robert Carlile to the United States and wrote appreciatively about the English birth control movement, indicating the fact that the movement enjoyed the patronage of influential people. He too, like Place, believed that a decrease in population would decrease

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[20] Langer, William.1975. "The Origins of the Birth Control Movement in England in the Early Nineteenth Century"; *Journal of Interdisciplinary History*:5(4):669-686.pp674

[21] Himes,Norman.1936.*op cit*

[22] *ibid*

[23] Langer, William.1975. *op cit*

[24] Himes,Norman.1936.*op cit*

pauperism. Owen was instrumental in shaping the American Birth Control Movement.[25]Owen initially propagated coitus interruptus as a method of contraception; this soon changed to vaginal syringe for douching.

Dr.Charles Knowlton's '*Fruits of Philosophy*' (1832) was anonymously published in New York and had the distinction of being the first study on contraceptive techniques. He also had the distinction of becoming the first person in the Western world to be convicted for distributing birth control literature.[26,27] Dr. Knowlton had recommended methods of douching with solutions of sulphate of zinc, of alum, or pearlash or of any salt acting as a spermicide.[28]Both Owen and Knowlton were in favour of putting the responsibility for contraception into the hands of the wife, arguing that contraception should naturally be the responsibility of the women.[29]

In 1843, Charles Goodyear patented the vulcanization of rubber and began the mass production of rubber condoms. This method became hugely popular in Europe and the USA within few years of its invention. Indeed, it became a profit- making endeavour with limited investment.[30]This device also gained the reputation as a device to protect men from syphilis and gonorrhoea when they had premarital or extramarital sexual intercourse.[31]By the mid-nineteenth century, other forms of contraception also gained popularity among the educated middle classes, largely professionals and among many free-thinking and secularist circles, although it failed to make a dent among the working class population.[32] In the 1860s and 1870s, there developed a market for contraceptives because of advertisements in the print media encouraging their use.

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[25] Langer, William.1975. *op cit*

[26] *ibid*

[27] Himes, Norman.1936.*op cit*

[28] *ibid*

[29] *ibid*

[30] Tone, Andrea.2002. " Making room for Rubbers: Gender, Technology, and Birth Control Before the Pill"; *History and Technology*,18 (1): 51–76

[31] A History of Birth Control Methods Report.2006.*op cit*

[32] Langer, William.1975. *op cit*

The growth of print advertisements was encouraged by the cheap rates of the US postal department thus making it easier to distribute material.[33]

The growth of birth control technology and the spread of information were of course opposed. One of the strongest voices and opponents of contraception was the anti-vice crusader Anthony Comstock. The increasing prominence of contraceptives along with the spread of advertisements with sexual overtones along with advertisements for prostitution brought him to take legal action.[34] He legally opposed members of the free lovers groups, Mrs. Victoria Woodhull and Miss Tennessee Claflin under the then existing obscenity laws for spreading information about contraception. This, however, proved unsuccessful because the court declared this case as trivial. After this he went to Washington to advocate for more stringent laws. He was successful in doing so when Congress passed a bill that came to be called the 'Comstock Law' in 1873.[35] This bill contained the following controversial passage -

> ------No article, or thing, designed or intended, for the prevention of conception or notice of any kind in writing or print, giving information directly or indirectly, where or how, or of whom, or by what means either of the things before mentioned may be obtained or made, shall be carried in the mail."[36]

Many advocates of contraceptives in the USA were charged with this law in the nineteenth century, often on the basis of fake cases.[37] But the campaign for birth control continued.

Feminists attribute the beginning of the birth control movement to the late nineteenth century when they raised a demand for "voluntary motherhood".[38] This was the first united feminist movement for the right to control their own fertility. It was advocated

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[33] Tone, Andrea.2006. "From Naughty Goods to Nicole Miller: Medicine and the Marketing of American Contraceptives"; *Culture, Medicine and Psychiatry.* 30: 249–267.

[34] *ibid*

[35] Cirillo Vincent.1974.*op cit*

[36] *ibid.*p.263

[37] *ibid*

[38] Davis, Angela.1981.*Women, Race & Class*, USA, Vintage Books.

by three types of feminists - suffragists; people active in such moral reform movements as temperance and social purity, in church auxiliaries, and in women's professional and service organizations; and the small numbers of members of the Free Love groups.[39]Free lovers and some of the suffragists differed in their political understandings but both the groups believed that women should be free of patriarchal oppression. At the same time, there was, among both groups, a fear of the withering away of the family system.[40] Suffragists and Free Lovers both were opposed to contraception based on the argument that they were 'unnatural'. Although Free Lovers were opposed to contraception they believed in free speech which was why Ezra Heywood agreed to publish advertisements of vaginal syringes/ douches. When prosecuted for the same he defended himself stating something which has been echoed by few other Free Lovers too. He said

> Contraception was moral when it was used by women as the only means of defending their only rights, including voluntary motherhood. Although artificial means of preventing conception was not generally patronised by Free Lovers but all women are not lucky enough to have free lovers as partners.[41]

While suffragists called for abstinence, free lovers fought for the acceptance of female sexuality and the right of a woman to say 'no' to her husband.[42] There were many from within the voluntary motherhood movement who supported eugenic and neo-Malthusian arguments. The feminist arguments of having the ability to say 'no' to husbands was combined with the eugenic argument that a woman will be able to give birth to a "superior" infant if she would only procreate with superior men.[43] Both eugenists and neo –Malthusians justified colonial exploitation of "inferior" people, but they also believed that it was unacceptable for wives to refuse to satisfy their husbands' sexual demands. Thus the movement to say no to a husband did not go

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[39]Gordon, Linda.1984. "Voluntary Motherhood: The Beginnings of Feminist Birth Control Ideas in the United States" in Leavitt, Judith Walzer (ed).1984. *Women and Health in America: Historical Readings*, Madison, University of Wisconsin Press. Ch.13.

[40] *ibid*

[41] *ibid.* pp 260.

[42] *ibid*

[43] *ibid*

down well with both these groups.[44]This movement also failed to include working class women fighting for their survival and was thus restricted to the bourgeoisie women, who were predominantly White.[45]In spite of the Comstock Law and the opposition from many men and the Church, contraceptives gained popularity and were publicly spoken about in the twentieth century. Laws that restricted access to contraception resulted in the emergence of a thriving underground black market for contraceptives.[46]

1.2-'Birth Control to Reproductive Rights'- Contraception in the Twentieth Century

1.2.1- Margaret Sanger and Birth Control

In the early twentieth century the demand for birth control outstripped the available supply.[47] The Comstock Law was most vociferously opposed by one of strongest proponents of birth control, Margaret Sanger. The birth control campaign was revived in 1910 with the demand for legal contraception.[48] Margaret Sanger became the torch bearer of this mission and has been described as the messiah of medicalised birth control. She believed that women should have the ability to control her own fertility, albeit within the acceptable limits of patriarchy and marriage.

Her stay in France in 1913 - where she learned about the 'French Pessary' from radicals promoting contraceptive techniques[49] - stimulated her visions of, as Andrea Tone puts it, "of sexual emancipation and political revolution through universal access to birth control".[50] With this mission in mind she returned to USA in 1914

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[44] Davis,Angela.1981.*op cit*

[45] *ibid*

[46] Tone, Andrea.2006.*op cit*

[47] Gordon, Linda.1986. "Who Is Frightened of Reproductive Freedom for Women and Why? Some Historical Answers"; *A Journal of Women Studies*, 9(1): 22-26

[48] *ibid*

[49] Tone, Andrea. "A Medical Fit for Contraceptives" in Wyer, Mary.et.al. (eds).2008.*Women, Science and Technology: A Reader in Feminist Science Studies*, New York, Routledge.

[50] *ibid*.p.no.167

publishing the journal *The Women Rebel* demanding legal contraception and women's rights.[51] The term 'Birth Control' was coined by her in one of the early issues of this journal. The information that she sent through mail was banned by the postal department. This led her to publicly distribute the descriptive pamphlet *Family Limitation* that got her into trouble with the law. She escaped to England and then Holland where she continued to study about contraception.[52] It was in Holland that she met Dr.Alleta Jacob and Dr.Johannes Rutgers whose efforts had helped establish the world's first contraceptive clinic in 1882. They were also instrumental in setting up a national system for contraception[53] promoting the Mensinga diaphragm that needed clinical expertise to fit. For many years Holland remained the only country where birth control clinics were officially allowed.[54] Learning about the 'Dutch system', Sanger was convinced of the physician's role in contraception.[55] She opened the first birth control clinic at Brooklyn in USA, in 1916, where she and her sister Ethel trained eight women at a time to utilize over-the-counter contraceptives. These comprised of condoms, suppositories and rubber pessaries. Her clinic was raided and she was arrested, generating a huge debate and protest which culminated in the Crane decision of 1918. This decision, named after the authoring judge, Frederick Crane, ruled that contraceptives could be used for medical purposes and that birth control information could be given out to any married person to protect his or her health. This entailed that clinics could operate freely if they were under the supervision of medical personnel.[56] The medicalisation of contraceptives and the dominance of physicians in the field of contraception had its roots in the nineteenth century, but this increased in the twentieth century, changing the course of the birth control movement forever. The Crane decision gave condoms legal and medical acceptability and resulted in the sudden growth of sales of condoms.[57] Simultaneously, in the UK, Marie Stopes, another crusader for birth control, opened her birth control clinic in 1920. This clinic,

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[51] *ibid*

[52] Tone, Andrea.2008.*op cit*

[53] Greer,Germaine.1984.*op cit*

[54] *ibid*

[55] *ibid*

[56] Tone, Andrea.2008.*op cit*

[57] *ibid*

named the Mothers Clinic for Constructive Birth Control, promoted the contraceptive, the Check pessary whose popularity decreased with the advent of the diaphragm.[58] The weakening of the rules against contraceptives was also the result of the First World War wherein the USA's 'Just Say No' policy had become a medical catastrophe with her soldiers being increasingly diagnosed with syphilis.

1.2.2- Birth Control across the Shores: Growing Influence of Neo-Malthusians and Eugenists

Two other reasons for the growth of the birth control movement were the increasing acceptance of eugenics as a 'science' and the increasing popularity of the ideas of neo- Malthusians. According to Davis, the reason was that both neo- Malthusians and eugenists were ideologies that justified colonial exploitation of the resources of the world, and indeed the abuse of black workers in the US South and the immigrant workers of North and West.[59]

The social history of birth control in the early twentieth century reveals the role of eugenics in both the USA and UK in securing the acceptance of family planning as a method of improving the "race".[60] The propagators of the 'voluntary motherhood' movement had used 'motherhood' as method of emancipation of women. This freedom, they believed, would in turn result in bringing about a eugenic effect in the population.[61] The growing neo-Malthusian ideas were combined with eugenic perspectives to create an argument that lower population numbers could be achieved along with ensuring the 'quality of the race'. This alliance was built as a result of the "alarming" decline of birth rate amongst the most prosperous and educated middle classes.[62] With increasing birth rates of the working class, Blacks, and the poor and coloured across the seas, the world's population seemed out of control. With famines in India and China, increased migration across the Atlantic gave rise to an 'alarmist' view in the USA and in Europe and indeed among the elites of the developing

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[58] Greer, Germaine.1984.*op cit*

[59] Davis,Angela.1981.*op cit*

[60] Soloway, Richard Allen.1978. "Neo-Malthusians, Eugenists, and the Declining Birth-Rate in England, 1900-1918"; *Albion: A Quarterly Journal Concerned with British Studies*, 10(3). pp. 264-286

[61] Gordon, Linda.2007.*op cit*

[62] Soloway, Richard Allen.1978. *op cit*

countries.[63] This led to the establishment of Neo-Malthusian Leagues and Eugenic Societies in the nineteenth century. These attracted the educated middle classes. These institutions had the financial support of capitalists such as Kellogg, Rockefeller, Harriman, Ford and Gamble.[64,65]

It were members of the Neo-Malthusian League, Dr.Charles Bradlaugh and Annie Besant who distributed nearly 133,000 copies of Charles Knowlton's pamphlet *Fruits of Philosophy* pamphlets in the summer of 1877 and also arrested for it.[66] This pamphlet, with detailed description of sexual anatomy and contraceptive techniques, became very popular. As a result there was a great deal of publicity surrounding the trial. In their defence, both Bradlaugh and Besant pointed out to the need for technology that should be available to help control fertility. They argued that it would be a crime against society to bring children into this world if they could not be provided for. Referring to the Malthusian argument of the doubling of population and pointing to a future laden with wars and crisis over diminishing resources, they painted a picture of poverty and starvation stalking the world. Utilising the examples of the famines in India and China, Besant insisted that they were "caused entirely by over-population".[67]They were both sentenced to imprisonment but were soon released on legal technicality. Their views soon became extremely popular with Besant's The *Law of Population* selling thousands of copies all over the world.[68]

The late nineteenth century also saw the development of an intense statistical database of births and deaths in many countries. There were regular publications brought out by neo-Malthusians like Charles Drysdale, the first president of the Malthusian League.[69] There was a large amount of funding available for the neo-Malthusian Leagues and Eugenic Societies, from their rich donors. They endorsed the sterilisation

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[63] Connelly, Matthew James.2008. *Fatal Misconception: The Struggle to Control World Population*, USA, Harvard University Press.

[64] Davis,Angela.1981.*op cit*

[65] Funding the Eugenics Movement- Available on http://www.eugenics-watch.com/roots/chap12.html- as accessed on 9th June, 2010.

[66] Greer,Germaine.1984.*op cit*

[67] Connelly, MatthewJames.2008. *op cit.* pp. 19

[68] *ibid*

[69] Soloway, Richard Allen.1978.*op cit*

of the criminals, the insane, feebleminded, the tubercular, syphilitic, alcoholic and any disease that was considered heritable at that point time.[70] Margaret Sanger and Marie Stopes also received large amount of funds and support from these groups for their clinics, although it was difficult to convince the eugenists to be part of the birth control endeavour.[71] Margaret Sanger was greatly influenced by the eugenists and by neo-Malthusian philosophy and as Angela Franks puts it, "easily went on to becoming one of the most influential of the eugenicists, promoting a vision of eugenic liberation that has had a greater reach than that of the more staid and scientific American Eugenics Society."[72]In 1921, Sanger established the American Birth Control League (ABCL), where, of the fifty members listed on the National Council of Sanger's, at least twenty three of them held prominent positions within the American Eugenics Society (AES) or who publically supported her eugenic ideas. Her eugenic ideas were often popularised through her writings. An example of this is in her book *The Pivot of Civilisation* of 1922 in which she writes "it is the importance of a qualitative factor as opposed to a quantitative one in population matters."[73]

Sterilisation abuses and forced abortion of Blacks and Puerto Rican women had become rampant because of the growing visibility of eugenics who acquired legal sanction after the Bell vs. Buck case of 1926. In this case, the judiciary declared that the state had the right to sterilise women for being 'feebleminded' and 'lazy' as it was deemed necessary for the creation of a 'perfect society'. This put authority into the hands of the powerful to control the fertility of the marginalised. This ideology which was embedded with rhetoric of "improving human race" divided race into the 'Blacks' and 'Whites' while ascertaining White supremacy.

1.2.3 -Race Suicide

Another controversy in the early decades of the twentieth century was of the idea of 'race suicide'. This led to increased sterilisations and forced abortions of Blacks and of other marginalised communities. This controversy which lasted from about 1905 to

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[70] *ibid*

[71] Connelly, Matthew James.2008.*op cit*

[72] Franks, Angela.2005.*Margaret Sanger's Eugenic Legacy: The Control of Female Fertility*. North Carolina, McFarland & Co, Jefferson.pp.32.

[73]*ibid*.pp.22

1910 gained prominence after President of the United States, Theodore Roosevelt in 1905 expressed fear of a declining White population proclaiming that the "race purity should be maintained" and openly condemning wilful sterility.[74] This was during a time when hatred of the Blacks and their lynching were common.[75] This campaign against race suicide greatly influenced birth control movement in many ways. Birth control use by the "superior race", the Whites came to be considered as a sin against the nation. There was increasing objection to family limitation arguing that the nation needed a steady population of stable families. There was a belief that decreased White population will increase the population of immigrants, non whites and poor.[76] The controversy over race suicide also brought to the forefront the gap between the middle class feminists and the working class and the poor, as feminists fought for birth control viewing it as way to attain careers and higher education. These facilities were out of reach of the poor with or without birth control; thus feminism came to be identified with the privileged women of the society. Within the suffragist movement, an 'alarmist' fear of race suicide led to the belief that Blacks, immigrants and poor in general had a moral obligation to restrict the size of their families. It would otherwise put a strain on taxes and charity expenditure of the wealthy. Thus, there entered racism and class-bias within the feminist movement.[77]

The growing influence of the theory of race suicide and the eugenicists medically supervised birth control clinics, affiliated with Sanger's parent organization, the ABCL, resulted in the decrease of birth control facilities to the poor and Blacks.[78] These clinics were also responsible for facilitating the domestic manufacture of diaphragms and spermicidal jellies. In all this Sanger was supported by her second husband J.Noah.H Slee president of the Three-In-One Oil Company.[79]

Simultaneously, there was the imbibing of the Malthusian beliefs in then colonised countries. For example in India there was the growth of the Madras Neo-Malthusian

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[74] Davis,Angela.1981.*op cit*

[75] *ibid*

[76] Gordon, Linda.2007.*op cit*

[77] *ibid*

[78] Tone, Andrea.2008.*op cit*

[79] Tone, Andrea.1996. " Contraceptive Consumers: Gender and the Political Economy of Birth Control in the 1930s";*Journal of Social History*,29(3):485-506

League which deployed arguments of their western counterparts against the lower caste population believing that an increase in their population could lead to catastrophe. The Malthusian argument was convenient as it placed the Hindu Brahminical male at the apex.[80]

1.2.4-Pharmaceutical Industry and Birth Control

In 1925, at the insistence of Sanger her husband Slee invested in the Holland-Rantos company which manufactured contraceptives for women such as spring-type diaphragms and lactic acid jelly. In her clinic, Sanger was finding it difficult – and expensive – to rely on smuggled female contraceptive devices.[81]Also, there were not many entrepreneurs interested in the manufacturing female contraceptives.[82] This company earned huge profits after the birth control boom of the 1930s because of the increasing demand for the contraceptives. The decade of the thirties was also the period of the Depression where contraceptives were in demand to limit fertility. Initially, it was an underground black market but post the Supreme Court's decision in the Young Rubber Corporation, Inc.v.C.I.Lee, in 1930 where the court ruled that as long as birth control was advertised for other purposes than contraception it was legal, a flood of interested entrepreneurs came to invest in the female contraceptive market.[83] The Depression was used as an opportunity by the pharmaceutical company to encourage young couples to forego natural methods of contraception and accept the more 'scientific' and 'reliable' methods of contraception.[84] Thus, contraceptive became the most lucrative business with female contraceptive devices earning huge profits as compared to male contraceptives. For the first time, women were to be the biggest consumers of products.[85] The boom in contraceptive market in the 1930s was also because of the resolution passed by the Anglican Church in favour of birth control and other Protestant denominations also relaxed their prohibitions. On the

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[80] S. Anandhi.2006.Indigenous Malthusian: Birth Control Debates in Early Twentieth Century: http://www.cwpe.org/node/46: As accessed by 10th June,2010

[81] Tone,Andrea.1996.*op cit*

[82] Tone, Andrea.2006.*op cit*

[83] Tone,Andrea.1996.*op cit*

[84] *ibid*

[85] *ibid*

other hand, the Roman Catholic Church officially banned any "artificial" means of birth control condoms, diaphragms and cervical caps, douches, suppositories and spermicide, fearing the unregulated growth of sexual activities and immorality.[86] But the decision of the Catholic Church did not deter women from using contraceptives. It also did not decrease the sales of the contraceptives. Just twelve years after the first company to launch female contraceptive entered the market, around four hundred firms were competing in the market for the huge profits that were to be had from this business. This growing business was correlated with the increase in medicalisation of the contraceptive with birth control clinics and physicians constantly promoting the diaphragm. In 1936, through Margaret Sanger's efforts, the Comstock Laws came to U.S. Circuit Court of Appeals decision. In this case, the United States v. One Package judgement, the Court ruled that doctors could distribute contraceptives across state lines. This increased the influence of the physician in promoting contraceptives. It was now possible to mail birth control devices and information throughout the country legally, paving the way for the legitimization of birth control by the medical industry and the general public. This allowed intensive promotion of contraceptives throughout the country.[87] Contraceptive practices of the 1930s were shaped through aggressive and continuous marketing, advertisements of 'female hygiene' products, and direct- to- home marketing which was successful in increasing their visibility. Andrea Tone states, "commercialization that manufacturers engendered at this time left an indelible imprint on the lives of ordinary women and men. It also revealed a world in which industry, gender, and reproduction were frequently and intimately intertwined."[88]

1.2.5- Black Genocide and Race Purification

While the contraceptives were becoming popular it was not becoming as accessible to all. Considering that the contraceptive was a 'private matter' medical insurance coverage was not provided in the 1930s because of which women from less privileged

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[86]The Catholic Church- As Available on- http://www.pbs.org/wgbh/amex/pill/peopleevents/e_church.html- As Accessed on 5th June 2010

[87] Anthony Comstock's "Chastity" laws- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_comstock.html- As Accessed on 5th June,2010

[88] Tone, Andrea.1996.*op cit.* pp.501

and marginalised communities did not have access to these contraceptives. Sterilisation and abortion remained an option that was largely promoted by the eugenic societies of those times. In other parts of the world too, eugenic policies were gaining prominence; sterilisation laws were passed in many parts of the Europe like Denmark, Norway, Sweden, Finland and Sweden without any protest. Eugenic experiments were being conducted in Mexico, Argentina, Brazil and France.[89] The prevailing Malthusian fear was aggravated in countries like India, China, Egypt North Africa, Philippines and Korea where activists from the First World promoted their views. This fear was also increased by birth control activist from America and Europe to Asian and African countries to set up institutions and information booths regarding contraception.[90] India became a launching pad from where the overpopulation argument would become a priority and influence many population policies all over the developing world.[91]

Margaret Sanger's Birth Control Federation of America (BCFA), in 1939 initiated their racist 'Negro Project' with the help of millionaire and industrialist Clarence Gamble. The movement planned to win Black cooperation by placing Blacks in highly visible positions.[92] Black influential leaders protested against the Negro Project and called it 'Black Genocide.' Even Black feminists who were propagating the use of contraceptive as vital to the emancipation of women were labelled as supporters of Black genocide.[93]Stringent immigration laws were passed in many countries.[94]The decade of the thirties also saw the emergence of the Nazi power under the authority of Adolf Hitler. Hitler's final solution for 'race purification' reached the extremes killing about six million Jews, and anybody who was considered 'unfit' by the Nazi regime. This included the gypsies, homosexuals, mentally challenged people, and patients with tuberculosis and leprosy. The Holocaust sends shock waves across the world.

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[89] Connelly, MatthewJames.2008.*op cit*

[90] *ibid*

[91] *ibid*

[92] Gordon, Linda.2007.*op cit*

[93] Davis, Angela.1981.*op cit*

[94] *ibid*

The World War II and defeat of Hitler tainted the image of the eugenic movement and the birth control movement which got associated with it.

1.2.6- Planned Parenthood: Institutionalising Birth Control

There had to be a revival from the setback for eugenics as well as the birth control movement as funds had started dwindling. An attempt for revival was made when these two groups came together at the annual meeting of the BCFA in 1940 for a symposium titled the "Race Building in a Democracy". The union of the groups resulted in the formation of Planned Parenthood, as birth control did not remain a politically appropriate word. Sanger was not happy with name as but accepted it after understanding its implications. In 1942, the organisation was christened the Planned Parenthood Federation of America (PPFA).[95] During the same time period the focus of the population debate shifted from quality to include wider environmental factors, with subjects like nutrition and disease replacing debates about negative eugenics. The focus to environmental factors led to the belief that problems of "feeblemindedness" or the "lazy native" could be solved or caused by environmental factors. The focus also shifted from forced to voluntary sterilisation; and birth control clinics became family planning centres.[96] Although the semantics had changed the basic ideology of retaining 'good stock' from among the human population, by preventing the poor from having more children, remained intact.[97] The responsibility of improving the image of the birth control through the concept of family planning fell upon the millionaire Frederick Osborn who was influential within the USA. He promoted the idea of the scientific study of population through organisations such as the Milbank Memorial Fund and Princeton University which became prominent later in policy oriented demographic studies.[98] There were efforts also made to acquire government funding and to establish contacts within the medical and social welfare

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[95] Mike Perry,The History of Planned Parenthood Available on http://www.ewtn.com/library/prolife/pphistry.txt - As accessed on 15th April,2010

[96] Davis, Angela.1981.*op cit*

[97] *ibid*

[98] Connelly, MatthewJames.2008.*op cit*

systems with the belief that this will help to reach out to a larger population.[99] Although eugenics had revamped their strategy, they continued to oppose the immigrants from Mexico and support the decline of Afro- Americans, ascertaining that their entire strategy still remained to "manipulate a large segment of society they considered unfit for parenthood".[100] There were attacks on Blacks and Hispanics in developed countries in 1945, after statements that their growing population posed a danger for the society. President Roosevelt's call for sterilisation as a solution to the problem of Black poverty was supported by the capitalist class and the media now increasingly powerful.[101]

1.2.7- Birth Of the 'Third World"

After the Second World War all the focus shifted to the newly free colonies which emerged as the 'Third World' (a Cold War term). Colonialism had led to the massive transfer of resources resulting in famines and starvation in the Third World countries.[102] The late nineteenth century and early twentieth century saw severe famines in the colonised countries which were attributed to the Malthusian argument of "too many to sustain". The exploitation of resources, unfair taxation policies, unfair famine policies were all legitimised on the basis of Malthusian arguments. This argument has been conveniently put forward by the colonisers to defend the growing system of private property and the drain of Third World resources.[103] Above all, the issue of structural inequalities leading to under-development were not addressed when the Malthusian argument loomed.[104]

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[99] Davis,Angela.1981.*op cit*

[100] Connelly, MatthewJames.2008.*op cit,* pp 107

[101] Davis,Angela.1981.*op cit*

[102] The Corner House: Briefing 27.2002. The Origins of the Third World: Markets, States and Climate Markets, Available http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/27origins.pdf: As accessed on 15th June,2010

[103] Sexton, Sarah and Nicholas Hildyard.2005. "Managing Resources, Managing People: The Political Uses of Population" – Available on http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/Surrey.pdf- As accessed on 15th June,2010

[104] *ibid*

After the end of World War II, the newly formed nations set out on their way to industrialisation following the Soviet model. There was a fear of shifting of power balance when the US's ally in the war became a Cold War competitor.[105] The importance of the Third World as a source of raw material was known to the First World countries and the fear that these countries will follow the communist model created paranoia among these nations.[106] Many policy-oriented demographers like Kingsley Davis tried to convince the US government to aid population policies within the newly formed nations fearing that population growth and poverty would lead to communism. There were huge investments made in the field of demography as an academic discipline based on such policies. Funding for these demographic studies emanated from US corporate capital such as the Rockefeller Foundation, the Ford Foundation and the Hugh Moore Fund[107]. The product of this investment was the overturning of the "demographic transition theory" that was essential to the "modernisation" process.[108] This theory held population as the dependent variable and socio-economic factors as the independent variable; population thus depended upon socio-economic environment. In the new Cold War period, this was done away with; population was seen as the independent variable, an obstacle to development.[109] This established axiomatically that the newly formed countries whose birth rates had not started declining had a huge population problem looming over them that hindered economic growth.[110]

In 1952, John D. Rockefeller who was an ardent supporter of the eugenic movement established the Population Council for research on population control. Many other organisations followed suit providing aid and support for the fellowships, scholarships and research funds to students from the Third World to study the 'population problem' of their countries, establishing that overpopulation was the most acute crisis

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[105] Rao, Mohan.2004.*From Population Control to Reproductive Health- Malthusian Arithmetic*, New Delhi, Sage Publications.

[106] *ibid*

[107] *ibid*

[108] Connelly, Matthew James.2008.*op cit.* pp 117

[109] Rao,Mohan.2004.*op cit*

[110] *ibid*

of the twentieth century.[111] It was not only the First World countries who feared the growing population of Third World, but it was also the elites within the southern countries who feared the growth of the millions of poor who will 'eat up' the resources of their country.[112]

India which had always been the forefront of the family planning programme was the first country to start a government run family planning programme in 1952. It was already influenced by the advocacy by Margaret Sanger. She had gained supporters for her theory of population among Indian elites and the national movement leadership, although the support of Gandhi eluded her.[113] The 'Third International Conference on Planned Parenthood' that was held in Bombay in1952, had birth control advocates from world over including Margaret Sanger, Elise Ottesen-Jensen and Dhanvanthi Rama Rau.[114] It was in this meeting that International Planned Parenthood Foundation (IPPF) was formed. Since then IPPF has spearheaded population control programmes in many countries.[115] Overpopulation resulting in environmental degradation was the premise on which population control in the Third World was propagated by the neo-Malthusians.[116] Birth Control through the use of contraceptive technology and sterilisation was seen as a solution to this problem and government family planning policies as the means to achieve this. Over the decades Third World women have been subjected to coercive population policies, as the Third World became a dumping ground for contraceptives and unethical clinical trials.[117]

1.2.8- The "Magic Pill" and Birth of the Contraceptive Generation

By the 1940s the importance of estrogen and progesterone in the female reproductive cycle was identified by scientists. Initially, experiments were conducted using these hormones with the hope that it would be used for therapeutic purposes. Great

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[111] *ibid*

[112] Connelly, MatthewJames.2008.

[113] *ibid*

[114] History of the International Planned Parenthood Federation: Available on http://www.ippf.org/en/About/History.htm- As accessed on 16th June,2010

[115] *ibid*

[116] Connelly, Matthew James.2008.*op cit*

[117] *ibid*

discoveries in medicine and science were made during this period, technology and antibiotics came to be regarded as the means through which all problems would be resolved.[118] In 1943, the scientist Russell Marker made the path- breaking discovery which came to be known as 'Marker degradation' where he was able to extract progesterone and create estrogen from vegetation. His work was taken further by Frank Colton and Carl Djerassi who were working for two different pharmaceutical companies Searle and Syntex respectively. They created two different versions of effective synthetic progesterone and the Birth Control Pill was born. Both Colton and Djerassi were unaware of the momentous discovery they had made.[119] It was Georgery Pincus who had been working for a convenient contraceptive since 1945, and was experimenting with progesterone at the Worcester Foundation for Experimental Biology, who made the connection between their discovery and the Pill. He had successfully experimented with suppressing ovulation in rabbits in 1939 and stepped up his work in 1953. This was after he received an invitation from PPFA to develop an 'ideal' contraceptive, after he had spoken of his interest to Margaret Sanger. In 1950s, Pincus approached the pharmaceutical company G.D.Searle for funding to develop the oral contraceptive. Searle initially refused him financial support because of the fear of getting involved with a product that was legally and religiously under scrutiny.[120] They agreed to give samples of the synthetic progesterone developed by Colton for his research work. It was Margaret Sanger who personally took interest in the development of the pill and found a patroness in Mrs. Katharine Dexter McCormick for his research.[121] It was Mrs. McCormick who provided the entire funding for the research. The most difficult was conducting human trials for his research of oral contraceptive and to obtain the approval of the FDA. For the trial he needed the support of a clinical physician and this he found in Dr. John Rock, the Catholic professor at Harvard for Obstetrics and Gynaecologist who was trying out the hormone progesterone to treat infertility in his clinic at Brookline, Massachusetts. The trials for the oral contraceptive were conducted under the guise of

[118] The Development of Synthetic Hormones- As Available on- http://www.pbs.org/wgbh/amex/pill/peopleevents/e_hormones.html- As accessed on 5th June,2010

[119] *ibid*

[120] G.D. Searle Develops the Pill-As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_searle.html- As Accessed on 5th June, 2010

[121] Greer, Germaine.1984.*op cit*

fertility research to escape the stringent laws of the Massachusetts anti-birth control law. It was observed that these contraceptives did not cause permanent sterility after continuous 20 day regime.[122] They next required a place for more large scale research .In 1955 Pincus selected Puerto Rica, because of the presence of vast number of poor women subjects. Further, officials in Puerto Rico officials there were supported birth control clinics. This was a perfect place as Pincus could demonstrate that this contraceptive was not 'complex' and could be used by women in developing nations and American inner cities.[123] The pill Enovid - G.D. Searle's brand name for their pill- was provided for this trial. By 1956 they were aware of negative effects of the large doses in which the pill was been administered but that did not stop the trials. Like other eugenists supporting the development of contraceptives, Pincus too believed that something had to be done as the "poor were multiplying too fast".[124]Although side effects such as bloating, nausea, dizziness, headaches, stomach pain and vomiting were reported, they were disregarded. Instead it was stated the complaints of women were psychosomatic in origin. The side effects were reported as 'minor'. In 1959, G.D.Searle applied to the FDA for license for their drug Enovid to be used as oral contraceptive.[125] The "magic pill" was on its way to be a success.

Pincus and Rock were confident that the FDA would soon pass the application but a number of months went by with no response. The biggest hurdle for the approval was that this would be the first drug that healthy women would be taking on a daily basis. Finally in 1960, oral contraceptive was officially approved by the FDA for short term use of no more than two years as the FDA was still not aware of its long term safety effects.[126] After the approval of the pill in 1960, the sales for it surged upward because of the convenience and 'freedom' that it offered women. Two years after Enovid was introduced around 1.2 million American used the pill; in 1965 this

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[122] The Boston Pill Trials- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_boston.html- As Accessed on 5th June 2010

[123] The Puerto Rico Pill Trials- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_puertorico.html- As Accessed on 5th June 2010

[124] Greer, Germaine.1984.*op cit.* 140

[125] The U.S. Food and Drug Administration Approves the Pill- As available on- http://www.pbs.org/wgbh/amex/pill/peopleevents/e_fda.html - As Accessed on 5th June 2010

[126] *ibid*

increased to 5 million and in 1973, about 10 million were using the pill.[127] It was initially prescribed to married women and by 1967 the use of the pill by married women had reached its peak. By the late 60s the pill was been offered to single women and 1972 after the age of majority got lowered it was the most commonly used drug.[128]

The 'wonder drug' which could prevent conception was extensively used although there was some religious opposition to its use. Many Catholics had hoped that the Vatican would approve the drug as Dr.John had argued that it was just an extension of the body's normal functioning as it did not destroy the sperm and comprised hormones already present in the female reproductive system. Hence, it came as disappointment to all when in 1968 eight years after the pill was approved, the Vatican in a press conference declared that the pill was an artificial method of conception and use of it would be considered a 'mortal sin'. [129] But women were not ready to let go the product that offered them an opportunity to freely engage in sexual activity without the fear of getting pregnant. The consequence the free access to the pill was that women were now able to the take up careers and study further and delay the age of marriage.[130]This access to the pill bought in the sexual revolution among the Americans who were protesting against the war in Vietnam and experimenting with their sexuality. [131]

The trials on the basis of which the pill was introduced into the market were condemned later for their ethical violations. Although at the time of the study the scientific research on humans was a little less regulated, many of the standards used in the study were ethically unacceptable even by the standards of the time. This included

[127] Oral Contraceptives: Available on http://pubs.acs.org/cen/coverstory/83/8325/8325oralcontraceptives.html-As Accessed on 21st June, 2010.

[128] Goldin, Claudia and Lawrence F. Katz.2002. "The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions"; *Journal of Political Economy*,110(4).

[129] The Pope Issues *Humanae Vitae* ("Of Human Life")- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_humvit.html -As Accessed on 5th June 2010

[130] Oral Contraceptives. *op cit*

[131] The Pill and the Sexual Revolution- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_revolution.html- As Accessed on 5th June 2010

enrolling women without explaining to them the purpose of the study and not reporting the side effects experienced by women. Many unethical trials conducted during the same time, such as Thalidomide disaster, were responsible for passing of the Kefauver-Harris Drug Amendment in 1962, which mandated stricter control on drug testing, marketing and advertising of drugs. Informed consent from patients became a prerequisite to conduct any trial.[132] At the international level there were ethical reconsiderations, especially post Second World War after the atrocities done on human beings in the name of experiments during the Nazi regime came to light. This completely changed the standards of how research was conducted within the developed countries; much clinical research then shifted to developing countries which did not have such stringent laws.

1.2.9- Emergence of the "New Eugenics"

The decades of the fifties and sixties saw the resurgence of the eugenic movement after the discovery of the 'double helix' in DNA in 1953. They did not promote contraception or sterilisation in the name of eugenics but under another name, namely of population control. They believed that it would be easier to influence public opinion by promoting the fear of uncontrolled population growth rather than eugenic ideas of 'good stock'.[133] Many international eugenic organisations came into existence during these decades to promote eugenic concept of population control. Germaine Greer has argued on this shift of eugenics effortlessly into the population establishment as

> -----It now seems strange that men who had been conspicuous in the eugenics movement were able to move quite painlessly into the population establishment at the highest level, but if we reflect that the paymasters were the same -- Ford, Mellon, Du Pont, Standard Oil, Rockefeller and Shell -- are still the same, we can only assume that people like Kingsley Davis, Frank W. Notestein, C. C. Little, E. A. Ross, the Osborn's Frederick and Fairfield, Philip M. Hauser, Alan Guttmacher and Sheldon Segal were being rewarded for past services. In other words, the population control movement was the same as the old eugenics movement -- the same money, the same leaders, the same activities -- but with a new excuse.[134]

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[132] The Pill and Informed Consent- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_informed.html- As Accessed on 5th June 2010

[133] Franks, Angela.2005.*op cit*

[134] Greer, Germaine.1984.*op cit.* 319

In 1960 a large number of doctors and scientist were part of the American Eugenic Society (AES) headed by Frederick Osborn. This society strongly supported by John D. Rockefeller and Osborn was greatly involved in the work of Population Council. The name of the AES was changed to Society for the Study of Social Biology (SSSB) in 1973.[135] In Britain, C.P. Blacker who had been the member of Eugenic Society and was the administrative chairman IPPF in 1960, pushed for the need for further eugenic studies by associating themselves with FPA and IPPF and collaborating with SSSB in relevant programmes.[136] Both IPPF and Population Council have engaged in million-dollar ad campaigns to influence public opinion and propagandise contraception in developing countries by hiring famous personalities such as musicians and actors.[137]

By 1969 the rise of "new eugenics" took place. They supported increase scientific sophistication in genetics and breakthrough in genetic engineering, through advancements in DNA technology and later, were responsible for initiating the Human Genome Project.[138] They believed they could provide technological "solutions" to problems such as poverty, disability and disease by selectively eliminating the "unfit".[139] The eugenicist promoted sterilisation of the 'unfit', their focus shifted to promotion of genetic counselling and furthered the growth of academic genetics and demography.[140] The "new eugenics" claimed to be different from the "old eugenics" from the Nazi regime but as Angela Frank argues there is "no difference in the ideology of the old or new eugenics."[141] She states that "eugenics is an ideology of control that views the human individual more as a locus of genetic potential and peril than as a person worthy of respect. The threat posed by eugenics to the human rights of supposedly genetically problematic persons is just as real now as before. Ethical deficiency is inherent in this ideology".[142]

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[135] Franks, Angela.2005.*op cit*

[136] Eugenics after World War II-As Available on http://www.eugenics-watch.com/roots/chap10.html-As accessed on 20th June,2010

[137] Franks, Angela.2005.*op cit*

[138] *ibid*

[139] *ibid*

[140] *ibid* .pp.87

[141] *ibid.*

[142] *ibid*

1.2.10- The 'Second Wave' of Feminism and the 'Contraceptive Revolution'

The feminist movement was revamped in the 1960s when the movement for "rights" with the second wave of feminism. Reproduction controversies became central to the feminist movement as it represented the unequal nature of the society where women had no access to any legal, economic and social right.[143] As Linda Gordon states "the call for women's control of their reproduction was signalled by the slogan 'control over our bodies' identifying patriarchy as the basis of the women's reproductive control". This movement challenged traditional gender roles of 'motherhood' and condemned control with the rhetoric of morality. They identified right to abortion and contraception as means to be free from these traditional roles along with legal right and economic right as other demands and the right to self- determination. Right to body through the right to abortion was a demand at the forefront of the feminist movement in the West.[144] .The Supreme Court's decision on Roe vs. Wade legalizing abortion in 1973 marked the victory of the struggles of feminists for their fight to control their own bodies and to make their own decisions. This judgement was delivered under the pressure of feminist organizing, marches, protests, and pickelines, through chants and slogans such as "Keep Your Laws Off My Body" "Abortion Is a Woman' s Choice" "Not the Church, Not the State: Women Shall Decide Our Fate".[145] The semantics of 'rights' and freedom were widespread among the feminist movement. Conservatives strongly opposed the growing influence of the feminist movement as they believed that abortion and access to contraception would lead to subversion of tradition, family, morality and the word of God. This conservatism deeply influenced by the fundamentalist Christianity focussed on the social and sexual issues of abortion and contraception and gained prominence in the larger political agenda. This also gave rise to the Right to Life movement initiated by the Church which has greatly influenced the availability of the contraception and abortion services within the US and also at the international fora. [146]

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[143] Gordan, Linda.2007. *op cit*

[144] A Socialist Feminist Agenda From Abortion Right to Reproductive Justice-Available on www.sistersong.net/publications_and_articles-As accessed on 2nd February,2010

[145] *ibid*

[146] Gordan, Linda.2007.*op cit*

This women's liberation movement, struggling to have control over their bodies, was composed largely of the White women, failed to address the issues of women of Colour. Women of Colour questioned the 'rights' that were being demanded by the liberation movement; they argued that control over one's body or choice cannot be looked in isolation and the liberation movement fails to the question the social condition within which these demands were made. Abortion or access to birth control had always been available to women of Colour, not as a right but with eugenic and Malthusian motives. Thus 'choice' as a concept for women of colour was mere disingenuous lip service. There was resistance to the coercion that had been masqueraded as "choice" and this can be summarised by quoting from an editorial from 1973, which was a cautionary note by the National Council of Negro Women while supporting the Roe vs. Wade case

> .....the key words are "if she chooses". Bitter experience has taught the Black women that the administration of justice in this country is not colour-blind. Black women on welfare have been forced to accept sterilisation in exchange for continuous of relief benefits and others have been sterilised without their knowledge or consent[147]

Angela Davis states that "the absence of women of Colour from the women liberation movement was present in the ideological underpinnings of the birth control movement itself." [148]The federal birth control programme that developed in the late 60s, expanded under the Johnson administration was condemned by Black Nationalists as genocide under the garb of poverty alleviation as not within the interest of the people of colour.[149] Black feminist agreed that sterilsation and abortion are forms of abuse if forcefully performed but they had disagreements with the Black Nationalist who claimed that it was black genocide. These women stated that birth control and abortion were vital for the emancipation of women and should be available as a 'right'.[150]

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[147] Silliman, Jael.et.al.2004.*Undivided Rights: Women of Color Organize for Reproductive Justice*, South End Press,Cambridge,Massachusetts.pp.5

[148] Davis,Angela.1981.*op cit*

[149] Nelson, Jenifer.2003. *Women of Color and Reproductive Rights Movement*, United States of America, New York University Press.

[150] Davis,Angela.1981.*op cit*

On one side the women of Colour were being excluded from the women liberation movement and on the other hand the pill or sterilisation and provision of intrauterine device (IUD) as a method of family planning was being vigorously promoted in countries such as India, Pakistan and Sri Lanka. In countries like India allocation to family planning initiatives in their five year plans were increasing and the overall health expenditure was decreasing. Family planning programmes were greatly influenced by the international organisations such as the IPPF while promoting these methods.[151]

1.2.11- Intrauterine Device

During the late sixties and early seventies the long term side effects of the pill were becoming apparent. These side effects were not related to the reproductive system and hence, initially, it became difficult to associate them with the pill. Once the association was established there were protests and Congressional hearing regarding the side effects of the pill.[152] The pharmaceutical company and developers of the pill were condemned for falsely projecting the pill as completely safe and undermining its side effects and promoting it as a method to control population explosion. Planned Parenthood was continuously campaigning to promote the pill as an entirely safe method of reversible contraception and most of the literature supporting the pill was generated from the camp of the population establishment.[153]After the side effects of the pill were known many of the women who were among the first generation users of the pill switched over to the IUD. [154]

Modern IUDs were the invention of 1920s but infections and injuries associated with IUDs resulted in their unpopularity. The 'population explosion' fear that was being propagated and the development of antibiotics that provided a method of treating

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[151] Rao,Mohan.2004.*op cit*

[152] McCain, John and Washington Women's Liberation. "Testimony on Oral Contraceptives" in Tone, Andrea. 1997. *Controlling Reproduction: An American History*, United States of America. Scholarly Resources Inc.

[153] *ibid*

[154] Madry. Jr, John and Russel.J.Thomsen "Testimony on Intrauterine Devices" in Tone, Andrea. 1997. *Controlling Reproduction: An American History*, United States of America, Scholarly Resources Inc.

uterine infections, created a renewed interest in IUDs in the population control establishment.[155] The Population Council of New York became interested in the method and called the First Conference on the IUD in 1962. Many demonstrations of IUDs and discussions around this contraceptive took place and it was agreed that this physician controlled contraceptive was a useful method of contraception in the developing countries as well as the developed countries. The devices were widely distributed by organisations like Population Council, the Ford Foundation, and the Pathfinder Fund. In 1964 the second conference on IUD was held. The pharmaceutical industry at this time was also supporting contraceptive research and development.[156] There was great interest developed in the IUD and it was being promoted in the family planning programmes of the developing countries.[157,158] It was found that there were many serious side effects associated such as heavy bleeding; ectopic pregnancies or septic abortions and the most frequent long term effect Pelvic Inflammatory Diseases (PID), an infection of the upper tract.[159]The problems associated with IUD came to the forefront after the controversy of the Dalkon Shield designed by Hugh Davis which caused five times more septic pregnancies.[160] Richard Sobol[161] gives an account of papers published by Hugh Davis which misrepresented the effectiveness and safety of the Dalkon Shield and making it attractive to the pharmaceutical enterprise A.H.Robins Company which subsequently owned it. Inspite of receiving evidence of its harmful side effects of Dalkon Shield as early as 1971, the company withheld data and strongly promoted the contraceptive.[162] The sales of IUD had started to decrease in the United States and the manufactures of the company turned their attention towards the markets in the Third World with the USAID

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[155] Sobol, Richard.1991.*Bending the Law: The Story of the Dalkon Shield Bankruptcy*, United States of America, University of Chicago Press.

[156] Committee on Contraceptive Development, National Research Council and Institute.1990. *Developing New Contraceptives: Obstacles and Opportunities*, Washington.D.C, National Academies Press.

[157] Margulies, Lazar.1975. "History of Intrauterine Devices"; *Bulletin of New York Academy of Medicine*,51(5)

[158] Hartmann, Betsy.1995. *Reproductive Rights and Wrongs: The Global Politics of Population Control,* Boston, South End Press.

[159] *ibid*

[160] Sobol, Richard.1991.*op cit*

[161] *ibid*

[162] *ibid*

promoting these contraceptives.[163] Over the years hundreds of women sued Dalkon Shield in the West while in the Southern countries women were inserted with this and other contraceptive such as Lippes Loop without even providing adequate information about the contraceptive.[164] IUD still persists as the contraceptive of choice among various governments in the Third World where the government has failed to invest in the overall health of women exacerbating the consequences of the IUD such as reproductive tract infections and PID.[165]

1.2.12- Bucharest Conference, Funding for Contraception and 'Family Planning'

In the late sixties and seventies were the heydays of the population control movement which saw widespread abuse of people's rights. On the other hand many of the organisations such as Ford Foundation, USAID and others within the population establishments were voicing their discontent about the need to go beyond 'family planning' as the term family planning was working against the objective of reducing the population of the poor in the Third World and within the First World.[166] This term 'family planning' stressed the right for parents to have an increased number of children rather restrict the number of which was the main aim of population policy. There was need felt by these international organisations to go beyond family planning which meant going beyond the voluntary to coercive measures.[167]

From 1965 to 1968 the U.S. Congress held a series of hearings on the relationship between population and economic development. The world food shortage problem in the mid-60s was co-related with the population problem. President Johnson in 1967 announced that $5.00 spent on birth control was the same as spending $100 in development and declared a War on Hunger. In the same year Congress, for the first time, specifically earmarked Agency for International Development (AID) money for population control activities. Over the next three years the issue of population and

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[163] *ibid*

[164] *ibid*

[165] *ibid*

[166] Connelly, Matthew James.2008.*op cit*

[167] *ibid*

economic development gained prominence and complete support was concentrated to birth control measure to achieve zero population growth in the developing countries. They also pledged the highest contribution by the nation to UNFPA.[168]But there was a growing discontent among many developing countries those who did not agree with the argument, of decreasing population through population control were going beyond that, questioning the neo-colonial exploitation. [169]

This attitude was visible at the World Population Conference, 1974, held in Bucharest, where there emerged a debate between the supporters of population activities and the proponents of the New International Economic Order (NIEO).[170] The supporters of NIEO questioned the imperialistic nature of the First World countries. They pointed to the continuing into exploitation of resources of their countries by the developed world while aggressively promoting family planning and questioned the dominance of the international organisations such as IPPF and UNFPA on the governments of the developing nations.[171] It is here that Mr. Karan Singh, the Indian Minister of Health and Family Welfare declared that 'development is the best contraceptive'. The developed nations were more focussed on the growing power of the earlier colonised countries and worried about increased redistribution of wealth and reverse 'colonisations' by the immigrant population and lack of accessibility to the markets of the developing nations. It was the Vatican and anti-choice organisations that benefitted from this clash as they put forward their objection to birth control and abortion.[172] This conference bought out the vested US interest and as Mathew Connelly puts it "Bucharest was the Waterloo of the population control movement".[173] Inspite, of the critique by the Southern countries, of the demographic projections of birth rate and its consequences, it did not restrain the Southern countries like India, Bangladesh and Pakistan from expanding internationally funded

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[168] Paddock, William C.1998. "The Emasculation of the Population Movement"; *Population and Environment: A Journal of Interdisciplinary Studies*, 19(5).

[169] Connelly, Matthew James.2008.*op cit*

[170] Singh, Jyoti Shankar.1998. *Creating a New Consensus on Population*, United Kingdom, Earthscan Publications Ltd.

[171] Connelly, Matthew James.2008.*op cit*

[172] *ibid*

[173] *ibid.* pp.316

planning programmes.[174] By the end of the seventies many countries had adopted fertility control measures. The aftermath of 'Emergency' in India where thousands of men were forcefully sterilised through the 'camp approach' bought the sterilisations abuses and contraceptive misuse to the forefront. Many of the international organisations such as Ford Foundation, SIDA and others who had openly supported these population control policies became wary of it. It became necessary to shift the focus to something beyond 'control' so as to have a better image of the work that they were doing.[175] These organisations discovered that placing the concerns of women such as gender equality, empowerment of women and education became the new means to achieve population control. The focus shifted to the use of contraceptives within the family planning programme with the intention of reducing maternal mortality and infant mortality and providing women 'choice' - to control her fertility and decide the spacing between her children.[176]

The mid- seventies was also the period when there was substantial decline in the amount of funding for the programme, partly as a result of the stagflation in the West. International governmental organisation, the USAID who were still focussed on producing "effective birth control" was investing their money into research. By the late seventies, USAID was responsible for seventy percent of the funding for developing new contraceptives in the market. During this time most of the contraceptives experimented with provider controlled contraceptive such as hormonal injectables and implants. Trials for these contraceptives were taking part in the developing countries although the FDA had not approved these contraceptives in the US markets. As Betsy Hartmann puts it "in the contraceptive research business, the Third World has long been an important laboratory for human testing."[177]

These investments were beneficial to the population control establishment as they were interested in maximising their profits by exploiting markets of the Third World. USAID invested 15 million dollars annually on birth control pills and this investment

[174] *ibid*

[175] *ibid*

[176] *ibid*

[177] Hartmann, Betsy.1995. *op cit.*pp 183

was made only in one company, Syntex Corporation, from 1972 to 1979 and AID bought 6.7 million dollars worth of IUD from Finishing Enterprises between the years 1982 to 1984. These population establishments are instrumental in promoting, advertising and researching about these contraceptives.[178] The introduction of injectables such as Depo-Provera and implants like Norplant have been collaborative efforts involving pharmaceutical corporations, international and national organisations, including universities, non profit groups and commercial firms, private organisations, clinical trials organisations and funding agencies.[179] These contraceptive collaborations promote their products through community-based distribution (CBD). This strategy has been used by many internationally funded NGOs since 1970s. This approach has many limitations as CBD programmes isolate fertility regulation services from the broader framework of reproductive health.[180]

After the 'Emergency' in India had tainted the image of population control programmes, the population establishment was hesitant about openly investing in coercive birth control measures. But there was already lot of money invested in population control programmes for these organisations to rethink their strategies and change themselves overnight. By 1980, around two billion dollars had been spent on population control programmes and 490 million dollars in international aid. [181] During this period there was an attempt to construct a stronger association between neo-Malthusians and the liberal feminists. In 1980 the National Women's Health Coalition (NWHC) was given a grant by the Population Crisis Committee (PCC) to promote menstrual regulation and early-term abortion in developing countries. This organisation, reconstituted as the International Women's Health Coalition (IWHC), became a major source of support and training for Third World providers of abortion. [182]

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[178] *ibid*

[179] Committee on Contraceptive Development, National Research Council and Institute.1990.*op cit*

[180] Correa, Sonia and Rebecca Reichmann.1994.*Population and Reproductive Rights: Feminist Perspectives from the South* . New Delhi, Kali for Women and DAWN.

[181] Connelly, MatthewJames.2008.*op cit*

[182] Hodgson,Dennis and Susan Cotts Watkins. 1997. "Feminists and Neo-Malthusians: Past and Present Alliances";*Population and Development Review*, 23(3): pp. 469-523

The focus of family planning programmes had shifted from India to China, as the centre of population control policies, with China adopting a one child policy. There was a growing influence of the anti-choice movement in the politics of population control. The population control movement was also facing a backlash for its aggressive and coercive policies from many countries such as Indonesia, Philippines and Pakistan. There was a need felt to involve more development issues within the population control debate especially women's issues.[183] Although UNFPA,USAID and WHO were reluctant about changing the fundamental policies of birth control, new strategies were adopted which included improving women's maternal health through providing women with higher incentives for sterilsation. Bangladesh, Africa, Singapore and other developing countries receiving funds from international organisations were asked to strengthen their population control strategies through provision of contraceptives, provision of incentive such as educational scholarship for accepting sterilsation or insertion of IUD. [184]

1.2.13-Mexico Conference: 'Population a Neutral Phenomenon'

In the USA the Republicans had come to power with Ronald Reagan taking charge of the White House. They had won the elections with help of influential activists of the 'pro-life' movement who were condemning the support provided by UNFPA and IPPF to family planning programmes the world over, especially China. They attacked USAID population programmes supporting contraception and abortion, while their main focus remained on reversing the Roe vs. Wade decision.[185] It was with this background that the second World Population Conference was held in Mexico in 1984. Contrary to the 1974 conference which was enthusiastically attended and convened by the developed countries, the 1984 conference was supported by developing countries. There were four preparatory groups in the run up to the conference which insisted that a small family size required economic and social improvement as a pre-requisite.[186] They also insisted on the couples right for deciding

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[183] Connelly, Matthew James.2008.*op cit*

[184] *ibid*

[185] *ibid*

[186] Tabah, Leon .1984. "Preparations for the 1984 International Conference on Population"; *Population and Development Review*, 10(1): 81-86

number of children and spacing measures. Caution was exercised when talking about the numerical targets to be achieved through birth control. Abortion was another sensitive issue which gained prominence during the conference. There was a recommendation to control migration and restrict the unplanned urbanisation within the countries. International migration needed to be controlled for both political and economical reasons and major causes of this continuous flow of illegal migrants were identified as refugee absorption, the brain drain and undocumented migration. The third group dealt with interrelationship between population, resources, environment and development.[187]

The conference revealed the shift in developing countries from their positions in the Bucharest Conference. Many African countries such as Nigeria and Kenya and Asian countries such as India, Pakistan, Bangladesh and Indonesia expressed their support for population programmes. There was increased support for population control programmes pledged by developed countries including Norway, Sweden and the UK in the light of the US decision to withdraw funds allocated to organisations carrying out abortion-related activities overseas.[188] This position of US came to be known as the 'Mexico City Policy'. At Mexico City the US delegation asserted that "population is a neutral phenomenon" in the development process, emphasized the need for developing countries to adopt sound economic policies that stressed open markets and an active private sector stating that it is the excessive state control that caused economic stagnation.[189]US funds to UNFPA and IPPF were withdrawn as a consequence of this policy.[190] The Holy See did not give its consent for the Mexico Conference as the conference had agreed to support family planning services for adolescents and concept of 'family' was not given importance.[191] The increasing role of NGOs in population was also given due importance in the Mexico Conference.[192]

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[187] *ibid*

[188] Singh, Jyoti Shankar.1998. *op cit*

[189] Hodgson, Dennis and Susan Cotts Watkins. 1997.*op cit*.pp 493

[190] *ibid*

[191] Singh,Jyoti Shankar.1998. *op cit*

[192] *ibid*

The decision taken by the USA in 1984 to deny funds to major institutions restricted overall funding for population activities but did not weaken the influence of population establishments on national population policies[193] From the mid-70s allocation to contraceptive development was between 25 and 30 percent of the total spent on basic research. Foundation funding for contraceptive development has been relatively stable throughout the 1980s, but lower than in the 1970s. The same pattern has been observed for USAID funding. Between 1983 and 1987, however, AID funding of contraceptive development increased by 138 percent (in constant dollars).[194] There was decrease in general funding by private organisations in the field of contraceptive development since the eighties. But there has been an increase in funds from multilateral organisations. The UNDP, the World Bank (WB), and the UNFPA joined WHO in sponsoring Human Reproduction Programme (HRP) in 1987. In the light of the US position to withdraw funds allocated to organisations carrying out abortion-related activities overseas WHO invested nearly nine million dollars for the development of new contraceptive in 1987. Apart from multilateral organisations, there were seven specialised contraceptive development organisations that have invested in contraception development.[195] Thus it is clear that contraception development is a field controlled by a handful of international organisations. There are also not many scientists who have been entering the field of contraceptive development because of liability fears. In addition, receiving patents for contraceptives has been hard as they require adherence to stringent rules in regarding to clinical testing and experiments on humans.

code name

During the period of late eighties a new contraceptive known by its generic name as Mifepristone or by its chemical compound name RU486 was introduced in to the market, it was an abortifacient. The clinical trials for this abortificient were conducted on Black and women of Colour. As funds for abortion and contraception reduced and insurance facilities being denied, this contraceptive quickly gained prominence in the

[193] Correa,Sonia and Rebecca Reichmann.1994.*op cit*

[194] Committee on Contraceptive Development, National Research Council and Institute.1990.*op cit*

[195] *ibid*

population establishment as a product that would solve the abortion problems of the world.[196]

1.2.14-RU486

It was a chemical abortifacient first synthesised in April 1980 by Roussel Uclaf, subsidiary of the large German Company, Hoechst.[197] In 1988, it was licensed by the French Ministry of Health to be marketed in France.[198] Meanwhile, in the same year US based Reproductive Health Technologies Project initiated an international campaign with the slogan "New technologies/New Choices" to bring this contraceptive into the US market.[199] This contraceptive was opposed strongly by many women's groups and also the Right- wing groups under the rubric of the 'pro-life' movement. The Right wing considered this contraceptive as an abortion as it killed the unborn foetus. The women's group opposition to the drug was based on the severe side effects of the pill which involved long term bleeding, abdominal pain, long term effects such as heart attacks and danger of strokes. FINRRAGE has likened RU-486 to taking a "drug cocktail": (1) RU486, (2) a prostaglandin injection or suppository to induce uterine contractions, (3) an anti-nausea drug, (4) pain medication (needed by 60 per cent of women, with more than 30 per cent requiring a morphine-type drug) and (5) antibiotics, if an infection develops.[200] The protests were also based on the fact that the trials for this drug were conducted on Black women and women of Third World countries. It was claimed that these drugs were a 'blessing' for women of Third World where it was difficult to access good abortion services.[201] This drug was removed from the market by the manufactures in 1989 but was brought back on the orders of the French Minister of Health who called it "the

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[196] Clarke, Adele and Theresa Montini.1993.*op cit*

[197] Clarke, Adele and Theresa Montini.1993. "The Many Faces of RU486: Tales of Situated Knowledges and Technological Contestations"; *Science, Technology, & Human Values*, 18(1) :pp. 42-78

[198] Klein, Renate and Lynette J. Dumble.1992. "RU 486/Prostaglandin Threats to Safe Pregnancy Termination"; *Reproductive and Genetic Engineering: Journal of International Feminist Analysis*, 5(2).

[199]Klein, Renate and Lynette J. Dumble.1992.*op cit*

[200] RU-486: A Dangerous Drug- As Available http://www.ru486.org/ru1.htm- As accessed on 17th June,2010

[201] Clarke, Adele and Theresa Montini.1993.*op cit*

moral property of women". Many pro-choice women's groups like National Abortion Rights Action League (NARAL), with state and local affiliates, National Organization for Women (NOW) and Feminist Majority supported the introduction of this abortificient into the market arguing that women needed a drug that they could control rather than undergo surgical procedure for abortion.[202] The availability of this drug after facing opposition from powerful groups was limited. In 1994, Roussel-Uclaf donated all its rights to Population Council which licensed it out to Danco Laboratories. They got FDA approval for the drug in 2000. This harmful drug continues to be administered on women of Color and Black.[203]

1.2.15- 'Cairo Consensus' and Reproductive Rights

By 1989 there was a run-up to the third World Population Conference which was to be held in 1994 in Cairo.[204] Although family planning programmes continued to receive international funding during this period, they were increasingly funded by the Third World governments indicating a growing neo-Malthusian commitment on their part. The 'Zero Population Growth' theory was weakening and the neo-Malthusians were constantly challenged about their theory of co-relation between increasing population and decrease in development. Indeed, a large amount of literature discredited their claims. They also were challenged by the growing influence of the Religious Right. On the other hand politically the period of Cold War, which had prompted neo-Malthusian theory to be widely spread and gain institutional funding had come to an end. The period after the disintegration of the Soviet Union presented a problem of the growth of a number of nations that needed immediate attention.[205] Furthermore there were 'state failures' occurring and many countries were adopting the Structural Adjustment Policies (SAPs) advocated by the World Bank under the New Economic Policies (NEP). There was growing fear of increased migration from the Southern countries into the Northern countries. At the same time

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[202] ibid

[203] Blumenthal, Paul,Jane Johnson, and Felicia Stewart.2000.

The Approval of Mifepristone (RU486) in the United States: What's Wrong With this Picture? – As Available on http://www.medscape.com/viewarticle/408923- As Accessed on 24th July,2010

[204] Singh,Jyoti Shankar.1998. *op cit*

[205] Hodgson, Dennis and Susan Cotts Watkins. 1997.

there was the fear of depletion of resources and 'environment conflicts' in the Southern countries fuelling more conflict and "environmental refugees".[206] These debates around environment had continued for decades and aggravated during the decade of the eighties. In the nineties, inspired by the model of Canadian political scientist Thomas Homer-Dixon, many came to believe that "scarcities of renewable such as crop land, fresh water and forests, induced in large part by population pressure contribute to migration and violent intrastate conflict in many parts of the developing world. This conflict in turn can potentially disrupt international security as states fragment or became authoritarian".[207] This theory was gaining prominence among the leadership of the USA. The literature that propelled the view of the 'degradation narrative' which established a relationship between poverty, population and environment drew heavily from neo-Malthusians.[208] This theory, for example, greatly influenced Vice-President Al Gore and President Bill Clinton.[209] After Bill Clinton took charge of the White House he signed orders to repeal the restriction on abortion and funding for contraception. He restored financing to IPPF and the UNFPA rejecting the idea that population growth was "a neutral phenomenon" in the development process.[210] In the developing countries the women's movement had started to criticize the inadequate consideration towards contraceptive safety, pitiable quality of services which ignored women's multiple reproductive health needs, the restricted range of contraceptives available, the preference for sterilization and the barriers to safe abortion. They had used the legal mechanism to attack the government and policy makers. Initially the women from these groups were not given much attention. But the movement grew stronger with women's rights being declared as part of universal human rights in the World Conference on Human Rights (WCHR), held in Vienna in 1993. The neo-Malthusians needed to do something to keep

[206] Hartmann, Betsy.2006. "Liberal Ends, Illiberal Means: National Security, 'Environmental Conflict' and the Making of the Cairo Consensus"; *Indian Journal of Gender Studies*.2006.13:195.

[207] Hartmann, Betsy.2006. *op cit*.pp 196

[208] *ibid,* pp 199

[209] *ibid*

[210] Hodgson,Dennis and Susan Cotts Watkins. 1997.*op cit*

population as a prominent issue.[211] Neo-Malthusian establishments believed that theory of environment conflict and forming a coalition with certain women's health groups would help to revamp their image.[212] This was done through private population oriented foundations such as Rockefeller Brothers Fund, Pew Charitable Trusts and by placing strategic people within the group preparing for ICPD. Homer-Dixon was bought in during the preparation for the ICPD to talk and convince the leaders about his theory. A Pew Global Stewardship Initiative (PGSI) was established to address issues related to population and consumption issues during the preparation of ICPD. Betsy Hartmann brings out the prominent role played by this initiative and their hired firm Future Strategies,Inc in influencing the leaders and common people of the US about the relation between environment degradation and population growth and the need for women's empowerment through contraception.[213]It was the IWHC which was initially funded by PCC and later by Hewlett, Mellon, Ford and McArthur Foundations which took the lead in what came to be referred to as the 'feminist population policy' at Cairo. As an attempt to build an alliance between the feminist and neo-Malthusians IWHC circulated "Women's Voices 94: Women's Declaration on Population Policies" a statement drawn up by 25 individuals with mostly uncontroversial goals. These included better health for women and children, women's rights, more justice and equality, less poverty, better social, sanitary and transportation infrastructure, education and reproductive health programmes for men.[214] This declaration called for reproductive health and rights to come together but within the framework of population policies in an attempt to influence government and international agencies. This declaration sidelined the views of Third World feminist, who criticised population policies and condemned the coalition between the liberal feminists and neo-Malthusians. The Women's Declaration was eventually endorsed by some 2200 organisations and individuals and 100 women's organisations

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[211] Sen, Gita and Carmen Barroso. 1996. "After Cairo: Challenges to Women's Organizations", Workshop on Reproduction Health, Rights and Women's Empowerment. Center for Development Studies. Sept 4-14.

[212] Hartmann, Betsy.2006.*op cit*

[213] *ibid*

[214] Women's Global Network for Reproductive Rights.2004. "A Decade after Cairo: Women's Health in a Free Market Economy"; The Corner House. Briefing 31

in some 100 countries.[215]Several NGO meetings were held in 1992 and one of the most important ones was the 40th Anniversary Congress of IPPF held in Delhi where the Director of Population Science, Rockefeller Foundation presented data comparing the demographic targets adopted by 12 major developing countries and bringing out the 'unmet need' for family planning which has become the major focus of discussion world over.[216]

Five round tables were organised before the end of 1993, concentrating on population and their relation to the environment, women's perspectives on family planning, reproductive health and reproductive rights, HIV/AIDS, and development strategies, communication, food security and ethics related to reproductive health.[217] The focus remained on population in all the meetings and not much mention was made about developmental issues. Nothing was said about the neo-liberal economic reforms that were literally taking away livelihoods from the poor even as it increased the rate of exploitation of poor people globally. The 'Cairo Consensus' which was finally adopted saw the coming together of Reproductive Health and Reproductive Rights. Population stabilisation was presented as the desirable ultimate goal without the use of coercion. Individual human rights and women's autonomy were propagated in national programs through increasing access to contraception and not in terms of their development advantages for aggregate populations. During this conference, donor nations agreed to provide one-third of total funding needed in order to meet the 'unmet need' for contraceptives. About the concept of 'unmet need' Saul Halfon states that it "in the conflict over "development" versus "contraceptive delivery" unmet need easily became a force for convincing policy-makers, politicians, demographers and others that a great deal could be accomplished by simply providing contraceptives to those who wanted them but did not have access." [218]

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[215] *ibid*

[216] Singh, Jyoti Shankar.1998. *op cit*

[217] *ibid*

[218] Halfon, Saul. 2006. *The Cairo Consensus: Demographic Surveys, Women's Empowerment, and Regime Change in Population Policy*. Lanham,Rowan and Littlefield Publisher.Inc,pp 169.

1.2.16-Women of Color and Reproductive Justice

The 'Cairo Consensus' along with neo-liberal policies have harmed Black and women of Colour the most. Understanding the consequences of the Cairo Consensus the women of Colour gave a call for Reproductive Justice. The first step towards this framework transpired two months after the September Cairo conference. A group of African-American women came together at an informal Black Women's Caucus at a National Pro-choice Conference sponsored by the Illinois Pro-Choice Alliance in Chicago in 1994 and fleshed out the concept of "Reproductive Justice."[219] Women of Color have always sought reproductive freedom but their issues of race and class got sidelined within the mainstream feminist movement. In the early part of the 1980s, Women of Color tried to increase their visibility by reaching out to men and women in neo-feminist circles. Many organisations working for women of Colour began in the eighties. These organisations came together to discuss issues regarding reproductive health, these issues were always discussed within a particular race and class that were the main causes of discrimination against women of Colour. They were the ones who were at the receiving end of the population control abuses or coercive sterilisation but there was mostly silence about the economic inequalities and power imbalances between the developed and the developing world's that constrain women's choices.[220] There was a need felt to critically examine both neo-liberal and neo-conservative policies that threaten women's lives worldwide after Cairo and also critique the 'unholy alliance' between the neo-Malthusians and feminists. This need to address issues of Black women and women of Colour gave rise to a framework of Reproductive Justice which was defined as "reproductive health integrated into social justice." Reproductive justice was further developed as an intersectional theory emerging from the experiences of women of Colour whose communities experience reproductive oppression. It is based on the understanding that the impact on women of colour of race, class and gender are not additive but integrative, producing this paradigm of intersectionality.[221]

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[219]Ross, Loretta.2006.Understanding Reproductive Justice ,Sister Song Women of Color Reproductive Health Collective – Available on-www.SisterSong.net- As accessed on 15th December,2009

[220] Ross, Loretta.et.al. "Just Choices: Women of Colour, Reproductive Health and Human Rights" in Silliman, Jael and Anannya Bhattacharjee (eds).2002.*Policing the National Body: Race, Gender and Criminalization*, South End Press, Massachusetts.

[221] Ross, Loretta.2006.*op cit*

1.3- Decade and a Half since Cairo

Cairo was heralded as a 'paradigm shift' in the history of reproductive health and rights. Women's empowerment through education was presented as prerequisite to achieve low fertility, a requirement for population stabilisation. This assumed that reproductive health framework would lead to comprehensive health programmes and provision of contraception without exploitation of women.[222] The Programme of Action adopted in Cairo has been used as advocacy tool the world over to demand for women's reproductive rights and access to health services. The governments of developing countries are now talking about 'reproductive rights', 'women empowerment' and 'women's rights'. This language has been co-opted by international development organisations like USAID, UNFPA and WB.[223]

But many have critiqued this Cairo Consensus as being old wine in new bottles, i.e. 'common ground' between the neo-Malthusians and the 'reproductive health feminists' at Cairo was about population control programme with a change in semantics. Women's empowerment became a means to achieve the end of decreasing population. It adopted the neo-liberal policies being implemented all over the world, primarily at the behest of the Bretton Woods institutions, namely the World Bank and the IMF.[224] These policies have resulted in failing health systems and decline in women's health as has been argued by many health advocates. It included family planning services as essential and suggested removal of constraints in obtaining contraceptives. The world over the health sector reforms were adopted which included privatising health services, user- fees and vertical- techno centric approach to health. There was increase in infections like AIDS and tuberculosis with limited health facilities and rising prices. This took a toll on the poor of the developing countries. Life expectancy in impoverished African countries fell.[225] [226] [227] Although the 'target-

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[222] Hodgson, Dennis and Susan Cotts Watkins. 1997.*op cit*

[223] The Corner House.2004.*op cit*

[224] Rao, Mohan.2006. "Introduction: Taming the Beast";*Indian Journal of Gender Studies*; 13; 163

[225] Turshen,Meredeth.2007. "What has Happened in Africa since Cairo?"; *Indian Journal of Gender Studies*,14:387

free' approach for family planning was adopted in country like India after the Cairo conference, it has not stopped the government from implementing rigorous population policies which limit the opportunities of the poor and marginalised.[228] Opening the markets and restriction in regulation resulted in many spurious drugs and contraceptives being dumped into the poor countries. SAP resulted in a widening gap between rich and poor, higher levels of income inequalities rise in unemployment and poverty. Even women's health was narrowed down to provisioning of contraception to fill the gap of the 'unmet need' of contraception while maternal mortality in developing countries was increasing. There has been an increase in women's poverty, violence against women and decline in their health as the basic services of good nutrition, maternal services, gainful employment are denied to women.[229] Many health advocates have questioned the weakening of the stands taken in Cairo in the wake of the structural adjustment policies which has failed to address macroeconomic inequities and failed to deliver reproductive and sexual health services. Market-oriented approaches have restricted quality services to the marginalised because there was neglect of primary health care.[230] The market oriented approach to health where the international development organisations were influencing policies worldwide. In spite of the rhetoric of rights based approach at ICPD it had recommended that more than 60 percent of the funds be allocated to family planning. Developing countries allocated the largest amount of funds to family planning, followed by bilateral assistance amongst which USAID had the largest proportion of contribution. The private foundations and NGOs contributed the next largest amount and among, the top private funders were Bill and Melinda Gates Foundation, Ford Foundation, the David and Lucile Packard Foundation, McArthur Foundation and Rockefeller Foundation. This funding was provided through NGOs making them more accountable to the private organisations. The funds were largely concentrated on developing countries

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[226] Hartmann, Betsy.2006.*op cit*

[227] Rao, Mohan.2005.op cit

[228] Rao, Mohan.2005. "Looking Back in Despair: Ten Years After Cairo"; *Indian Journal of Gender Studies*,112: 115

[229] The Corner House.2004.*op cit*

[230] *ibid*

like sub-Sharan Africa, Asia Pacific Region and Latin America and Caribbean and Eastern and Southern Europe. There was more concentration on provider controlled contraceptives and family planning programmes were still promoting sterilsation in many of the developing countries.[231]

There has been a growing influence of the fundamentalist which was accentuated by the market oriented approach, neo-Malthusian thinking influenced immigration, environment and population policies world over. There was co-option of the rights rhetoric so as to pacify the women's movement. George Bush who took over as the president of the United States in 2001 once again implemented the 'golden gag rule' decreasing funds for contraception and abortion services. In 2002, donor support for contraceptives declined by 12 percent from 2001. USAID fund decreased 25 percent of the total donor support as compared to 30 percent in 2001.[232]

Post 9/11 there was security fears which lead to stringent immigrants laws the world over, fundamentalist thinking has increased and theories such 'youth bulge' and the 'welfare queen' are used to propagate an 'alarmist' fear growing population of immigrants and Blacks among the Americans. There was a growing fear of Third World population, which fast gained attention as a place from where terrorism was propagated. Environment conflicts and degradation became the centre around which growing population of the Third World was discussed. The answer to all this has been narrowed to controlling the population of immigrants and Blacks.[233] The pattern of contraceptive funding has remained consistent over the years as observed by the 2007 Donor Support for Contraceptives for STI/HIV Prevention.[234] Overall the decade and half after Cairo has seen an increase in structural inequalities within and across the globe and the worst affected are the women.

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[231] The Corner House.2004.*op cit*

[232] UNFPA.2002.Donor Support for Contraceptives and Condoms for STI/HIV Prevention, New York

[233] Hendrixson, Anne.2004. "Angry Young Men, Veiled Young Women", *The Corner House*, Briefing 34.

[234]UNFPA.2007. Donor Support for Contraceptives and Condoms for STI/HIV Prevention, New York

The history of contraception traced brings out a web of powerful ideas and institutions that are interconnected and shape policies and programmes that influence the 'choice' of birth control methods and family planning services that are available to women. The controversies of contraceptives in the present times are rooted in this history. In the next two chapters an attempt is made to present a comprehensive picture of how these controversies have affected the growth and spread of contraceptives. Two types of contraceptives, namely, long acting contraceptives and emergency contraception as examples.

CHAPTER TWO

THE CONTINUING CONTROVERSIES WITH LONG-ACTING CONTRACEPTIVES

Long acting contraceptives are those contraceptives, for use by women that do not require daily or bi-weekly use. These hormonal contraceptives are provider controlled and are to be used once every three months or so in the case of injectables and once every five years in the case of implants. These contraceptives have been mired in controversy even before they were introduced into markets. While promoters talk about the 'freedom' it offers to women, freeing them from the bondage of everyday use of contraception and the vagaries of their remembering to use them, opponents have raised issues of motive, and safety. Women's groups and health advocates have pointed to its indiscriminate and coercive use among women from Black communities, among women of Colour and women in poor countries and lower class backgrounds, highlighting therefore real and potential abuse.

2.1- Long acting contraceptives: Injectables and Implants

Hormonal contraceptives that are delivered in the form of injectables or implants are long acting contraceptives. These contraceptives act on the body for a period of few months (one to three) in the case of injectables or upto five years in the case of the hormonal implants.

2.1.1- Injectables

Injectable contraceptives are steroidal preparations that are administered intramuscularly into the body through the medium of an injection. There are injectables with formulations of progesterone only and combined injectables available in the market. A comprehensive table of the injectable formulation available, developer, brand name along with its injection schedule is given below.

Table 1: Formulation, Developer and Injection Schedule[1]

Formulation	Developer	Brand Name/Manufacturer	Injection Schedule
Progestin only: 150 mg depot medroxyprogesterone acetate (DMPA)	The Upjohn Company	Depo-Provera/Upjohn Megestron/Organon	Every 3 months, 12 weeks, or 90 days
Progestin only: 200 mg norethindrone (norethisterone) enanthate (NET EN)	Schering AG	Noristerat[a]/Schering AG Doryxus/ Richter Gedeon Ltd.	Every 2 months
Progestin + Estrogen: 25 mg DMPA + 5 mg estradiol cypionate	Upjohn, WHO	Cyclofem, Cyclofemina, Novafem/Aplicaciones Farmaceuticas (Mexico), PT Tunggal (Indonesia), Lunelle/Upjohn (US) Cyclogeston/ PT Triyasa Nagamas Farma (Indonesia)	Every month
Progestin + Estrogen: 50 mg NET EN + 5 mg estradiol valerate	WHO	Mesigyna, Norigynon/ Schering AG	Every month
Progestin + Estrogen: 150 mg Dihydroxy Progesterone Acetophenide + 10 mg estradiol enanthate	Squibb Pharmaceutical Company	Perlutan, Topasel, Agurin Horprotal, Uno-Ciclo/ Various manufacturers in Latin Americca	Every month
Half-dose: 75 mg Dihydroxy Progesterone Acetophenide + 5 mg estradiol enanthate		Anafertin, Yectames/ Various manufacturers in Latin America	Every month
Progestin + Estrogen: 250 mg 17μ - hydroxy- progesterone Caproate + 5 mg estradiol valerate	Chinese researchers; Squibb Pharmaceutical Company	Chinese Injectable No. 1	Every month, 2 injections in first month

Source: Injectable Contraceptives for Women.1999.http://www.gfmer.ch/Endo/Lectures_11/Arcangues.htm:Injectable Contraceptives for Women

[1] Injectable Contraceptives for Women .1999-Available on - http://www.gfmer.ch/Endo/Lectures_11/Arcangues.htm:Injectable Contraceptives for Women-As Accessed on 15th March,2010

Controversies around injectables contraceptives will be studied using the case of Depot medroxyprogesterone acetate (DMPA) or Depo-Provera (brand name) three month progesterone only injectable as this is illustrative of the issues raised by all injectables.

According to the *Population Report 2006* brought out by Information & Knowledge for Optimal Health (INFO), a project of the Johns Hopkins Bloomberg School of Public Health's Centre for Communication Programs (CCP) and supported by the USAID.[2] About 32 million women use injectables globally. Injectables are said to be the fourth most popular method, chosen by 38 percent of women using modern methods.[3] The *Report*[4] claims that the sales of injectables from 1995-2005 have doubled worldwide. It is said to be the most popular method in sub-Sharan Africa (SSA) and sales have said to have increased within all developing countries. It is the concentration of 'increased sales' within developing countries that has become one of the major sources of controversy.

Depo Provera was originally manufactured and promoted by the US pharmaceutical firm Pharmacia & Upjohn Inc. The patent is now owned by the transnational pharmaceutical giant Pfizer Inc.[5] It was registered in 179 countries by 2006.[6]

Depo Provera was synthesised in 1954 and in 1960 it was approved by the FDA for treatment of endometrial and renal cancers.[7] It was also given permission to be used for preventing spontaneous abortions although this permission was later withdrawn in

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[2] About Population Reports- Available on http://info.k4health.org/pr/about.shtml- As Accessed on 9th December 2009

[3] Population Reports .2006. "Expanding Services for Injectables: How Family Planning Programs and Providers Can Meet Clients' Needs for Injectable Contraceptives": Available on http://info.k4health.org/pr/k6/published/k6.pdf- As Accessed on 10th, December 2009.

[4] *ibid*

[5] Satyamala, C.2000.*An Epidemiological Review of the Injectable Contraceptive-Depo-Provera.* India, Medico Friends Circle and Forum for Women's Health.

[6] Population Reports .2006. *op cit*

[7] Satyamala, C .2000.*op cit*

1971 as studies did not support the claims made.[8] It was observed around the early 60s that women on whom DMPA was used for premature labour consequently experienced a delay in return of fertility following child birth. It was this that led to its development as fertility-regulating agent.[9] In the late sixties, Upjohn Co applied for the approval of this drug as a contraceptive. However permission was not granted as carcinogenic effects of the drug were discovered during animal testing.[10, 11] In 1971 tests conducted on beagle dogs and rhesus monkeys showed that Depo Provera was carcinogenic in high doses and this resulted in the FDA calling a halt to the trials of these drugs. Again, in 1978 FDA denied approval to the drug because of carcinogenic effects shown on animals and increased risk of birth defects seen in human foetuses exposed to the drug.[12]In 1983 FDA continued to deny approval to Depo Provera[13] into the US market.Then in 1992, Depo Provera got approval from FDA to be marketed as an injectable in the US. The reason for this change in decision will be examined subsequently.

2.1.2- Clinical Pharmacology

Depo Provera is a three-monthly injectable contraceptive containing a synthetic progestin that resembles the female hormone progesterone. Each dose contains 150 mg of the hormone which when injected intramuscularly releases hormones slowly into the blood stream from the site of intramuscular injection.[14]

The mode of action of DMPA is complex and involves many levels. It acts on the pituitary gland, suppressing both Follicle Stimulating Hormone (FSH) and

[8] *ibid*

[9] Injectable Contraceptives for Women .1999- Available on – *op cit*

[10] Hartman, Betsy .1995.*Reproductive Rights and Wrongs-The Global Politics of Population Control.* Boston, South End Press.

[11] Gupta, A.J .2000.*New Reproductive Technologies, Women's Health and Autonomy-Freedom or Dependency.* New Delhi, Sage Publications.

[12] Depo Provera Fact Sheet.2007: Available at http://www.cwpe.org/node/185: As accessed on 20th April,2010

[13] *ibid*

[14] Depo Provera Contraceptive Injection Medroxyprogesterone Acetate Injectable Suspension, USP-Available on-http://media.pfizer.com/files/products/uspi_depo_provera_contraceptive.pdf - As Accessed on 15th January,2010

Luteinizing Hormone (LH) and thus inhibits follicular maturation ovulation for about 14 weeks. It also thickens the cervical mucosa, decreasing the chances of sperm penetration. In addition, endometrial thinning takes place with inactive glands. Finally, there is decreased tubal motility.[15,16]

A new formulation of Depo-Provera has been developed specifically for injection into the tissue just under the skin (subcutaneously). It was approved by the FDA in December 2004 under the name 'depo-subQ Provera 104'and is to be administered every 3 months.[17] The hormonal dose of the new subcutaneous formulation (DMPA-SC) is 30% less than DMPA (IM), 104 mg instead of 150 mg. The pharmacology and mode of action of Depo Provera SC is the same as that of Depo Provera IM.[18,19]

This new formulation will be delivered by subcutaneous injection, made available in prefilled syringes. These prefilled syringes will be manufactured by Uniject, owned by the International Non Governmental Organisation (INGO) Program for Appropriate Technology in Health (PATH), and licensed to the pharmaceutical company Becton Dickinson for sale. Pfizer, the manufacturer of Depo Provera SC, has registered the new formulation in the US and expects product registration in developing countries beginning in late 2011. In anticipation of product availability, PATH is assisting the USAID to coordinate planning among a range of partners for possible global rollout of the product.[20] These prefilled syringes have special short needles meant for subcutaneous injection. With these syringes it is expected that women will be themselves be able to inject Depo Provera.[21]

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[15] *ibid*

[16] Injectable Contraceptives for Women .1999. – *op cit*

[17] Kaunitz et. al .2009. "Subcutaneous DMPA vs. Intramuscular DMPA: a 2-year Randomized Study of Contraceptive Efficacy and Bone Mineral Density"; *Contraception* ,80 :7–17

[18] Depo-subQ Provera 104- Available on-http://www.path.org/files/RH_depo-subq_brief.pdf-As accessed on 17th April,2010

[19] Expanding Services for Injectables- Available on-http://info.k4health.org/pr/k6/published/k6.pdf: As accessed on 18th April,2010

[20] Increasing Contraceptive options Providing Depo-subQ Provera 104™ in the Uniject® device: Available on http://www.path.org/projects/uniject-dmpa.php: As accessed on 20th April,2010

[21] WHO Family Planning Cornerstone.2007.*A Global Handbook for Providers Evidence-based Guidance Developed through Worldwide Collaboration.* Geneva.

2.2- Implants

Norplant, an implantable contraceptive was first developed by the Population Council a non-profit, INGO. It was primarily developed for use in developing countries.[22] The Population Council licensed it out to Leiras Pharmaceuticals to produce and market it.

The Population Council initiated research that led to the development of Norplant in 1967.[23] To aid the Councils project it was supported by Ford Foundation and Rockefeller family and Rockefeller Foundation.[24] Initially tolerance studies were conducted in Chile, India, Brazil and Italy to ascertain the kind of progestin to be used.[25] The first publication on a contraceptive implant for women releasing progestogen appeared in 1969.[26] Between the period 1970 and 1975 clinical trials for Norplant were conducted to test effectiveness of the progestin levonorgestrel and later a randomized double-blind clinical trial was conducted in the countries Brazil,Sweden,Chile,Finland and Denmark combined, the Dominican Republic and Jamaica to determine whether to administer the new contraceptive method on the general public.[27] The Norplant system that is administered was decided on in1974.[28] The trials in Chile, Brazil and India had showed increased numbers of ectopic (outside the uterus) pregnancies among the failures. Therefore, in 1975 Population Council increased the dose of progestin, thus reducing chances of pregnancy as well as risk of ectopic pregnancy.[29] In 1983, Norplant became the first approved implant through the Finnish National Drug Regulatory Authority to enter the markets. Norplant was

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[22] Ollila, Eeva.1999. *Norplant in the Context of Population and Drug Policies*. Finland,.STAKES National Research and Development Centre for Welfare and Health.

[23] Injectable Contraceptives for Women .1999-*op cit*

[24] Global Teamwork in Developing a Contraceptive Implant.1990.*Choice and Challenge*, New York The International Development Research Centre in collaboration with Population Council.

[25] *ibid*

[26] Implantable Progestogen Contraceptives: Monitoring for Unintended Pregnancies

.2005- Available on- http://apps.who.int/medicinedocs/en/d/Js8117e/3.1.html- As Accessed on 20th May,2010

[27] Global Teamwork in Developing a Contraceptive Implant.1990.*op cit*

[28] Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke.1993.*Norplant: Under Her Skin. The Women's Health Action Foundation*, Netherlands, Women and Pharmaceuticals Project, and WEMOS.

[29] Akhter, Farida .1992.*Resisting Norplant-Women's struggle in Bangladesh against Coercion and Violence*, Dhaka,.Narigrantha Prabartana.

approved by the FDA in December 1990.[30]Since 1990, several new implants have been registered. Norplant has been removed from the markets since 2008 by its manufacturers and is no longer available in the market. Norplant -2 was introduced by the same manufacturer, namely Population Council; it has the same components only difference is duration of the implant period is reduced to three years. Many other injectables also have been introduced into market since then. A brief of which has been presented below.

2.2.1- Clinical Pharmacology

Norplant contains six silicone rods, each containing 36mg of the progestin levonorgestrel.[31] The Norplant capsules were initially made with the hard tubing formulation but the formulation was slightly modified and changed to soft tubing. The soft tubing implant released slightly more levonorgestrel per day and has lower pregnancy rates than the hard tubing implants.[32]Since 1991, practically all Norplant capsules have been manufactured with soft tubing.

Norplant prevents conception in two ways, one by suppressing ovulation in slightly more than 50% of menstrual cycles and, two, by thickening cervical mucus so that it is impermeable to the sperm. This contraceptive is sub dermally inserted into the skin which requires a minor procedure for insertion. It also requires a minor surgical procedure for its removal, as there can be tissue formation around the implants after they have been inserted. It remains inserted within the arm for a period of five years during which period, this contraceptive releases approximately 85 micrograms of levonorgestrel per day in the first few months that decreases gradually to 35mg/day after the first 18 months it further decreases to an average of 30μgm/day over the remaining three and a half years of the five year period.[33]

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[30]Owen, Susan and Caudill, Sally- Contraception and Clinical Science- "The Place of Women in Reproductive Technology", Parrott,Louisselle Roxanne and Condit Celeste Michelle (eds).1996. *Evaluating Women's Health Messages-A Resource Book*, California, Sage Publications.

[31] Ollila, Eeva.1999. *op cit*

[32] Meirik, Olav.et.al .2003."Implantable Contraceptives for Women"; *Human Reproduction Update*,9(1): 49-59

[33]Hickey,Martha and Catherine d'Arcangues.2002. "Vaginal Bleeding Disturbances and Implantable Contraceptives" ;*Contraception*,65:75–84

Norplant-2 (Jadelle) was launched in 1998 in Finland. It is similar to Norplant, but consists of only two, rather than six, silastic rods containing 75 mg of levonorgestrel. Its performance is same as Norplant and provides protection against pregnancy for three years. [34,35] Single implant systems are Implanon that releases etonogestrel over three years; Nestorone implants for breastfeeding and non breastfeeding women that lasts up to two years; and Uniplant,is, effective for one year and releases nomegestrol acetate.[36]

This chapter chooses to review Norplant, as new age implants continue to have the same characteristics. The controversies around Norplant would provide an insight into the new age implants in relation to their working, the actors that provide these contraceptives and the woman who access these contraceptives.

The controversies around both injectables (Depo-Provera) and implants (Norplant) have been about issues of safety, efficacy and ethics.

2.3- Safety

One of the major factors that have influenced the safety debates are the side effects of long acting hormonal contraceptives. Injectable and implants have always been associated with physical side effects that have been mentioned below.[37,38,39]

Side effects of injectables

- First 3 months:
  - Irregular bleeding(Metrorrhagia)
  - Prolonged bleeding (Menorrhagia)
- At one year:
  - No monthly bleeding (Amenorrhoea)
  - Infrequent bleeding (Oligomenorrhea)
  - Metrorrhagia
- Weight gain

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[34]Ollila, Eeva.1999. *op cit*

[35] Hickey, Martha and Catherine d'Arcangues.2002.*op cit*

[36] *ibid*

[37] Sama-.2003.*Unveiled Realities-A study on Women's Experiences with Depo-Provera, an Injectable Contraceptive,* India, Sama-Resource Group for Women and Health .

[38] A Saheli Report.1999.*Enough is Enough-Injectable Contraceptives Net-En:A Chronicle of Health Hazards Foretold.* India, Saheli Women's Resource Centre, Sama-Resource Group for Women and Health.

[39] Akhter, Farida. 1992.*op cit*

- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive

Side effects of implants

- Changes in bleeding patterns including:
- First several months:
  - Lighter bleeding and fewer days of bleeding
  - Irregular bleeding that lasts more than 8 days (Menometrorrhagia)
  - Oligomenorrhea
  - Amenorrhea
- After about one year:
  - Lighter bleeding and fewer days of bleeding (Hypomenorrhea)
  - Metrorrhagia
  - Oligomenorrhea
- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea

Women with lower body weights conceive sooner than women with higher body weights after discontinuing Depo Provera. The effect of hepatic and/or renal disease on the pharmacokinetics of Depo Provera is not known.[40]

Carcinogenic effects and problems with the heart, adverse effects on the infant born, bone mineral deficiency leading to osteoporosis, hypertension and clitoral hypotrophy[41,42] are among the long term side effects of long acting contraceptives.
One of the most common side effects of injectables and implants are irregular bleeding, spotting for longer durations and cases of amenorrhea in women. Menstrual disturbance is a common reason for discontinuation of these methods.[43]In a multi

[40] Depo Provera Contraceptive Injection Medroxyprogesterone Acetate Injectable Suspension, USP-*op cit*

[41] Satyamala,C.2000. *op cit*

[42] Akhter, Farida. 1992. *Op cit*

[43]Hickey,Martha and Catherine d'Arcangues.2002. *op cit*

centre trial study of two types of implants, menstrual disturbances accounted for 90 percent of the reported side effects and led to a discontinuation rate of 11 percent at the end of first year.[44]In a trial conducted of injectable contraceptive 'Net-En' by the Indian Council for Medical Research (ICMR), the cumulative discontinuation rates due to menstrual disturbances were 21.2 per cent for the first year and 43.5 per cent for the second year.[45] In another study done by WHO, on Depo Provera, discontinuation rates were 33.3 per cent to 75 per cent and 49.5 per cent to 91.3 percent. An Indian study on DMPA reported a 32 per cent dropout rate after the first dose and 70.8 per cent after the second dose. [46]

Amenorrhea is another side effect resulting from these contraceptives. In a multinational comparative clinical trial with menstrual experience of 372.5 women years with Depo-Provera, prolonged amenorrhoea increased with duration of the use and 35 per cent women had developed total amenorrhea by the end of one year .[47] In clinical studies of Depo-Provera contraceptive injection, 55 percent of the women studied reported amenorrhea after one year of use and 68 percent of the women studied reported no menstrual bleeding after two years of use.[48] Absurdly, but not surprisingly, it is argued in some papers [49,50 ,51,52] that, it is beneficial for women not to have their periods as it will help them to work without bothering about their monthly cycles and will help them be more active. This is indeed one of those cases

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[44]Cheng, L.et.al.2000."Contraception: Once a Month Administration of Mifepristone Improves Bleeding Patterns in Women using Subdermal Contraceptive Implants Releasing Levonorgestrel", 2000; *Human Reproduction*,15(9)

[45]Ravindra R P.1999. Reject the Injectables- Available on http://www.issuesinmedicalethics.org/072ed047.html- Accessed on 5th January ,2010

[46] *ibid*

[47] WHO task force as cited in Satyamala.C.2000. *op cit*

[48] Depo Provera Contraceptive Injection Medroxyprogesterone Acetate Injectable Suspension, USP -As Available on -www.**pfizer**.com/files/.../uspi_**depo_provera**_contraceptive.pdf- As Accessed on 15th Nov,2009

[49] Solter, Cathy.1999. *"Comprehensive Reproductive Health and Family Planning Training Curriculum Module 6: DMPA Injectable Contraceptive"*, USA, Medical Services Pathfinder.

[50] E, Alison.et.al.2007. "Acceptability of Contraceptive-Induced Amenorrhea in a Racially Diverse Group of US Women"; *Contraception* 75,450– 453.

[51] SOGC Clinical Practice Guidelines.2006. "Canadian Contraception Consensus-Update on Depot Medroxyprogesterone Acetate(DMPA)", 174

[52] Solter, Cathy.1999. *op cit*

where there is confusion between a side-effect and between what is normal and what is not. Similarly, it has been argued that weight gain, a side-effect, may be beneficial since many women in poor countries are hungry and underweight. It has also been stated that this is a particular advantage to women in countries like India since menstruating women are not permitted to participate in some religious functions.[53]

Decreased libido or a lack of sex drive is one of the other side effects of the use of long acting contraceptive which can be harmful not only to the family life of the person but can inhibit the person from enjoying a satisfying adulthood. [54]

These injectables and implants contain hormones which interfere with functioning of the three vital organs of the body, namely the hypothalamus, the pituitary gland and the ovaries. These organs play a vital role in physical, mental and emotional development. Psychological problems such as depression and sudden mood changes have been associated with these contraceptives.[55]

One other side effect is weight gain. This could hamper not only daily working routine but also cause fatigue and tiredness when working. In case of adolescents who are conscious of their body type, weight gain could hamper their self esteem and confidence.[56]

Safety concerns regarding these physical side effects have been interpreted as 'minor'. At Depo-Provera hearings conducted on the appeal by Upjohn company by the FDA in 1983 after this contraceptive failed to get approval on account of it being carcinogenic, Dr Juan Zanartu (Professor of Human Reproductive Endocrinology at the University of Chile Medical School) and Dr. Fred Sai (IPPF, another INGO belonging to the population establishment) had taken it for granted that side effects like headache, amenorrhea, irregular bleeding, decreased libido are concerns that women can endure with 'reassurance' from a trusted friend or counsellor.[57] This view

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[53] A Study by Sama-Resource Group for Women and Health.2003. *op cit*

[54]Corea, Gena. "Depo-Provera and the Politics of Knowledge" in Patricia Hynes, (ed).1989.*Reconstructing Babylon: Essays on Women and Technology*, London, Earthscan Publications Ltd.ch.12.

[55] Gupta, A.J.2000.*op cit*

[56] A Study by Sama-Resource Group for Women and Health.2003. *op cit*

[57] Corea, Gena.1989. *op cit*

of providing counselling as a solution to side effects has been supported by other international organisations such as the WHO, the Population Council and pharmaceuticals companies. Counselling is expected to prepare women and also encourage them to comply with the usage of long acting contraceptives.

Work documented by many experts and researchers.[58,59] have shown that, within socio cultural settings of countries, irregular bleeding can lead to exclusion from social rituals and being part of the daily activities at home. In societies where the proof of being fertile is presented through monthly menstrual cycle, it becomes vital to the status of women to continue to have her regular menstruation cycles.[60]Also, in some countries like Africa, India and Bangladesh where people lack basic hygiene facilities such as running water or are unable to purchase necessary hygiene products due to their cost, continuous or prolonged bleeding, irregular bleeding patterns can cause a great deal of embarrassment and discomfort to women and her family.[61] Irregular or abrupt bleeding also leads to tiredness and weakness in women which cannot be backed up with good nutrition or adequate rest as these are not luxuries enjoyed by the women in developing countries.[62] Women's groups have argued that suffering from contraceptive induced amenorrhea can prove detrimental to a women's status within the society where menstruation is considered as a sign of fertility. Women themselves go through insecurities and self doubt after suffering from a condition of irregular bleeding or amenorrhea.[63] It is also thought by those promoting these contraceptives that decreased libido cannot be a problem as women do not need arousal before the sex act. People stating this; fail to understand the problems and pain women go through in a family life when they cannot enjoy the act of sex.[64] Clearly, issues that profoundly impact on women's health and well being were being

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[58] Hartman, Betsy.1995. *op cit*

[59] Parsons, Claire 1990. "Drugs, Science, and Ethics: Lessons from the Depo-Provera Story";*Reproductive and Genetic Engineering- Journal of International Feminist Analysis,* 3.

[60] Ali.K.A.2002. "Faulty Deployments: Persuading Women and Constructing Choice in Egypt"; *Comparative Studies in Society and History*,44(2):370-394

[61] Parsons, Claire.1990. *op cit*

[62] Sama-Resource Group for Women and Health.2003. *op cit*

[63] *ibid*

[64] Corea, Gena.1989. *op cit*

dismissed as of no consequence or "minor" simply with the intent of promoting these contraceptives, regardless of their health consequences to the users and the conditions under which they were being used.

The solution of providing 'good counselling' have been decried by feminist groups and health advocates. They believe that rather than offer a proper picture of the problems that women face, counsellors may persuade women to comply with the use of long acting contraceptives. There have been cases in Bangladesh where women have been brought in huge trucks for the injectable camps in an effort to meet targets.[65]Indeed in Indonesia, such camps are referred to as "safaris". [66]In such cases counselling women is hardly a possibility or something desired by doctors under pressure to reach targets of contraceptive use. Thus it is that the abuse of provider controlled contraceptives in not just an unlikely fear among critics of such methods.

2.3.1- Long Term Side effects

HIV/AIDS

Injectables and implants do not provide protection from HIV/AIDS. It is a pandemic disease since the 1980s which has particularly severely affected the SSA countries, precisely the countries where use of long-acting contraceptives is being promoted. SSA reports extremely high rates of maternal mortality. In addition, 90 percent of deaths among urban African women of reproductive age are caused by HIV infection.[67] Sub-Saharan Africa bears two thirds of the global AIDS burden and three-quarters of all-AIDS related deaths. Based on their reproductive biology, it was also noted that women are two to eight times more likely to contract HIV during vaginal intercourse.[68] Along with this there is also presence and fear of spread on STIs. Clearly, common sense demands that under these conditions, the contraceptives preferred must be condoms.

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[65]Akhter, Farida.1995.*op cit*

[66] Rao, Mohan.2004.*From Population Control to Reproductive Health- Malthusian Arithmetic*, India, Sage Publications Pvt.Ltd.

[67] Visvanathan, Nalini.2009. *"Hormonal Contraception and HIV Disease Acquisition: A Limited Review and Reassessment of Findings"*, Population and Development Program's Reviving Reproductive Safety Project (A Discussion Paper), Hampshire College, Amherst.

[68] *ibid*

The World Health Organization's *Medical Eligibility Criteria for Contraceptive Use* however states that women at risk of HIV infection or those who are HIV-infected may use hormonal contraception with no restrictions.[69] This statement was supported by Africa Regional Meeting which held a conference on 'Hormonal Contraception and HIV: Science and Policy' in Nairobi, convened by the IPPF and Family Health International (FHI) in 2005.[70] However, studies conducted among sex workers presented at the conference, showed an increase in incidence of HIV among users of long-term contraceptives. At the same time, other studies from Thailand and Zimbabwe showed no over-all increase in risk of HIV. The consensus that emerged was that studies among sex workers could not be extrapolated to clients of family planning as the overall risk of acquiring HIV is typically lower among clients of family planning services than that of sex workers.[71] The recommendations included emphasises on the use of dual protection for preventing STIs and HIV. They also recommended the need for further research in relation to hormonal contraception and HIV/STI.[72] Nalini Vishwanathan's review of the relation between HIV and hormonal contraceptives however points to other studies - and meetings - which have found a strong association between hormonal contraceptives and incidence of HIV.

The FHI studies pointed to inconclusive and contradictory findings calling for more research.[73] However, evidence regarding conflict of interest soon emerged when it was noted that the lead investigator for FHI, Dr Charles Morrison had stocks in Pfizer, the company that owns Depo-Provera.[74]Also it was noted that FHI had a contract to increase the sales of Depo-Provera through community based distribution.[75] Funding

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[69] Dr. Charles Morrison and Kim Best.2004.Hormonal Contraception and HIV: An Update-http://www.fhi.org/en/RH/Pubs/booksReports/hcandhiv.htm- As accessed on 25th May 2010

[70] Hormonal Contraception and HIV: Science and Policy-Available on http://whqlibdoc.who.int/hq/2006/WHO_RHR_06.4_eng.pdf-As accessed on 30th May,2010

[71] *ibid*

[72] *ibid*

[73] Visvanathan, Nalini.2009. *op cit*

[74] *ibid*

[75] *ibid*

for this project was to come from the Contraceptive and Reproductive Health Technologies Research and Utilization program of the USAID.[76]

Women's groups have opposed recommendations of dual protection and counselling, stating that it tough for women to negotiate or lay down demands in matters related to sex. This is especially the case when the male is aware that the woman is at low risk of getting pregnant. Encouraging the use of condoms is unlikely under the circumstances. This problem cannot be improved through just counselling. Hence, the risk of HIV due to long acting contraceptives still remains compelling.[77]

Long acting contraceptives and Breastfeeding

It has been indicated that progestogen- only injectables are relatively safer than other contraceptives containing estrogens, ensuring that women are safer from estrogen-related side effects.[78] But long- term side effects with Progestogen-only contraceptive methods get minimised in this process. Progesterone- only contraceptives have not been shown to affect milk production negatively; however, the potential effects on the development of the brain or functioning of the liver in newborns exposed to these hormones through breast milk have not been well documented. The following paragraphs taken from WHO reports summarises the answer to the controversies about progesterone- only contraceptive being safe for breastfeeding women.

> .....The direct evidence regarding the use of combined and progestogen-only methods of contraception in women breastfeeding newborns less than six weeks of age generally suggests that hormonal contraceptive use does not affect infant health, growth or development. Although this body of evidence appears reassuring, these data are severely limited by the following: short lengths of follow-up and small numbers of exposed infants studied; wide diversity in timing of blood and urine samples collected; the use of varying, insensitive cognitive and development tests; the use of various contraceptive formulations; and the timing of contraceptive initiation.[79]

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[76] Injectable Contraceptive Use Rises in Madagascar-Community-Based Distribution Boosts Rural Access to Family Planning- Available on http://search.fhi.org/cgi-bin/MsmGo.exe?grab_id=108735485&extra_arg=&page_id=1303&host_id=1&query=injectables&hiword=INJECTABLES+INJECTABLE+- As Accessed on 30th May,2010

[77] Depo Provera Fact Sheet.2007: *op cit*

[78] SOGC Clinical Practice Guidelines.2006. *op cit*

[79]Progestogen-only Contraceptive Use During Lactation and Its Effects on the Neonate: As Available on- http://whqlibdoc.who.int/hq/2009/WHO_RHR_09.13_eng.pdf- As Accessed on 20th December, 2010.

> .....Despite anecdotal clinical reports that Progenstone Only Contraceptives (POCs) might diminish milk production, direct evidence from available clinical studies demonstrates no significant negative effect of POCs on breastfeeding performance or on the health of the infant. In general, these studies are of poor quality, lack standard definitions of breastfeeding or outcome measures, and have not included premature or ill infants. Theoretical concerns about effects of progestin exposure on the developing, neonatal brain are based on studies of progesterone effects in animals; whether similar effects occur after progestin exposure in human neonates is not known.[80]

These contraceptives work on the premises that they are safe unless proven otherwise.

A study by WHO and FHI shows that children born to mothers using Depo Provera are five times more likely to be born with limb defects and chromosomal abnormalities than with women who use no contraception.[81] This injectable can be present in the breast milk of the mother who feeds her child. Depo Provera is likely to be present in the body even after discontinuing the use of the contraceptive for a period of few months to a year. Hence, conception in women becomes only possible after some months of discontinuation of the injectable.[82]

Bone Health and Long -acting Contraceptives

Decrease in bone mineral density (BMD) is a major long- term side effect of the injectable. DMPA suppresses the hypothalamic-pituitary-ovarian axis, resulting in a hypoestrogenic state and a decline in bone metabolism.[83,84] It can cause osteoporosis, a condition which weakens the bones and makes the bone more susceptible to fractures. Thus it can also lead disability and prolonged pain among women, especially older women.

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[80] U.S. Medical Eligibility Criteria for Contraceptive Use.2010.*Morbidity and Mortality Weekly Report*, 59.

[81] Satyamala,C.2000.*op cit*

[82] *ibid*

[83] Scudder, Laurie.2008. Are There Contraindications to Switching From Intramuscular to Subcutaneous Depo-Provera?- Available on http://www.medscape.com/viewarticle/584971: As Accessed on 19th May,2010.

[84] WHO/HRP.2005.*Technical Consultation on the Effects of Hormonal Contraception on Bone Health-Summary Report*. Geneva

In 2004, Pfizer, Inc., owner of Depo-Provera, submitted data to the FDA indicating Depo Provera users experiencing significant loss of BMD. FDA announced a label change for Depo Provera including a black box warning. On November 17, 2004, the FDA placed a black box in DMPA package labelling and issued a Talk Paper which stated:

> .....Although Depo-Provera Contraceptive Injection has been used for decades for birth control throughout the world and remains a safe and effective contraceptive, FDA and Pfizer, the drug's manufacturer, are taking this action to ensure that physicians and patients have access to this important information. The black box warning for Depo-Provera highlights that prolonged use of the drug may result in significant loss of bone density, and that the loss is greater the longer the drug is administered. This *bone density loss may not be completely reversible after discontinuation of the drug.* Thus, the warning states that a woman should only use Depo-Provera Contraceptive Injection as long-term birth control methods (for example, longer than two years) if other births control methods are inadequate for her(emphasis added).[85]

This greatly affected the use of Depo-Provera.[86] In 2005 after FDA announced label change WHO and UNDP - UNFPA - WHO - WORLD Bank Special Programme of Research, Development and Research Training in Human Reproduction organised a 'Technical Consultation on the Effects Hormonal Contraception on Bone Health'. In this consultations many different presentation were made associating bone health to hormonal contraception. Cross sectional studies presented on DMPA and bone health showed correlation between DMPA use and decrease in bone health. Studies reviewed, based on over one or two years of follow-up, recorded a significant decline in BMD at the spine, hip, femoral neck and whole body among DMPA initiators or continuers compared with non-user groups. New users lost more bone than continuing users and mean changes in BMD decreased with increasing DMPA cumulative use. This consultation finally recommended that there should be no restrictions on the use of the DMPA, including no restriction on duration of use, among women aged 18 to 45 who are otherwise eligible to use the method. They mentioned key evidence gaps in this consultation, which included effects of hormonal contraceptive use on fracture risk later in life in both developing and developed country populations. There was uncertainty on whether women using DMPA fully recover BMD to their potential after discontinuation or not, although the WHO warning above clearly stated that they

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[85] Editorial- "Depo-Provera's Black box: Time to Reconsider ?" 2005. *Contraception*,72:165– 167.pp 165

[86] *ibid*

did not. There was also limited understanding on whether adolescent who use this drug will attain their full BMD potential. The influence of risk factors for osteoporosis and its effect on DMPA use fracture risk was not understood. It was stated that the consequence of DMPA on lactating women was not known. The incidence of fracture in developing country populations was not known. The patterns of DMPA use among women in different settings were questioned. Despite all these gaps, this drug was recommended for use.[87]

A study by Kaunitz and et al, [88] sponsored by Pfizer International, revealed that there is indeed loss of bone mineral density in women. The study, however, argued that this could be reversed once the contraceptive usage is stopped. The study also compares the intra- muscular and the subcutaneous a method of using the injectable, observing no major difference in the loss of BMD. The study concluded: 'the contraceptive DMPA-SC and DMPA-IM are highly effective in preventing pregnancy, and the advantages of DMPA as a contraceptive generally outweigh the theoretical concerns regarding bone health.[89]The Society of Obstetricians & Gynaecologists of Canada and the Society for Adolescent Medicine also recommended DMPA, provided there is appropriate patient education on calcium and vitamin D supplementation, encouragement of weight-bearing exercise, smoking cessation, and decreased alcohol and caffeine intake.[90]

Thus this drug has been recommended for use inspite of all these inaccuracies presented. These contraceptives are most frequently used on women from developing countries coming from low-income groups with limited knowledge and understanding about the side-effects and even limited opportunities to take care of themselves. Women from low-income groups find it hard to have a nutritious square meal; in such cases recommendations such as supplements along with meals may well be quite like eating cake since they lack bread.

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[87] WHO/HRP.2005.*op cit*

[88] Kaunitz. Andrew.et.al.2009. *op cit*

[89] *ibid.*pp 16

[90] Scudder, Laurie.2008. *ibid*

In the case of implants, there are further issues of concern. One critical fact is that women are lost to follow up, because of the gap of five years from insertion to removal. Another concern is that the procedure for insertion and removal can be harmful to the woman. According to the *Population Report* [91] and Population Council[92]

> .....Implants are inserted on the inside of the upper arm or lower arm six to eight cm above or below the elbow. Special care must be taken during the insertion to place the implants just under the skin. If the implants are inserted too deeply locating and removing them can be difficult. Maintaining sterile techniques throughout the procedure is essential to prevent infection. Removing the implant is usually more difficult than inserting them. Problems can occur if the insertion was done improperly-that is if the implant was placed too deep. There have reports about nerve injury most commonly associated with deep placement and removal. If the clinician is unable to remove all the capsules at one time the woman should return at another time after her arm heals. Removing the remaining implants is easier when the arm is healed.

It has been observed that the cost of removal dissuaded women from going to the medical facilities. There have been cases in countries like America where these contraceptives were made available through Medicaid which is the government insurance. This also made the doctor reluctant to remove the contraceptive before the time period. This had become disadvantageous to poor and black women who were the recipients of these 'welfare' facilities. [93] Cases of women being denied removal of Norplant before the stipulated five years were also recorded in other countries. As a study by Ward et al[94] confirmed that in Indonesia women found it difficult to get their implants removed because of authorities' refusal. In Bangladesh women were informed that they had 'given their word' that they would not demand removal before five years.[95] In both places influential people like village heads and religious heads were roped in to 'counsel' women to accept implants for the duration of five years. In Egypt too, hospital staff showed reluctance to remove the implant before the completion of five years despite requests from women to do so.[96] Women also faced

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[91] Liskin,L, Blackburn, R., and Ghani, R. 1987. "Hormonal Contraception: New Long-acting Methods"; *Population Reports*, Series K, 3.

[92] Norplant – Available on www.popcouncil.org/what/norplant.asp -As Accessed on 10th October,2009

[93] From Norplant to Contraceptive Vaccine- As Available on-http://www.assatashakur.org/forum/afrikan-wholistic-health/16646-norplant-contraceptive-vaccine.html- As Accessed on 20th May,2010

[94]Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke.1993. *op cit*

[95] *ibid*

[96] *ibid*

inconvenience due to the presence of hormones in the body even after the implants were removed.

2.3.2- Contraindications

Contraindications to these drugs include diabetes mellitus; liver diseases, proven allergy to the substance in the drug, depression, blood-clotting problems, weight problems, pregnancy women, unexplained vaginal bleeding, breast cancer, or desires to become pregnant within 8-24 months.[97]

Before using these contraceptives women have to undergo a number of tests including, a complete body check-up, pelvic examination and breast examination to ascertain if these contraceptives are appropriate for them. It becomes very difficult to carry out these tests in many developing countries where the public health system remains in a dismal state and when the drug is being promoted through family planning programmes. In addition they require tests, from the simple test of blood pressure to laboratory examination of blood sugar to ascertain their suitability. Again these are not tests that are available in most resource poor settings where the contraceptive is being introduced.

Women using these contraceptive may have complications or may continue to believe in the effectiveness of these contraceptives even after the period of the injectable or implant has expired. Follow up of women; appropriate care and proper documentation are therefore necessary conditions to ensure good health of women using these contraceptives. Unfortunately these too are rarely followed in the health centres of developing countries. A study done in Thailand [98]showed that there was alarming misplacement of records and many women were lost to follow up. Proponents of these contraceptives however believe that this is another problem that can be solved through 'counselling'.

In order to promote use of injectables it was proposed that these contraceptives can be safely administered by paramedics if trained properly in community based programmes. These trainings would cover methods of communicating to people

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[97] Depo Provera /Norplant- Available on http://www.faqs.org/health/topics/51/Depo-Provera-Norplant.html: Accessed on 14th May,2010

[98]Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke. 1993. *op cit*

regarding side effects. [99] This represents medical double standards with quality of care issues being sidelined for Third World populations.

2.4- Efficacy

The population lobby promotes these contraceptives based on the argument that both injectables and implants have high efficacy levels of providing freedom from pregnancy. This claim is supported by low failure rates of these contraceptives. Annual pregnancy rate for Norplant is below or well below 1 per 100 each year of use, up to the end of 5 years.[100]Depo Provera has a pregnancy rate of 0.3 pregnancies per 100 women. But this effectiveness is based on 'typical use' that means in proper accordance with the set instructions without error. This depends on adherence to the injection schedule, timing and injection technique.[101] Injectables and implants are also considered efficient as they do not have to be taken regularly and women do not have control over these contraceptives. Women's health advocates have however observed that many women are lost to follow up or do not return for the next injection on time. Injections have to be taken intramuscularly and it is important that the area which is injected is not rubbed[102]as it will accelerate the process of absorption of the drug. It becomes very difficult to change existing 'injection culture' within developing countries where a particular technique of injecting is followed.[103]

Another argument by health advocates is that this inability to control the contraceptive makes the women dependent on the provider and does not allow her to exercise her own free will over her body. This also prevents women from deciding to quit the usage of the drug in case it results in side effects. This method of contraceptive provisioning becomes even more controversial when used in family

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[99] Community-Based Distribution (CBD) of DMPA: As Available on http://search.fhi.org/cgi-bin/MsmGo.exe?grab_id=108735485&extra_arg=&page_id=96&host_id=1&query=injectables&hiword=INJECTABLES+INJECTABLE+-As Accessed on 30th May,2010

[100] Olav Meirik, Ian S.Fraser and Catherine d'Arcangues1.2003. "Implantable contraceptives for Women";*Human Reproduction Update for the WHO Consultation on Implantable Contraceptives for Women*,9(1): pp. 49-59

[101] Satyamala, C.2000. *op cit*

[102] A WHO Family Planning Cornerstone, *A Global Handbook for Providers Evidence-based Guidance Developed through Worldwide Collab*oration .2007.*op cit*

[103] Forum for Women's Health.1995. "Contraceptives: Our Choices, Their Choices" in: Karkal, Malini.ed.1995. *Our Lives Our Health*. New Delhi, Coordination Unit, World Conference on Women, Beijing,Ch.8.

planning programmes or in population control programmes of developing countries where it becomes an easy instrument of coercion and control over women's bodies. When administered through the State it becomes an easy way of controlling women's fertility and through this controlling a particular State or community. Organisations such as the Population Council, UNFPA, USAID and FHI have promoted these contraceptives in developing countries and to ethnic minorities even before they got approval to be marketed officially. Depo Provera was used coercively in refugee camps in South East Asia, among black women in South Africa and black women in USA and Aboriginal women in New Zealand.[104] In the 1980s at Phoenix and Oklahoma City Indian Health Services, Depo-Provera was used on Native women with disabilities. The reason given was for "hygienic purposes" – or to stop the menstrual periods of patients with developmental disabilities. Raymond Jannett of Phoenix IHS commented that "Depo-Provera turns [Native women patients] back into their sweet, poor handicapped selves."[105]

In India there were efforts to introduce Net En into the family planning programme in the 80s. This met with resistance from women's groups. The government then discontinued the idea but subsequently trials have been undertaken in 2008.The summary report presented by the Indian government looks upon the contraceptive favourably.[106]Norplant was first introduced in Indonesia in 1981 and has since been the subject of several introductory studies and was accepted into the National Family Planning Programme in 1987. These are mostly based on the studies sanctioned by the Population Council.[107] In Bangladesh the trials began in 1985 but there were already plans to incorporate implants into the national programme. This acceptance was based on the WHO bulletin reports[108] which had mentioned the technical aspects of the

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[104] Gupta, A.J.2000.*op cit*

[105]Smith,Andrea. "Better Dead than Pregnant: The Colonization of Native Women's Reproductive Health." In Jael,Silliman and Bhattacharjee.Annaya (eds).2002.*Policing-The National Body: Race, Gender and Criminalisation*. London, Secker and Warburg.ch.5.pp 135

[106] Study on 2 Monthly Injectable Contraceptive Norethisterone Enanthate (200mg)- Available on http://www.mohfw.nic.in/dofw%20website/Final_Net-En_Report.pdf- As accessed on 15th December 2009

[107] Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke.1993.*op cit*

[108] Akhter, Farida.1995. *op cit*

contraceptive with no mention about the safety measures required for the implantation of this contraceptive especially in the real situation in Bangladesh.

A number of women's and health groups in developing countries have resisted this control of women's reproduction. Their concerns can be summarised by quoting the Declaration of People's Perspectives on "Population" Symposium between December 12 and 15 of 1993 in Comilla, Bangladesh[109] where it was asserted that

> ....that long-acting and provider-controlled contraceptive technologies developed by Population Control Establishments for women in the South where population controllers promote longer acting Injectable or implantable contraceptives leave women as little room as possible to resist contraception should they want to bear a child. A woman can "forget" to take the Pill but once Norplant is inside the body, she cannot remove it herself. These maximum control contraceptives manipulate women's hormonal and immune systems effecting in long-term changes in their bodies. Therefore, long-acting contraceptives like Norplant are not an advance in contraceptive technology but an advance in control. They are purposeful instruments inspirited by eugenicists whose programs of population control were designed explicitly to curtail the number of black, indigenous, disabled and poor white peoples.
> We note with special concern the situation of indigenous peoples in various countries who are subjected to coercive methods of fertility control in order to appropriate their land, their commons, their culture. Their traditional family planning and health practices are discarded in favour of modern technology and practices that result in their extermination. We are deeply concerned about the plight of people with disabilities who are often subjected to physical abuse and are being used for experimentation and implementation for contraceptive drugs and devices such as Depo-Provera and Norplant."

These contraceptives are being promoted under the garb of providing women with contraceptive 'choice'.

2.5- Ethics

Bhutta has argued that "if research is the 'brain' of the health system then ethics would constitute its 'conscience'.[110] Ethical concerns came into the forefront at the end of World War II when Nazi scientists and physicians were held guilty for the widespread atrocities and inhuman 'medical' experiments carried out in concentration camps. This led to the first international set of guidelines on ethics of medical research. The "Recommendations Guiding Physicians in Biomedical Research involving Human Subjects" was adopted in the 18th World Medical Assembly, Helsinki, Finland in 1964. The Helsinki Declaration, as it came to be called, has been amended over the years. There were 12 basic principles for the conduct of human

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[109] Akhter, Farida.1992. *Depopulating Bangladesh. Essays on the Politics of Fertility and Reproductive Rights*. Dhaka, Narigrantha Prabartana.

[110] Bhutta, Z.A.2002. "Ethics in International Health Research: A Perspective from the Developing World";*Bulletin of the World Health Organization* ,80 (2).pp.116

biomedical research. These principles were physician oriented and were not adequate to address the issue of research in developing countries. Then Council for International Organisations of Medical Sciences (CIOMS) in collaboration with WHO proposed guidelines for biomedical research involving human subjects. This was amended in 1993 as the "International Ethical Guidelines for International Research".[111] [112]

Research trials are conducted to prove the efficacy and safety of contraceptives for human use. Medical research is organised, sponsored, commissioned or subsidised by the pharmaceutical industry.[113] The onus of proving the safety and efficacy of the product is on the company or organisation producing it. Contraceptive research does not have high priority in the world's pharmaceutical industry.[114] Political, religious and ideological issues rather than strict scientific criteria and market potential heavily influence development of contraceptive products.[115] There are few products and few producers who control the market for contraceptives. Contraceptive research in developing countries is entirely donor driven and influenced by international politics. It has been argued that funder driven research in contraceptives has not shown sensitivity to ethical issues. The 80s and '90s have thrown up numerous instances of unethical contraceptive research of Depo-Provera and Norplant being conducted without observing ethical requirements like informed consent and the need to follow up participants.[116]

The CIOMS states: "All research involving human subjects should be conducted in accordance with three basic ethical principles, namely respect for persons, beneficence and justice."[117] All research is to have respect for persons and give prime

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[111] ibid

[112] Saheli.1998.*Target Practice:Anti Fertility Vaccine Research and Women's Health*, New Delhi, Saheli Women's Resource Centre.

[113] Gupta,Amit Sen. Research for Hire.2001.Available on http://www.issuesinmedicalethics.org/094di111.html: As accessed on 2nd May 2010

[114] Segal, S.J.1999. "Liability Concerns in Contraceptive Research and Development"; *International Journal of Gynecology & Obstetrics*, 67(2)

[115] *ibid*

[116] Gupta, Amit Sen.2001. *op cit*

[117] Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002. *International Ethical Guidelines for Biomedical Research Involving Human Subjects* , Geneva.pg 10

importance to the respect for autonomy and bodily integrity. This is especially the case involving vulnerable populations, ensuring security against harm or abuse to dependent or vulnerable populations with impaired or diminished autonomy. [118]

It is observed that trials of injectables and implants have targeted the most vulnerable population within developing countries and Blacks and Hispanics within the developed countries. In many cases women from slums were being targeted without their knowledge or consent. During the period between 1967-1978 one of largest test on humans of Depo-Provera began and was conducted for eleven years through the Grady Clinic in Atlanta, Georgis on 14,000 women. 50 per cent of the subjects in this experiment were Black, low-income, and rural women.[119] They were not told about the side effects associated with Depo-Provera and trials were conducted on many women without their knowledge or consent, violating FDA regulations. Several women got cancer and/or died during the trials, but these cases were not reported to the FDA as was required. The director of the study, Dr. Robert Hatcher, did not even send one legally required annual report during the entire study. Women with medically contraindicated conditions, such as cancer, were still given the shot. Record keeping on the clients was sloppy – over 13,000 women were lost to follow-up. In response to criticism, Dr.Hatcher stated that 'it did not have any detrimental impact on patients'.[120],[121]Norplant was first tested on Brazilian women in 1975 by the University of Bahia without completing the procedures for mandatory authorisation from the Ministry of Health which was a legal requirement.[122]

The second principle of ethical research is "beneficence". Beneficence is concerned with the "ethical obligation to maximize benefits and to minimize harms and it also deliberates against the infliction of harm on persons; this aspect of beneficence is

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[118] *ibid*

[119] Jael ,Silliman, Bhattacharjee.Annaya (eds).2002.*op cit.*

[120] *ibid.* pp 133

[121] http://www.cwpe.org/node/185?KeepThis=true&TB_iframe=true&height=700&width=900 as accessed on 15th January,2010

[122]Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke .1993.*op cit*

sometimes expressed as a separate principle, nonmaleficence (do no harm)"[123] This principle states that it is necessary to conduct research, ensuring maximum benefits from a research conducted with no harm or minimal harm to the patient. Depo Provera trials from the beginning have failed to comply with this principle.

When the results of animal trials of the Depo Provera were released they clearly indicated the carcinogenic effect of this contraceptive. Based on the results of these trials, the FDA did not sanction Depo Provera. However, in 1987, the WHO reviewed guidelines on research of hormonal contraceptives. A special meeting was called to reconsider the guidelines for research. It was argued her that the trials on beagle dogs did present an adequate picture of its effects on women. They also denounced the wastage of time on conducting trials on animals while proposing to hasten the process of these trials on women. Based on these arguments the WHO came up with two suggestions. It was observed that the contraceptives trials held failed to give an appropriate picture of the possible side effects of contraceptives. The second was about the unreliability of animal trials and the lack of surveillance on a large number of women. After the approval of Depo Provera for trials on women, these contraceptives have revealed, not unexpectedly, various long term harmful health effects on women.[124]

The third principle of research ethics explicitly states that "populations chosen should not be targeted from amongst the least vulnerable populations"[125] As we have seen, this has been violated more often than not. Norplant trials when initially conducted in 1981 choosing women coming to the health centres as subjects for trials based on misrepresented media advertisements.[126] There were efforts made by community workers to encourage women from slums who used Depo-Provera to be a part of the trials. These women were given materialistic incentives for being part of the trial. Vulnerable populations such as mentally challenged women were targeted. Indeed,

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[123] Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002.*op cit.*pg 11

[124] Forum for Women's Health.1995.*op.cit*

[125] Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002. *op cit.* pg 11

[126] UBINIG.1990. "Research Report Norplant, The Five Year Needle: An Investigation of the Norplant Trial in Bangladesh from the User's Perspective" ; *Reproductive and Genetic Engineering: Journal of International Feminist Analysis*.3 (3)

the infringement of the rights of these subjects was openly proposed by the organisations promoting these contraceptives. This is evident for example in the following statements made by proponents of the contraceptives: "these contraceptives should be used by 'subgroups' of the larger populations including poor women, women of colour and immigrants, "socially irresponsible" women such as drug addicts and the mentally retarded".[127] These contraceptives were considered of 'ideal advantage' or 'favoured by a sector of the population who need continuous motivation' or statement made was that 'even among the vast population of the United States you find subgroups of people who have the same problems as the Third World'.[128]These statements reflected the values of those in power towards their subjects which are against anything that is stated in the ethical guidelines. In all these trials statements insisted that women had consented to use these contraceptives.[129]

Guideline four of the CIOMS has put down directives for individual informed consent. This states that: "Informed consent is based on the principle that competent individuals are entitled to choose freely whether to participate in research. Informed consent protects the individual's freedom of choice and respects the individual's autonomy."[130] According to this, investigators should ensure that the prospective subject adequately understands the information provided to her. The investigator should give each one full opportunity to ask questions and should answer them honestly, promptly and completely. Guideline six of the same directive emphasises the obligation of the sponsors and investigators to: first, refrain from unjustified deception, undue influence, or intimidation. Second, seek consent only after ascertaining that the prospective subject has adequate understanding of the relevant facts and of the consequences of participation and has had sufficient opportunity to consider whether to participate. And third as a general rule, obtain from each prospective subject a signed form as evidence of informed consent — investigators

[127] Corea,Gena.1989, *op cit.*pp 197- 200

[128] *ibid.*pp.197

[129] *ibid*

[130] Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002. *op cit.* pp 20

should justify any exceptions to this general rule and obtain the approval of the ethical review committee.[131]

Trials of long acting hormonal contraceptives have been carried out on women in developing countries who are seen as 'easy targets'. It was observed in a case report of a training session of Thailand that women using Norplant had been given no or minimal information about it. This training was held in 1986 where 101 women received Norplant free of charge over a period of one month. Most insertions were done on one day of December when over sixty women were brought in a truck resulting in a nurse referring to it as 'a big party'. These women had got most of their information from the media (mis)representations or from pamphlets which had inadequate information.[132]

This raises further questions raised about informed consent, namely the conditions under which consent is sought and provided. How will consent be taken from women who are attending overcrowded public health facilities? Is there time to explain and make certain that the woman understands what is being said to her? Are there enough personnel to do this? Do they have privacy and training to obtain informed consent? Another important factor that has been noticed is that nurses and other paramedic staff administering the injectables and implant sometime lack the information about the side effects. Thus women from whom informed consent is being sought often have only partial, and favourable, information. In the case of 'camp approach' used in certain family planning programmes where these injectables are administered to large numbers, informed consent becomes a mere formality.

In documents[133,134] produced by organisations that are proponents of injectables and implants, much emphasis is placed on informed consent. These documents give detailed description of the place where the counselling should take place; importance to privacy and the amount of time spend on counselling. The 'consent' problem raised by feminists have been co opted by these documents. By addressing the consent issue

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[131] Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002. *op cit*

[132] Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke.1993.*op cit*

[133] *Family Planning: A Global Handbook for Providers Evidence-Based Guidance Developed through Worldwide Collaboration* .2007.*op cit*

[134]Solter,Cathy.1999. *op cit*

these documents acknowledge the struggles of the women's groups. But there are problems that still need to be addressed regarding consent; merely giving lip service will not benefit the users. Co option of the language does not mean that it materialises into action. The fact about consent - like other aspects of contraceptives - is that reality on the field is vastly different from what is thought of in the laboratory. They differ from country to country, and from setting to setting. These differences in settings and in cultures are not addressed in the documents.

A formal Ethical Review Committee, while eminently desirable, also fails to ensure safety in these trials. On the contrary, it has been argued that external funding places such committees are under pressure to approve or conduct trails that have been approved in the funding countries. Financial incentives to researchers and institutions may be sufficiently powerful to shape the research agendas in the developing world.[135] Promoting of these contraceptives obtains legitimacy in many countries if they get approved by the FDA in the USA. It was noticed that approval of the sales of long acting contraceptives by the FDA increased its sales the world over, especially in Third World countries although FDA approval was for the US population.

2.6- Legality and Long Acting Contraceptives

Legal measures have become a tool of confronting the strong lobby promoting these contraceptives. In India, a case was filed by the Stree Shakti Sanghatana, Saheli, Chingaria and several individuals through a writ petition in the Supreme Court of India in 1986 asking for a stay on the Phase IV clinical trials of the injectable contraceptive Net-En. The petitioners, women's groups from different cities, argued that the earlier trials had flaws such as lack of informed consent. They also argued that in view of hazardous nature of the drugs and the unsuitability of hormonal long-acting contraceptive for the ill-equipped health delivery system, the drugs could not be introduced into the family planning programme.[136] This resulted in the contraceptives not being incorporated into the National Family Planning Programme. With the support of health advocates and lawyers groups, women who had

[135] London, Leslie.2002. "Ethical Oversight of Public Health Research: Can Rules and IRBs Make a Difference in Developing Countries?"; *Health Policy and Ethics Forum*,92(7)

[136] Bal, Vineeta, Laxmi Murthy, Vani Subramanian.2000. *op cit.*

experienced severe side effects with Norplant have filed several cases in many countries.[137] Cases against DMPA had been filed stating that it caused reduced BMD[138]and in 2004 Pfizer inserted a new label on Depo Provera advising that it caused osteoporosis - permanent bone mineral density loss.[139] But there are loop holes to all systems, including the judicial. Long acting contraceptives were used as a tool to inflict punishment against Black women. In the case of a Black woman, Darlene Johnson, a 27 year pregnant mother of four, convicted of child abuse, the California judge ordered that Norplant should be implanted in her body as a part of four-year probation besides a year in jail. Due to such legal interventions, in many states in the USA, women on welfare, with either a criminal record or a record of substance abuse or child neglect, must have a Norplant implanted in order to be eligible for welfare. Thus the vast majority of women subjected to Norplant are Afro-Americans or Hispanics. This exploitative nature of the judiciary is something that National Women's Health Network and Women of Colour groups had warned against.[140]

Long-acting Contraceptives which have been in the midst of debates for issues of safety, ethics and efficiency, still continue to be used indiscriminately on Third World women and Blacks. There were contraceptive that was use control and with the ability to prevent conception after intercourse available, but they were kept under wraps because of opposition from the religious and anti-choice groups. They were only made public recently when their potential to be used as tool for limiting population was understood by the population establishment under the guise of 'control over one's body'. The next chapter examines this claim while understanding debates around emergency contraceptives.

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[137] Contraceptive Research, Introduction, and Use: Lessons From Norplant.1998.http://www.nap.edu/openbook.php?record_id=5946&page=108 as accessed on January 20th,2010

[138] Depo Provera Osteoporosis and Depo Provera Bone Mass Density Loss- Available on http://www.monheit.com/depo-provera/index.asp - As accessed on January 20th,2010

[139] Depo Provera Attorneys- Available on-http://anattorneyforyou.com/legal/depo-provera.htm -As accessed on January 25th,2010

[140] Srinivas, K Ravi.; Kanakamala, K .1992. "Introducing Norplant: Politics of Coercion"; *Economic and Political Weekly*, 27(29): 1531-1533.

CHAPTER THREE

THE 'EMERGENCY' OF EMERGENCY CONTRACEPTION

There have been controversies around Emergency Contraceptives ever since they were introduced. These have centred around health and social consequences, along with efforts by religious and other fundamentalist groups to have them banned claiming they contribute to promiscuity. Advocates and opponents continue to debate the issue of where to place emergency contraceptive (EC) pills in the basket of fertility control. Debates around EC have been related to reducing the risk of an unintended pregnancy to giving women a right to control over her sexuality. A number of actors and stakeholder like advocacy groups, women's groups; religious institutions and professional associations lobby both for and against increased availability of EC, including legislative actions from both sides.[1]

3.1- Emergency Contraception: An Introduction

Emergency contraception is the use of a contraceptive method after an act of unprotected sex.[2] There are three methods which are currently available to be used as EC: one, an EC pill approved specifically for emergency contraception; two, high doses of commonly available birth control pills that contain synthetic estrogen and progesterone; and three, insertion of a Copper T IUD.[3] These contraceptives are intended for 'emergencies' which include after sexual intercourse without the use of contraception, failure of regular contraceptive method, when a condom breaks or slips, a daily oral contraceptive is missed, or for sexually assaulted women.[4] This chapter reviews EC pills which are commercially available in the market.

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[1] Sherman, Christy. 2005. " Emergency Contraception: The Politics of Post-Coital Contraception"; *Journal of Social Issues,* 61(1): 139-157

[2] Brunton, Jennifer and Margaret.Beal.2006. "Current Issues in Emergency Contraception: An Overview for Providers"; *Journal of Midwifery & Women's Health*, 51(6).

[3]The Facts About Emergency Contraception-Available on ://www.arhp.org/publications-and-resources/clinical-fact-sheets/facts-about-ec Accessed on 10th January,2010

[4] Parke.Chris.2005. "Adolescents and Emergency Contraceptive Pills in Developing Countries"; *Family Health International*, WP05–0.

3.1.1- History

The idea that higher dose of sex hormones can prevent pregnancy when used after intercourse has been known for the last forty years. However, availability of these contraceptives and information regarding them has been limited. Until recently, emergency contraceptives were not encouraged or publicly discussed as an option to prevent unintended pregnancy. They were called the 'best kept secret' for decades because pre- September 1998, no dedicated emergency contraceptive pills product had been approved, labelled, and marketed. Emergency hormonal contraception was available only through "off-label" use of oral contraceptive pills. Despite decades of use of EC pills around the world, the off-label status of these pills was of concern to some providers in the U.S. They were wary of legal liability in the event of manufacture of what they saw as a product of limited profit potential.[5]

There are two types of EC pills, one with a combination of estrogen and progesterone and the other, progesterone -only contraceptive pill.

High doses of steroidal contraceptives were first used as emergency contraception in the 1960s and reported throughout the 1970s.[6] In 1966, Morris and Van Wagenen demonstrated that large doses of estrogen were effective in preventing pregnancy after unprotected intercourse, and this treatment was used for pregnancy prevention in instances of rape. High rates of gastrointestinal side effects limited the widespread use of this method. Kesseru et al in 1973, proposed the use of levonorgestrel alone as a post-coital pill, to be taken after every sexual intercourse during the cycle, a method through which the task of taking a daily pill could be avoided.[7] This method failed to get any notice as the effectiveness of this method was much lower than that of the combined pill.

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[5]A Brief History of Contraception-Available on http://www.plannedparenthoodnj.org/library/topic/emergency_contraception/brief_history_of_ec: As accessed on 25th April,2010

[6] Schiappacasse, V, S. Diaz .2006. "Fulfilling Women's Reproductive Intentions Access to Emergency Contraception";*International Journal of Gynaecology and Obstetrics*,94: 301—309

[7] Kesseru E, Larranaga A, Parada J. 1973. " Postcoital Contraception with dl-norgestrel"; *Contraception;*7:367.

By 1974 doctors in Canada had confirmed that if a woman took two tablets of a birth control pill Ovral, within 72 hours of having sex, and two more pills 12 hours later, her chances of becoming pregnant would be safely reduced and most would not become pregnant.[8] In 1977 Dr. Albert Yuzpe, a Canadian scientist, published his study on the use of combined oral contraceptive pills for post-coital contraception, and this method became the new standard. The addition of progestin allowed for a smaller dose of estrogen; this reduced side effects without compromising efficacy. This came to be known as the Yuzpe regime.[9]

The first country to register a product specifically for emergency contraception was UK, in 1984.[10] However, the availability of this contraceptive method was limited in many countries until the 1990s.[11] In 1992, two important articles by James Trussell and Felicia Stewart coined the term "emergency contraceptive pills". These articles laid out the theoretical and scientific data on emergency contraception and argued that making EC widely available in the US could greatly reduce the number of unintended pregnancies and abortions.[12] In an attempt to bring emergency contraceptive pills into the market, in 1994 Centre for Reproductive Law and Policy (CRLP) filed a citizen petition with FDA on behalf of a coalition of leading medical and public health groups, including Planned Parenthood. The petition asked FDA to require that manufacturers include information about EC use in the product packaging of certain formulations of birth control pills.[13]In 1995 a meeting was held at Rockefeller Foundation conference centre in Bellagio, Italy, hosted by South-to-South Cooperation in Reproductive Health and co-sponsored by IPPF, FHI, The Population Council and WHO. At this meeting, 24 experts from different fields came together to

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[8] Coeytaux, Francine and Barbara Pillsbury.2001. "Bringing Emergency Contraception to American Women: The History and Remaining Challenges"; *Women's Health Issues*,11(2)

[9]Brunton, Jennifer and Margaret.W.Beal.2006. *op cit*

[10] Schiappacasse, V, S. Diaz .2006. *op cit*

[11] *ibid*

[12] Coeytaux,Francine and Barbara. Pillsbury 2001. *op cit*

[13]A Brief History of Contraception-Available on http://www.plannedparenthoodnj.org/library/topic/emergency_contraception/brief_history_of_ec: As accessed on 25th April,2010

discuss emergency contraception.[14] This conference was supported by Rockefeller Foundation.[15] Subsequently, seven agencies The Concept Foundation, the IPPF, the Pacific Institute for Women's Health, Pathfinder International, PATH, the Population Council, and WHO/HRP came together to form the Consortium for Emergency Contraception with the objective of bringing the 'second chance' contraceptive into the mainstream reproductive health arena worldwide. This initiative concentrated mostly on the developing countries.[16] The consortium was formed in a situation where there were no dedicated products for emergency contraception. Concept Foundation on behalf of the Consortium, signed an agreement with Gedeon Richter, to produce a new product, Postinor-2. Consortium provided input into labelling and packaging; the agreement included provisions for preferential public-sector pricing. Since its launch Postinor-2 has been registered in 42 countries till the year 2006.[17]

The American College of Obstetricians and Gynaecologists in 1996 published a "practice pattern" defining and promoting emergency contraception. In February 1997, the FDA issued a Federal Register notice declaring six brands of oral contraceptives to be safe and effective for emergency contraception and publishing the dosage to be used.[18] The WHO in 1998 established through a multi centre comparative study that levonorgestrel (0.75 mg given twice) was the gold standard in hormonal emergency contraception with higher efficacy and lower incidence of side effects than the Yuzpe regimen.[19] The FDA approved Preven, the first dedicated EC product in 1998.[20] France became the first country in the world to distribute a

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[14]South- East Asia Advisory Committee on Health Research Twenty- First Session- Available on http://repository.searo.who.int/bitstream/123456789/5544/2/sea_achr_21_inf.18.Pdf: As accessed on- 21st April,2010

[15] WHO Consensus Statement on Emergency Contraception. 1995.*Contraception*,52:211-213.

[16] Our Beginnings –Available on-http://www.cecinfo.org/about/history.htm-As Accessed on 1st January,2010

[17] *ibid*

[18] Coeytaux, Francine and Barbara.2001. *op cit*

[19] Tirelli, Alessandra Angelo Cagnacci and Annibale Volpe.2008. "Levonorgestrel Administration in Emergency Contraception: Bleeding Pattern and Pituitary-ovarian Function"; *Contraception*,77:328–332.

[20] EC in the News- Available on http://ec.princeton.edu/news/index.html-As Accessed on 15th February,2010

dedicated product in pharmacies without prescription or parental consent.[21] Levonorgestrel (0.75 mg, pack of two) was officially added to the WHO Model List of Essential Drugs, 11th edition, 1999.[22] By 2005, 109 countries had registered around 50 dedicated products that are available in public services, pharmacies, NGOs or through social marketing and 45 countries included emergency contraceptives in their national norms. The FDA in 2006 approved behind-the-counter sales for dedicated emergency contraceptive Plan B—1.5 mg of levonorgestrel after a long and contentious regulatory process for non-prescription sale to men and women 18 and older; younger women still required a prescription to purchase it, and younger men could not buy the contraceptive at all. A one-pill version Plan B One-Step was approved in 2009, and a generic version of Plan B (Next Choice) was also approved in 2009.[23] By 2006, EC pills were sold in pharmacies without the requirement of a medical prescription or by a collaborative drug therapy agreement (behind the counter) in 35 countries and in only 6 countries are they sold over the counter (Bangladesh, India, New Zealand, Norway, Senegal and Sweden).[24]

3.1.2- Clinical Pharmacology

Described in the scientific literature as "post-coital contraception" or "the Yuzpe method," this came to be known colloquially as the [25] "morning-after pill".[i] The Yuzpe regimen has been used as an 'off-label treatment' for emergency contraception. Although newer treatment regimens have been developed, the Yuzpe regimen is still used today.[26] It used four tablets of the standard contraceptive pill, which contains 250 mcg of levonorgestrel and 50 mcg of ethinyl estradiol. There is a two-dose treatment with combined EC pills to prevent pregnancy after unprotected intercourse;

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[21] Contraception Pill Strictures Are Eased by a Judge.2009. Available on ://www.nytimes.com/2009/03/24/health/24pill.html?_r=2&scp=2&sq=plan%20b&st=cse-As accessed on 2nd April,2010

[22]EC in the News- Available on http://ec.princeton.edu/news/index.html-As accessed on 15th February,2010

[23] Trussell, James, Elizabeth G. Raymond, 2010. "Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy" –Available on http://ec.princeton.edu/questions/ec-review.pdf :As accessed on 5th April,2010

[24] Schiappacasse, V and S. Diaz .2006. *op cit*

[25] Coeytaux, ,Francine and Barbara.2001. *op cit*

[26] Brunton, Jennifer and Margaret.W.Beal.2006. *op cit*

the first dose is to be taken as soon as possible and the second dose is taken 12 hours after the first.[27] Single dose treatments with Levonorgestrel are also available given in single 1.5 mg dose, to be taken either soon after or within 72 hours of unprotected sexual intercourse. It can reduce the risk of pregnancy by 75 per cent to 89 per cent if used immediately after the act.[28] Delaying the first dose by 12 hours increases the odds of pregnancy by almost 50 per cent, and its efficacy diminishes linearly with time. Much of the activity is gone by 72 hours, although there is some residual activity with delays in use of up to 120 hours.[29]

The mode of action of the EC pills in the body is not predictable. It is observed that the mechanism of action and effectiveness varies with the phase in the menstrual cycle when administered. EC pills act to prevent pregnancy in one of three ways: (a) delaying ovulation, (b) preventing fertilization, and (c) preventing implantation of a fertilized egg. The prevention of implantation is not the primary mode of action, indicating the regimen may work more like a traditional contraceptive.[30] [31] This is important in view of the criticisms that EC is an abortificient, which it clearly is not.

It is probably most effective in the follicular phase, when it interferes with the ovulatory process by inhibiting the LH surge.[32] There are histological or biochemical alterations in the endometrium after treatment with the regimen, leading to the conclusion that combined EC pills may act by impairing endometrial receptivity to implantation of a fertilized egg. EC works by inhibiting or delaying an egg from being released from the ovary when taken before ovulation. There is also the possibility that

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[27]Fau´ ndes, Ani´bal.et.al.2007"Emergency Contraception under Attack in Latin America: Response of the Medical Establishment and Civil Society";*Reproductive Health Matters*;15(29):130–138

[28] S O G C- Clinical Practice Guidelines.2003.Emergency Contraception, 131.

[29] EC in the News- Available on http://ec.princeton.edu/news/index.html-As accessed on 15th February,2010

[30] Sherman A, Christy. 2005. *Op cit*

[31] Davidoff ,Frank and James Trussell.2006. "Plan B and the Politics of Doubt"; *Journal of American Medical Association,*296 (14):1775-1778

[32]Ghosh, Bhaswat.et.al 2009. "Ectopic Pregnancy Following Levonorgestrel Emergency Contraception: A Case Report"; *Contraception, 79*:155–157.

it prevents the sperm and the egg from meeting by affecting the cervical mucus or the ability of sperm to bind to the egg.[33]

3.1.3- Side effects of emergency contraceptives include nausea and vomiting, delay in menses, irregular vaginal bleeding, abdominal pain, breast tenderness, headache, dizziness, and fatigue. Cycle disturbances like dysmenorrhoea, intermenstrual bleeding[34] and cycle length modifications are common side effects. After taking EC, a woman's next menstrual cycle may start earlier or later than expected and the menstrual flow may be lighter or heavier than usual. Most women will start their next period within seven days of the expected date.[35] There have been no teratogenic risks found with pregnancies that occur while women are taking high dose birth control pills. Pregnancies that occur do not need to be terminated just because EC was used.[36] There are few studies to understand the contraindications that may occur due to repeated use[37]

There is continuing controversy about the possibility of ectopic pregnancy in the use of EC with levonorgestrel in the peri and post-ovulatory phase. Progestin may possibly affect tubal function although peri and post-ovulatory administration of levonorgestrel does not seem to impair corpus luteum function or endometrial morphology. There is a possibility that high levels of progesterone may cause ciliary dysfunction and subsequently be the cause of an ectopic pregnancy. The administration or use of progestin-only pill lowers the absolute rate of ectopic pregnancy; however, if pregnancy does occur, the chance that it will be ectopic is

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[33]Safety of Levonorgestrel-Alone Emergency Contraceptive Pills-Available onhttp://www.who.int/reproductivehealth/topics/family_planning/ec/en/ As Accessed on 21st March 2010

[34]Tirelli, Alessandra Angelo Cagnacci and Annibale Volpe.2008. "Levonorgestrel Administration in Emergency Contraception: Bleeding Pattern and Pituitary-Ovarian Function"; *Contraception*,77:328–332

[35]Emergency Contraception-Available on http://www.nlm.nih.gov/medlineplus/ency/article/007014.htm As accessed on 25th March,2010

[36] *ibid*

[37] International Consortium for Emergency Contraception.2003.*Repeated Use of Emergency Contraception: The Facts* (Policy Statement.), New York.

threefold higher than for pregnancies occurring while using no contraceptive method.[38]

A big question still concerns the number of doses that can be taken by a female during one menstrual cycle. But it is the not side effects that have been the cause of controversy with EC.

3.2- Emergency Contraception: Definition of Life and its Politics

EC has been politicised based on the understanding of its mode of action, whether it acts to prevent the implantation of a fertilised egg. One of the most debated issues has been that EC functions as an abortificient. These voices of dissent have been especially strong from the Catholic Church and the anti-choice movement who do not believe in abortion as women rights but believe in the right of the unborn foetus to life.

Anti-choice groups such as the American Association of Pro-Life Obstetricians and Gynecologists have argued that the pill could cause abortions, using a definition of "pregnancy" that includes a non-implanted fertilized egg. The anti-choice group called Concerned Women for America states:

> ....."For a woman to become pregnant, a series of events must happen over a period of about a week and a half, including: 1) she must ovulate 2) her egg must be fertilized by male sperm, and 3) the fertilized egg must implant itself into the lining of her uterus."
>
> However, that third requirement, implantation in the uterus, is more a political construct than a scientific qualification. Embryologists have long believed that a pregnancy begins at fertilization, rather than implantation in the uterus. After fertilization, the tiny human being has all his or her genetic information. To address the myth that the "product of fertilization" is not a real human being, philosopher and biologist Dianne Irving wrote:
>
> Scientifically, there is absolutely no question whatsoever that the immediate product of fertilization is a newly existing human being. A human zygote is a human being. It is not a "potential" or a "possible" human being. It's an actual human being—with the potential to grow bigger and develop its capacities.
>
> Long before implantation, there is a real human being living inside the mother's body.[39]

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[38]Sheffer-Mimouni, Galit et.al.2003."Ectopic Pregnancies Following Emergency Levonorgestrel Contraception";*Contraception,* 67 :267–269

[39] Contraception or Deception? .2006-As Available on http://www.cwfa.org/articledisplay.asp?id=1559&department=CWA&categoryid=life As accessed on 5th April 2010

These arguments were also presented during debate over the counter approval hearing of Plan B.[40] They have strongly opposed the scientific definition of when life begins.

Conservative politicians and fundamentalist opinion leaders have opposed the introduction of EC in many countries, particularly in Latin America. There were lawsuits filed against regulatory bodies or the Ministries of Health by anti- choice groups in Chile, Peru, Colombia, Mexico, Ecuador, Argentina and Brazil, based on the argument that the Constitution of these countries protects human life from the moment of fertilization of an egg. In many other countries, like in UK for example, over the counter sales were challenged in the court of law. [41],[42] People have rigorously opposed the use and publicising of EC pills. The scientific definition around which life begins has ostensible been the basis of the opposition and support by these different groups.

Supporters of emergency contraception argue that according to definitions endorsed by the federal government of the USA and a number of medical organizations such as FDA/National Institutes of Health and ACOG, "life begins when a fertilized egg implants in the uterine lining".[43] [44] In 2002, a Judicial Review ruled that pregnancy begins at implantation, *not* at fertilisation, thus emergency contraceptive is not considered an abortificient.[45] In 2004, a review of the scientific literature by experts at the Karolinska Institute in Stockholm concluded that the contraceptive effects of a one-time dose of levonorgestrel, the active ingredient in Plan B, "involve either blockade or delay of ovulation .rather than inhibition of implantation."[46]Later in the

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[40] New Emergency Contraception Drug Stirs Old Arguments: Available on http://www.ourbodiesourblog.org/blog/2010/02/new-emergency-contraception-drug-stirs-old-arguments:As accessed on 29th March 2010

[41] Fau´ ndes, Ani´bal.et.al.2007. *op cit*

[42] V. Schiappacasse and S. Diaz.2006. *op cit*

[43] Pruitta L,Sandi and Patricia Dolan Mullen.2005. "Contraception or Abortion? Inaccurate Descriptions of Emergency Contraception in Newspaper Articles 1992–2002";*Contraception*;71 :14–21.pp-15

[44]Trussell, James, Elizabeth G. Raymond, 2010. *op cit*

[45] As cited in FFPRHC Guidance.2006.Emergency Contraception; *Journal of Family Planning and Reproductive Health Care,* 32(2): 121–128

[46] Ackerman, Todd.2006. "Emergency Contraception Science and Religion collide"; *Annals of Emergency Medicine*; 47(2).pp 154

year, the Chilean Institute for Reproductive Medicine reported that the drug interfered with ovulation 82 per cent of the time in women who took it.[47] Blood tests on those women showed that the drug suppressed the monthly surge of LH, which triggers ovulation. Studies in rats and capuchin monkeys show that levonorgestrel, given after fertilization, does not prevent pregnancy and that, when given before ovulation, it interferes with the ovulatory process. This study showed that levonorgestrel EC is very effective in preventing pregnancy when it is administered before ovulation, but is ineffective in preventing pregnancy once fertilization has occurred. [48] Thus it could be established that main mechanism of action is interference with the ovulatory process.[49]

Although it has been established that life does not begin at conception and also that emergency contraception cannot be considered an abortificient, fundamental groups and right wing groups continue to oppose the emergency contraception based no scientific and medical rationale pseudo or junk science i.e. science which breaks all the rules of science in order to pursue a political agenda.[50]They have skilfully used semantics such as Fetal Parenthood Pro-life and Right-to-life which immediately implies that the 'opposition' is 'anti-life'. Here the right to life is only relevant to the fetal while women's life and her rights are considered inconsequential. [51]

3.3- Politics, Religion and Conscience Laws

Abortion has always been a strong political, arousing fierce opinions, all over the globe. But ever since the Roe vs. Wade judgement in 1973, it has galvanised the Rights movement in the USA, bringing together with Catholics and Protestant

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[47] *ibid*

48 Noé Gabriela et.al.2010. "Contraceptive Efficacy of Emergency Contraception with Levonorgestrel given before or after Ovulation"; *Contraception,* 81(5):414-420

[49] Fau´ndes, A, V.Brache, F.Alvar ezb.2003. ''Emergency Contraception—Clinical and Ethical Aspects''; *International Journal of Gynecology and Obstetrics* ;82: 297–305

[50] Fried, Marlene.2006. "The Politics of Abortion : A Note";*Indian Journal of Gender Studies*;13: 229

[51] The Paradoxical Right to Life- As Available on http://gadfly.igc.org/liberal/abortion.htm- As Accessed on 13th, July 2010

fundamentalists. It is this coalition that has vociferously opposed EC on the grounds that it is an abortificient. The problem of course with this coalition is not that no debate is possible, nor is it possible for them to respect science. Indeed, these very groups have taken credit for the murder of doctors performing abortions. Nationwide bills were introduced to limit the availability of EC. Some forms of refusal law or conscience law were also put in place.[52ii]

Conscience clause laws allow medical providers to refuse services to which they have religious or moral objections. Initially, these laws were focussed on allowing doctors to refuse to perform abortion if they had moral objections. But the scope of the law was widened to allow not only providers and staff to refuse their participation, but institutions and employer-paid health plans as well. Passed in 1973, the Church Amendment was the first conscience clause enacted into law. This was in response to the Supreme Court's decision to permit legal abortion in the Roe vs. Wade judgement the same year. This amendment passed by the Congress states that "public officials may not require individuals or entities who receive certain public funds to perform abortion or sterilization procedures or to make facilities or personnel available for the performance of such procedures if such performance would be contrary to [the individual or entity's] religious beliefs or moral convictions."[53] In 1997 this was also extended to managed care providers such as Medicare and Medicaid who could refuse to pay for counselling services provided for abortion related services.[54]

The Bush Administration on December 18, 2008 through a regulation finalised and implemented three Federal Health Care Conscience Protection laws i.e. the Weldon Amendment (2004).[iii] The Public Health Service Act Section 245 (1996)[iv] and the Church Amendment (at various times in 1973).[v]

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[52] Griffin,Leslie.2006.Conscience and Emergency Contraception; *Houston Journal of Health,Law & Policy*, 6(299).

[53] From Right-Wing to Pro-Choice: The Shifting Goalposts of "Abortion Neutrality" .2009. Available on http://www.religiondispatches.org/archive/politics/2088/from_right-wing_to_pro-choice:_the_shifting_goalposts_of_%E2%80%9Cabortion_neutrality%E2%80%9D_-As accessed on 12th April,2010

[54] White,Katherine Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights.Available on-http://www.questia.com/googleScholar.qst;jsessionid=MGgBGjZGdTFp5nrKPVk5vt7fnYwGZGr1j3WRSBhGCc5ppqm38hJG!-1212072275!-1754635462?docId=5001276118-As Accessed on 2nd May,2010

These conscience laws were supported by the Catholic Church as well as the anti-choice organisations. Studies undertaken have proved that exercising the conscientious law is harmful to women and violates the rights of the patients. They also have spelt out duties of pharmacy licensees to dispense prescription medications that satisfied health needs of the population they served and that this obligation could override claims of conscience.[55] Organizations, such as the Victorian Human Rights Commission (Australia) believe that competing rights and responsibilities need to be balanced. A person's freedom of belief can be compromised if it infringes on the health and safety of another individual. A doctor's right to freedom of conscience must be balanced against the legal rights of patients wishing to make free and informed choices. Sometimes limits on human rights are necessary in a free and democratic society that respects the dignity of each individual.[56] The International Federation of Gynaecology and Obstetrics Committee for the Ethical Aspects of Human Reproduction and Women's Health similarly recognized the duty of practitioners "to inform their patients of all medically indicated options for their care, including options in which the practitioners decline to participate."[57]

The Roman Catholic Church has been the strongest religious opponent of EC being available and accessible in the market worldwide. The Church has always had anxieties about women's sexualities and morality. Church doctrines, ever since Eve, have been concerned with the evils of sexuality, especially female sexuality, with the sexual woman being seen as a source of danger.[58] Contraception has always been discussed in the background of this fear of women losing her morality and breaking the connection between sex and pregnancy. This would lead to a society where unregulated sexual activity would be common. To control women's sexuality and her behaviour it was thought necessary to have a medical control over her access to

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[55] Mcleod, Carolyn.2010. "Harm or Mere Inconvenience? Denying Women Emergency Contraception";*Hypatia*; 25(1)

[56] Weisberg,Edith and Ian S. 2009. "Fertility Regulation Rights to Emergency Contraception";*International Journal of Gynaecology and Obstetrics*;106:160–163

[57] G.I. Serour.2006. "Ethical Guidelines on Conscientious Objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health";*International Journal of Gynecology & Obstetrics*;92(3)

[58] Barrett, Geraldine and Rosalyn Harper.2000. "Health Professionals' Attitudes to the Deregulation of Emergency Contraception (or the problem of female sexuality)"; *Sociology of Health & Illness*, 22(2)

contraception. Although, contraception became highly medicalised it was always under the scrutiny of the religious institutions.

The Vatican, along with other religious fundamentalists, was opposed to the rights-based framework adopted in ICPD (1994) and the Beijing conference (1995) where it was reiterated that women have the right to control their sexuality. Emergency contraception was opposed because it was believed to lead to uncontrolled and immoral sexual behaviour. It was looked upon as an evil because it allows woman to control her sexuality after the act of sex which, according to the Catholic Church, should only be an act of reproduction. This was equated with abortion of the unborn and thus condemned.[59] In the USA since the eighties, politics has always been influenced by the religious Right. Since the time of President Ronald Reagan (1980) these groups have had a direct influence on politicians in the executive branch, legislative and justice systems. These groups have drafted bills, supported juridical claims of unconstitutionality and executive orders to reduce or eliminate access to emergency contraception.[60] In the USA atleast, the influence of the Vatican pales in comparison to these groups. Yet the Vatican on its part was very vigilant at ICPD+5 when there was a move to introduce the expression "emergency contraception" believing that it was a move to introduce an abortion pill under the pretext of a post-coital pill. The Holy See, with the support of Argentina, Nicaragua and some other countries managed not to have this expression approved. [61]

The Catholic Church called for Church- based hospitals to refrain from offering EC to clients, including rape victims. They made efforts to repeatedly stall a decision on the over-the-counter availability of Plan B, the brand name for the most common form of EC in the USA. But the advisory committee of FDA passed EC with an overwhelming majority (28–0 and 23–4) stating that Plan B was safe for use in a non-prescription setting and should be granted over –the- counter status for all women in December 2003. In spite of this, FDA did not provide over- the- counter status to Plan

[59] ibid

[60] Fau' ndes, Ani'bal.et.al.2007. *op cit.*

[61] H. E. Mons. Jean-Louis Tauran.2000.The Defence of life in the context of International Policies and Norms..Available on- http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20000211_tauran-acdlife_en.html: As accessed on 11th February,2010

B stating that there was inadequate data proving that EC could be used safely by young adolescents in the absence of professional supervision. Dr. Galson the Acting Director for the Centre for Drug Evaluation and Research (CDER), of FDA reasoned that it is "very difficult to extrapolate data on behaviour from older ages to younger ages" because of the diminished capacity of adolescents to make rational decisions and the "large developmental differences" between early- and mid-adolescence. This conclusion was in contradiction to the FDA's long history of extrapolating data for other contraceptives, including prescription oral contraceptives.[62] This move of FDA was criticised by the committee members, civil society organisations various politicians and women's groups.

In August 2005 one of the woman committee members Dr. Wood, Assistant Commissioner and Director of the FDA Office of Women's Health, resigned from her position in protest against the FDA move to delay the process of granting permission for over- the- counter sales of EC. In her statement she said:

> ....Sadly, your recent decision to not approve Plan B emergency contraception, overturning the clear scientific and clinical evidence, contradicts both the FDA mission and my commitment to women's health. The rationale offered is not convincing, and is in fact a denial of access to a product clearly established as safe and effective for all women who need it."[63]

This opposition by the anti-choice groups and the FDA was supported by the Bush *fils* administration. This administration after being elected in 2000 brought back the Mexico policy or the 'golden gag rule' of Ronald Reagan who openly denounced abortion and contraceptive services for the people. Funding to organisations providing these services was greatly altered and cut. They encouraged states, pharmacist and other health care providers, institutions, and insurers to refuse to offer or cover contraceptive services.[64]

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[62] United States District Court Eastern District of New York, Case 1:05-cv-00366-ERK-VVP ,Document 282 Filed 03/23/2009 .pp.13

[63] *ibid.*pp 24

[64] Kulczycki, Andrzej.2007. "Ethics, Ideology, and Reproductive Health Policy in the United States"; *Studies in Family Planning,* 38 (4).

Schools were asked to include family life education which talked about abstinence-till-marriage rather than provide counselling and information regarding contraceptive services. Grants to schools were cut if family life education was not provided. Aid to organisations that provided contraceptives to underdeveloped and developing countries was also cut if these countries/organisations included abortion in their package of reproductive health services. Indeed policy over this period also discouraged provision of condoms in the HIV/AIDS programme arguing that abstinence alone was advisable as policy and not safe sex.[65]Thus, the anti-choice groups and government policy resulted in less access to contraceptive services around the world. This acutely contributed to the HIV/AIDS epidemic in Sub Saharan Africa. These same powers leaned heavily on the FDA to deny over- the- counter status to the proposed dedicated EC. They were successful in showing once again that politics triumphs over science, or indeed sense.

On the other side, legal advocacy to reduce the age limit has been going on for years. It was the Centre for Reproductive Rights funded by the Compton Foundation's "Population and Reproductive Health" programme,[66] along with the Reproductive Health Technologies Project and numerous women's health organizations that filed a Citizen's Petition to the FDA, to switch EC to over-the-counter-status. After four years of waiting, the Centre filed suit in federal court against the FDA, alleging that the agency's failure to approve Plan B for over-the-counter use impermissibly denied women access to emergency contraceptives. After FDA finally acted on the Plan B application and Citizen's Petition in 2006, announcing that it would approve the distribution of emergency contraception without a prescription, but only at pharmacies and only for women 18 or older who could produce government-issued identification as proof of age. No drug besides Plan B had been subjected to a two-tiered prescription/over-the-counter structure based on age.[67] This entire debate on EC concentrated on the harm reduction argument. The arguments were that

[65] Fried,Marlene.2006.*op cit*

[66] Compton Foundation: Available on http://www.discoverthenetworks.org/funderprofile.asp?fndid=5371&category=79-As accessed on 20th May 2010

[67]Tummino v. von Eschenbach (NY) :Available on http://reproductiverights.org/en/case/tummino-v-von-eschenbach-ny:: As accessed on 10th May,2010

decreasing the age limit and increasing access to contraception would reduce unintended abortions and births. The provision of these services would also help save taxpayers money being wasted on abortion services and welfare.

There was continuous advocacy to decrease the age limit of the sales to 17 years and above.[68] Again, a citizen's petition was filed where the Supreme Court found that the FDA "acted in bad faith and in response to political pressure," "departed in significant ways from the agency's normal procedures," and engaged in "repeated and unreasonable delays."In addition, the Court found that the FDA's justification for denying over-the-counter access to 17 year olds "lacks all credibility," and was based on "fanciful and wholly unsubstantiated 'enforcement' concerns."In March 2009 the Court gave orders for FDA to act within 30 days.[69]The age limit to access emergency contraception changed over to 17 years in April 2009 after a long struggle.

3.4- Morals and Emergency Contraception

Moralistic concerns in relation to these contraceptives were another major debate. Contraceptives have been sold with the help of the medical language of reproductive health, controlling pregnancy or avoiding diseases. As Stycos observes (1977)[70] "organisation of family planning services, and the very language which is employed to refer to it, has been described as contributing to the 'de-sexing' of birth control." In relation to this EC occupies a precarious position in the spectrum of contraceptives as it is to be taken after the act of having sex, making the talk of the sexual act an important part of the discussion. A number of studies have found that medical staff and personnel and pharmacist have found it hard to deliver these contraceptives or have opinions regarding the moral behaviour of the clients who ask for these services. The demand for these contraceptive have been related to the promiscuity, irresponsible behaviour, a pattern of deviance and with the opinion that young women

[68] Trussell, James, Elizabeth G. Raymond, 2010. *op cit*

[69] Tummino v. von Eschenbach (NY): *op cit*

[70] As citied in Ziebland, Sue.1999. "Emergency Contraception: An Anomalous Position in the Family Planning Repertoire?"; *Social Science & Medicine*, 49.pp.1416

buying ECs have a 'loose character' with no morals.[71]Studies have quoted that there is a fear among the medical profession that once these contraceptives gain familiarity these contraceptives can be used as regular contraceptives causing harm to the women's health.[72] [73] Hawkes (1995)[74] has argued that the discourse on responsibility and irresponsibility are indicative of anxieties about young (especially poor and non-white) women's uncontained, unregulated sexuality. There also have been moral concerns among women who have to access these contraceptives, that there will be a judgemental attitude from the provider's side. Then women perceive that *any* request for EC represents a significant threat to their moral identity.[75]

3.5- Population Decline and Emergency Contraception

Population and EC have a historically long association. They view that reduction of unintended pregnancies will help in bringing larger demographic changes in different countries.[76] These are based on the projections of huge rates of reduction in unintended pregnancies with the use of EC. It is claimed that each year about 210 million women around the world become pregnant. Among them, about 75 million pregnancies (36 per cent) are unplanned and/or unintended. Most of these unplanned/unintended pregnancies are not carried to full term, but aborted, often in unhygienic conditions leading to serious consequences. It is estimated worldwide that about 46 million pregnancies (22 per cent of the total pregnancies and 61 per cent of the unplanned/unintended pregnancies) are aborted.[77] It is also estimated that among the

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[71] ibid

[72] Gainera,Erin et.al. 2003.Bringing Emergency Contraception Over the Counter: Experiences of Non-Prescription users in France, Norway, Sweden and Portugal; *Contraception*, 68:117–124

[73] Indian Docs Worry Emergency Contraception Misued: Available on http://www.womensenews.org/story/reproductive-health/081016/indian-docs-worry-emergency-contraception-misused: As Accessed on 25th March,2010

[74] As cited in Ziebland, Sue.1999. *op cit*

[75] Fairhursta , Karen.et. al. Emergency contraception: Why Can't You Give it Away? Qualitative Findings From An Evaluation of Advance Provision of Emergency Contraception.2004;*Contraception*, 70 :25–29

[76] The International Consortium for Emergency Contraception-Available on http://www.cecinfo.org/index.php -As accessed on 1st January,2010

[77] Sharing Responsibility Women Society and Abortion Worldwide-Available on Http://Www.Guttmacher.Org/Pubs/Sharing.Pdf-As Accessed on- 13th May 2010.

total pregnancies each year in South and South-East Asia, about one-third are unplanned or unintended. For instance, 30 per cent in Bangladesh, 21 per cent in India, 35 per cent in Nepal and 35 per cent in Pakistan are unplanned pregnancies.[78] Pregnancy following rape could potentially be reduced by 88 per cent if all women had access to EC after a sexual assault, a reduction of 22,000 pregnancies each year.[79]These organisations working towards population stabilisation have been pushing the need for EC to be available over- the- counter in a number of countries. Major influence among them has been International Consortium for Emergency Contraception (ICEC) and the regional consortiums all over the world which are Latin American Consortium for Emergency Contraception, Asia Pacific Network on Emergency Contraception, Arab World Regional Network, East Europe, Newly Independent States (NIS) and the Balkan region, EC Afrique.[80] The ICEC consortium consisting of the Concept Foundation, the IPPF, Pacific Institute for Women's Health, Pathfinder International, PATH, the Population Council and the WHO/HRP. This consortium was initially funded by the Compton Foundation, the Packard Foundation and supported by USAID and WHO and other organisations for their initial round of studies and advocacy work.[81]They offered technical assistance to governments, international agencies and NGOs for the introduction, marketing and promotion of EC in different countries.[82] The first four countries where the Consortium tested different strategies for the introduction of EC were Mexico, Indonesia, Kenya, and Sri Lanka.

Within a few years of the formation of the consortium EC had been introduced or propagated in many developing countries all over the world like Indonesia, Sri Lanka, Latin America and Caribbean countries, SSA countries, the USA and UK through organisations and agencies such as the FHI, the Population Council, the WHO/HRP,

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[78] Mohammed, Sharif, Ismail Hossain, M. E. Khan, Moshiur Rahman Mary Philip Sebastian .2005.*South East Asia Regional Training Manual Emergency Contraceptive Pills.* USAID,Population Council and Frontiers of Reproductive Health, New Delhi.

[79] Trussell, James, Elizabeth G. Raymond, 2010. *op cit*

[80] Regional Consortia- Available on http://www.cecinfo.org/worldwide/regionalConsortia.htm As accessed on 5th April,2010

[81] Mainstreaming Emergency Contraception -A Report on the Compton Foundation's Emergency Contraception Initiative — 2002-2007 – As available http://www.comptonfoundation.org/ec_initiative.html-As accessed on 8th May 2010

[82] Ellertsona, Charlotte et.al.2002.Information Campaign and Advocacy Efforts to Promote Access to Emergency Contraception in Mexico; *Contraception,* 66: 331–337

PATH, the IPPF, the UNFPA and Population Service International (PSI). These organisations worked with governments or with local women's organisation.[83]

In countries like India, Bangladesh, Pakistan and Nepal introduction of emergency contraceptive into the family planning programme and promotion through NGO's has been relatively easy because of the influence exerted by international organisations. In most of these countries, the reproductive health programmes receive substantial funding from INGOs and bilateral donors. This public- private partnership between the governments and the international NGOs has led to the introduction of these contraceptives without much debate. They have been successful in introducing EC in the family welfare programmes and also have been promoting it through strong social marketing in many developing countries.

In 2001, the consortium on National Consensus for Emergency Contraception in India was organised following which the Government approved its use in the country and included it in the National Family Welfare Programme.[84] In 2003, India's National Reproductive and Child Health program introduced EC pills. The Government of India claimed that unsafe abortions were still a leading cause of maternal mortality, nearly eight per cent of the total, and also a major contributor to maternal morbidity. The prevention of an unwanted pregnancy through methods of emergency contraception will help to reduce the number of maternal deaths from unsafe abortions and also to reduce the fertility levels.[85] India approved non-prescription, over-the-counter access to levonorgestrel-only emergency contraceptive on August 31, 2005.

EC pills in Pakistan were made available through the Ministry of Population Welfare (MOPW) and the Greenstar Social Marketing program. In April 2008, the Ministry of Health (MOH) also began the introduction of EC in twenty health districts served by the USAID-funded Family Advancement for Life and Health (FALAH) project, implemented by the Population Council. Materials developed for the other South

[83]http://webcache.googleusercontent.com/search?q=cache:http://www.cecinfo.org/publications/newsletters/Update_Highlights10.96-10.97.rtf-Emergency Contraception Update Highlights: 10/96 to 10/97

[84] http://www.aiims.ac.in/aiims/events/Gynaewebsite/ma_finalsite/drmittal.html-As Accessed on 4th April, 2010

[85] Ministry of Health and Family Welfare Government of India.2008.Guidelines for Administration of Emergency Contraceptive Pills by Health Care Providers. Family Planning Division, New Delhi.

Asian countries were translated into Urdu and Sindhi and used. FRONTIERS in Reproductive Health (which is supported by USAID, implemented by Population Council and FHI) and the Population Council's Pakistan office developed and organized a two-phase South-to-South collaboration to initiate the process of introducing the method within the MOH's program nationwide after an extensive visit to Bangladesh to see the implementation of the programme followed with a workshop.[86]

Organisations such as Compton Foundation, USAID, Population Council and others are also helping and funding women's organisations to raise their voice for obtaining EC directly from pharmacists. This is supported by the argument that any obstruction to access to contraceptives is a denial of women's rights. They have used different measures to increase access. One of the most important measures for this has been the use legal mechanism. In Peru, for example, from 2004 onwards a public opinion and legal battle over EC was launched, with the Catholic Church and organisations associated with it trying to obtain a ban while women's and medical organisations sought the government to provide it. After many appeals, in December 2006, the Constitutional Court passed the verdict in favour of the women's organisations' demand to oblige the Ministry of Health to provide EC, giving full legal support to its distribution through government clinics.[87]

The Feminist Majority Foundation USA, funded by the Compton Foundation's "Population and Reproductive Health" programme [88] organized a petition urging the FDA to stop playing politics with women's lives; more than 70,000 Americans sent an e-mail to the FDA in support of making Plan B available over-the-counter, without a prescription and without an age restriction.[89] This campaign was instrumental in

[86] M.E. Khan.et.al.2008.Introduction of Emergency Contraceptive Pills in the Public Health System of Pakistan, A South-to-South Collaboration Frontiers in Reproductive Health, Population Council., Pakistan.

[87] Fau´ndes, Ani´bal.et.al.2007. Emergency Contraception under Attack in Latin America: Response of the Medical Establishment and Civil Society;*Reproductive Health Matters*;15(29):130–138

[88] Compton Foundation: Available on http://www.discoverthenetworks.org/funderprofile.asp?fndid=5371&category=79-As accessed on 20th May 2010

[89] EC in the News- Available on http://ec.princeton.edu/news/index.html-As accessed on 15th February,2010

obtaining the FDA approval for EC. In 2002, the High Court in England directly addressed the question of whether EC emergency contraceptive pills act as abortificient. Following an exhaustive review of scientific evidence, the Court held that pregnancy is not established prior to implantation and, thus, because the EC pill cannot dislodge an implanted egg, it cannot, as a matter of law, terminate a pregnancy.[90] The three main reasons within harm reduction that are often mentioned by the organisations promoting EC are:, there is no evidence to support the assertion that the current dedicated levonorgestrel pills are abortificient. Scientific evidence is clear that EC is not effective after Fertilisation. Secondly, access to the means to prevent an unwanted pregnancy is supported by the universally accepted right to decide whether and when to bear children, the human right to non-discrimination based on sex and age, and the right of access to essential medicines and to benefit from the fruits of scientific progress. Thirdly, it is argued that as many as eight out of every ten women who have timely access to EC after unprotected intercourse will have prevented an unwanted pregnancy and possibly an abortion, an outcome which should be supported by all.[91]

Based on these arguments of harm reduction there have been suggestions to increase access to EC. Their demands include universalization of access to EC, also in relation to that increase in access to the emergency contraception through advance prescriptions and counselling in hospitals and schools regarding the usage of these contraceptives. Inspite of the claims of decreasing population no published study has yet demonstrated that increasing access to EC can reduce pregnancy or abortion rates in a population.[92] Scientists claimed that reduction in population through reduction of unintended pregnancies has not occurred at desirable levels. This has resulted in funds cut for the product through aid agencies.[93] [94]

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[90] Compton Foundation. *op cit*

[91] Fau' ndes, Ani'bal.et.al.2007.*op cit*

[92] Trussell, James, Elizabeth G. Raymond, 2010. *op cit*

[93]Editorial.2009. "Emergency Contraception: Have We Come Full Circle?", *Contraception*, 80: 1–3

[94] Trussell, James, Elizabeth G. Raymond.2010.*op cit*

Anti- choice groups have also taken this issue up on the basis of scientific data stating that increased access to over- the- counter EC has not resulted in the reduction of unintended pregnancies. Anti- choice groups have strongly condemned the introduction of emergency contraception for the purpose of reducing population. These organisations have started campaigns against both DEC and the population growth myth.[95] [96]

Another argument made by the anti- choice groups are the increased rates of HIV/STI related cases among different populations around the world. Their argument also revolves around the belief that increased access to EC can lead to an increase in promiscuous behaviour and also will result in increased cases of rape and paedophilia. Moral concerns over unmarried, young women having access to these 'abortion pills' have also raised concerns among these groups.[97]These arguments do not talk about women's rights or her position in the society. Nor, as we have seen above, are these arguments supported by empirical evidence.

3.6- Emergency Contraception and Media

Media advertisements are another medium through which pharmaceutical companies and international organisations are trying to promote EC so has to increase the usage of the contraceptive. Views such as lack of awareness about of how to get an EC, and the period of usage of the contraceptive act as barrier to their use have been expressed by a number of organisations and papers in medical literature. These include global reviews from different parts of the world such as Australia, New Zealand, the UK, the USA and South Africa.[98] [99] [100] A survey in Finland reached the conclusion that ECs

[95] H. E. Mons. Jean-Louis Tauran.2000.The Defence of life in the Context of International Policies and Norms..Available on- http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20000211_tauran-acdlife_en.html: As accessed on 11th February,2010

[96] http://pop.org/ As accessed on 29th March 2010

[97] http://www.aaplog.org/rightofconscience.aspx- As accessed on 5th April 2010

[98] Persleva, A.et.al.2002. Emergency Contraception: Knowledge and Use Among Danish Women Requesting Termination of Pregnancy;*Contraception*, 66 :427–431

[99] Muia, Esther et.al. 1999.Emergency Contraception in Nairobi, Kenya: Knowledge, Attitudes and Practices Among Policymakers;*Contraception*;60:223–232

are used `appropriately' in that country, but that nevertheless more information about the method is needed.[101]

A 1997 Kaiser Family Foundation survey revealed that though US providers were nearly unanimous (98–100 per cent) in the view that EC pills are safe and effective, only about 10 per cent said they routinely discuss the method with clients, and between 40 per cent and 63 per cent said they always discuss it with clients seeking treatment after unprotected intercourse.[102] Outreach and educational campaigns are geared towards pharmacist providers, women and men of all ages, and younger adults are targeted to explain both the benefits and the risks of the method.[103] Advocacy initiatives have used language such as respect for autonomy of women and freedom of conscience in deciding on contraceptive use, women's right to health and right to benefit from scientific progress to promote EC. This promotion has been taken over by the pharmaceutical companies in many countries. This information has mostly targeted young unmarried women, and is based on the emotion of guilt. There have been complaints that in an attempt to promote, these contraceptives are being misrepresented.

Women's Capital Corporation, initial owners of Plan B, was issued a FDA warning in 2002 for the kind of media and print advertisements that they released. It warned that the advertisements about Plan B were misleading about both efficacy and side effects and did not promote an appropriate image of these contraceptives as an 'emergency' contraceptive.[104]

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[100] Westley, Elizabeth and Anna Glasier.2010. "Emergency contraception: Dispelling the Myths and Misperceptions"; *Bulletin of World Health Organisation,* 88(4):241-320

[101] Ziebland, Sue.1999. "Emergency Contraception: An Anomalous Position in the Family Planning Repertoire?"; Social *Science & Medicine*, 49.

[102] Simondsa, Wendy and Charlotte Ellertson.2004. "Emergency Contraception and Morality: Reflections of Health Care Workers and Clients"; *Social Science & Medicine* 58 : 1285–1297

[103] Gainera, Erin et.al.2003. "Bringing emergency contraception over the counter: experiences of non-prescription users in France, Norway, Sweden and Portugal"; *Contraception* ,68 : 117–1

[104] FDA Warning Letters-Available on http://www.pharmcast.com/WarningLetters/Yr2002/November2002/WomensCapital120302.htm-as accessed on 29th April,2010

In India the government has included these contraceptives in the family planning programme without IEC. The information received from media advertisements sponsored by pharmaceutical companies such as Cipla and Mankind have been the main source of information. Women's organisations have protested against these media campaigns as they trivialise the issue, and in the mode of portrayal of women. The advertisements, they argue, trivialised important and complex issues of sexuality and women's control over her body. Advertisements raised serious concerns of promoting the drugs as regular contraceptives. They also misrepresented abortion.

It is has been argued that EC pills are unlikely to result in meaningful choices for women in India and other developing countries contrary to the advertisements claims as long as there are profound gender-based inequities including heavy reliance on female sterilization.[105] Another concern raised is that within a patriarchal society where women have limited say in relation to matters regarding her sexual life, these advertisements and easy availability of products gives way to 'unfreedom' rather than freedom and liberty. Men can refuse to use contraceptives during a sexual act as the option of EC always exists, even as women are expected to be sexually available. The projections of abortion rates and unintended pregnancies also show very narrow approach to address the issue of reproductive health services. EC cannot be looked upon as a magic bullet that will replace the need to offer health services to the population.[106] The Drug Controller Generals office of India took cognizance to voices of protest by banning advertising of all emergency contraceptives like Unwanted-72 and I Pill on January 11, 2010. Almost immediately there was a committee set up which advised that advertisements should be allowed to be aired and this should include advertisements by the private sector as well as the union secretary. Certain

[105]Emergency Contraceptives in India: Beyond the Magic Bullet-Available on http://www.thefreelibrary.com/Emergency+contraceptives+in+India:+beyond+the+magic+bullet.-a0119853760-Accessed on 10th May,2010

[106] Should Sale of Emergency Contraceptives be Restricted?- As Available on http://www.dnaindia.com/speakup/report_should-sale-of-emergency-contraceptives-be-restricted_1324171- As Accessed on 18th June,2010

guidelines were laid for these advertisements where it became mandatory for the present the EC to be used only in case of an 'emergency' [107]

Organisations and groups opposing these media representations did not necessarily oppose ECs. What they opposed was that these ECs were projected as routine contraceptive in order that the pharmaceutical companies make profits, exploiting a lucrative market. None of these advertisements indicated the health consequences of repeated use or the failures of the method or indeed the side effects. This is especially the case in populations with little access to quality medical care. The danger they pose is the emergency caused by the routinisation of ECs.

Jim Sedlak (Executive Director of STOPP International, a project of the anti-abortion American Life League), based on an investigation on Planned Parenthood Federation and other organisations involved in promoting EC, stated that

> ------FDA over the counter approval to Plan B would not only represent an ideological victory for Planned Parenthood Federation of America, but it would also generate a financial windfall. Because of a series of shrewd business agreements, the organization could be in position to make a minimum of $100 million profit over a five-year period from Plan B sales if the FDA gives the go-ahead for over-the-counter distribution. These details were based on internal Planned Parenthood e-mails which were made public during a California court case. These documents detail how Planned Parenthood worked out a deal with Barr Pharmaceuticals, Plan B's owner. Under a five-year agreement, Planned Parenthood would be able to buy Plan B from Barr at bargain-basement prices, undercut local pharmacies, and clear an average $20 profit on each Plan B kit. The story begins in 1997, when the Women's Capital Corporation was formed for the express purpose of bringing a morning-after pill to market in the United States and Canada through a public/private partnership. Five non-profit Planned Parenthood affiliates made equity investments in the corporation, so these affiliates were positioned to share in any profits Women's Capital generated. Those profits began to be realized two years later, when the FDA approved Plan B as a prescription medication on July 28, 1999. By the end of the year, Planned Parenthood had already sold more than 100,000 units of Plan B. The sales figure at Planned Parenthood alone climbed to more than two million units by 2003, generating tremendous interest in Plan B and enhancing the value of the interest those five Planned Parenthood affiliates held in Women's Capital Corporation. In a deal worth about $21 million, Barr's purchase of Women's Capital Corporation was finalized in February 2004. As equity holders in Women's Capital, the five participating Planned Parenthood affiliates shared in the profits of that sale. But that's not the end of the story, and that's not the only way Planned Parenthood has profited - and will continue to profit - from Plan B. One of the documents is a February 9, 2004 e-mail, executives were told that Planned Parenthood was "in the midst of confidential discussions" with Barr and that Planned Parenthood's "immediate

[107]Lift Ban on Emergency Contraceptive Ads: Panel- http://lite.epaper.timesofindia.com/getpage.aspx?articles=yes&pageid=11&max=true&articleid=Ar01104&sectid=9edid=&edlabel=TOIPU&mydateHid=04-03-2010&pubname=Times+of+India+-+Pune+-+Times+Nation&title=Lift+ban+on+emergency+contraceptive+ads%3A+Panel&edname=&publabel=TOI As accessed on 2nd April,2010

> interest is to develop and protect our market base."PPFA vice president of medical affairs, Vanessa Cullins, M.D., to all Planned Parenthood affiliate CEOs wrote that "Barr's senior management has informed us that they are committed to hold intact public sector pricing and the Planned Parenthood special pricing at $4.50 and $4.25, respectively, for the next five years. This will remain valid whether the product becomes an over-the-counter product or continues with prescription status."[108]

EC pills are distributed through local and district hospitals in India at a cost of Rupees 30 (approximately $1) — a third of their actual cost. Several private manufacturers have been granted approval for manufacturing and marketing emergency contraceptive products. In August 2007, Indian pharmaceutical giant Cipla launched I-pill, a single-dose morning-after pill available for around $1.80. Around 200,000 units of the drug have been sold every month since its launch.[109] "I-pill (now patent is owned by the company Piramal in India) featured in the top-300 pharmaceutical products and recorded sales of Rs. 31 crore for the year 2009 as recorded by ORG IMS.[110]

Even in UK this is looked upon as a method to reduce the government's burden on reproductive health services. It is argued that encouraging self-medication and shifting some of the cost of health care on to consumers, reduces the National Health Service (NHS) drugs bill. The deregulation on loperamide in 1983 and hydrocortisone in 1987 were estimated to have saved the NHS £2.7 million in prescription costs and general physician time by 1989 .[111],[112] These strategies to increase revenues and also to reduce the governments burden of taking care of the reproductive needs of the women by shifting the burden on to individuals has not been well received by many. High prices of emergency contraception at 24/euro or 37/$39 in pharmacy purchase

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[108] Planned Parenthood cut Sweetheart Deal with Producer of 'Emergency Contraceptive' Plan B.2005. As Available on-http://www.lifesitenews.com/ldn/2005/aug/050825a.html As accessed 3rd April,2010

[109]Indian Docs Worry Emergency-Contraception Misused.2008.-Available on http://www.womensenews.org/story/reproductive-health/081016/indian-docs-worry-emergency-contraception-misused As accessed on 25th March,2010

[110]Piramal Healthcare Acquires "i-pill", a Leading Emergency Contraceptive Brand from Cipla Available on http://www.fiercebiotech.com/press-releases/piramal-healthcare-acquires-i-pill-leading-emergency-contraceptive-brand-cipla#ixzz0pihOC1u1 As Accessed on 10th April,2010

[111] Barrett, Geraldine and Rosalyn Harper.2000. "Health professionals' Attitudes to the Deregulation of Emergency Contraception (or The Problem of Female Sexuality)"; *Sociology of Health & Illness*, 22(2)

[112] Bond, Christine.2008. "The Over-the-counter Pharmaceutical Market –Policy and Practice"; *Eurohealth*; 14(3).

in countries UK and Chile become a burden on women as they cannot access these contraceptives. [113]

It has been argued that providing over- the- counter services has not always been beneficial. Two negative outcomes that have resulted from over-the-counter access to EC in the US are the potential loss of opportunities for physicians to counsel patients about use of more effective, longer-term contraceptive methods. Developing and developed countries have raised voices against the unmonitored growth of these contraceptives which may prove harmful. Another consequence is an increase in price, from about $25 per treatment to about $45, and loss of insurance coverage in many, if not most, cases.[114] This high price has been extremely beneficial to the private markets in developing and developed countries.

[113] Sarkar, N. N. 2008. "Barriers to Emergency Contraception (EC): Does Promoting EC Increase Risk for Contacting Sexually Transmitted Infections, HIV/AIDS?"; *International Journal of Clinical Practice*, 62 (11):1769–1775

[114] Trussell, James, Elizabeth G. Raymond, 2010. *op cit*

Notes

[i] "Morning-after pill" has long been used to describe the postcoital use of high-dosage hormonal contraceptives, but the term is misleading because emergency contraception can be used before the "morning after". Thus, advocates have embraced the terminology "emergency contraception." Opponents of emergency contraception object to the term because they contest its status as a contraceptive, calling it instead an abortificient, which it isn't.

[ii] Following President Barack Obama's rescinding of the global gag rule, five states in the US have passed bills that recognize "personhood" at the moment of conception. Again, this testifies to the organized religious Right in the country.

[iii] The Weldon Amendment Act adopted in 2004 prohibits discrimination against health care providers who refuse to pay for, provide coverage for within the health plan, or refer for, abortions. Number of professionals including physicians and other health care professionals, hospitals, provider-sponsored organizations, HMOs, and health insurance plans that do not cover abortion are covered within this Act.

[iv] Section 245 of Public Health Service Act (PHSA) places restrictions on the federal government as well as state and local governments receiving federal financial assistance. This act prohibits discrimination against both individuals and institutions (including doctors, hospitals, and postgraduate training programs) refusing to undergo training in, require or provide training in, provide referrals for, or perform, abortions. This act was signed by President Clinton in 1996. It also protects institutions who do make arrangements for abortion referrals

[v] The Church Amendments named after former Senator Frank Church (Democrat, Indiana) was enacted in response to the 1973 Supreme Court decision in *Roe v. Wade* , to address concerns that doctors and faith-based hospitals would be forced to perform abortions or sterilizations as a condition of receiving federal funds. This amendment prohibits courts and other public officials from enforcing individuals or institutions who receive grants under certain federal programs to perform or assist in abortions or sterilizations or to provide facilities or personnel for the same. This act also forbids discrimination against physicians or other health care personnel because of their religious or moral objections to performing abortions or sterilizations. Employment, promotion, termination, and extension of staff privileges are the areas around which discrimination is prohibited. This act also provides extended protection to individuals, including researchers and laboratory staff participating in HHS-funded behavioural or biomedical research (including research funded by the National Institutes of Health).

DISCUSSION

DISCUSSION

Birth control-individual choice, safe contraceptive methods, as well as abortions when necessary-is a fundamental prerequisite for the emancipation of women

-Angela Davis, *Women Race and Class* (p. 202)

Historically, women have wanted to control their ability to reproduce and it was the progress of scientific technology that allowed birth control to be accessible and available to all. This technology has been at the crux of the debate between 'choice and control' since the beginning. These concerns have been the result of different power relationships that have dominated the field of contraceptive technology. There is no one perspective that can be attributed to the development of contraceptive industry in its present form. Many powerful institutions like the population control establishment consisting of the neo-Malthusians and eugenicists, the feminist movements, the right- wing groups, anti-choice groups and 'step cousin' to all these, the commercial market for contraceptives, have all influenced 'choice'

Choice and control came to be defined in distinct ways over different time periods. This is embedded within the change of semantics from 'birth control' to 'reproductive rights.' This shift in semantics is also posed as an indication of a shift from 'control' to 'choice.' Examining this shift within the history of colonialism, racism, growth of feminism and the politics that lead to the growth of contraceptive technology brings to light that the line between choice and control has blurred over the years.

'Overpopulation' has been the reason which has been historically used to blame the poor and the marginalised for their misery from within the developed and developing countries. The history of colonialism in developing countries was responsible for resource drain in their countries leading to poverty. Racism is rooted in the historical legacy of slavery depriving the blacks of their rights and giving rise to an enduring discrimination. History of colonialism and racism have resulted in poverty, poor health conditions and lack of resources but these issues are easily sidelined when

'over population' within these countries and races is blamed for their poverty and backwardness These have been sidelined through private and government-run agencies which have exerted a powerful influence on the population policies of many developing and developed countries. Sterilisation has been the most advocated and used form of birth control. It was often promoted and at times coercively used on these populations. This has been promoted in collaboration with the medical institutions or the medical profession under the guise of increasing technical efficiency of the contraceptives. This influence of the medical profession has helped to medicalize the very nature of contraception. It is partly the technical nature of the issue and partly the sexism of the medical profession that has led to the fact that contraceptives have mostly targeted women. This targeting of women has been fundamental to contraceptive technology and is representative of the patriarchal system in which subordination of women has been an essential pre-requisite. Within this system a woman's relationship with the society and her identity is equated with her ability to reproduce and become a mother. The reification of 'motherhood' and women's reproduction is central to the control of women's sexuality that is at the heart of patriarchy. Women's ability to reproduce has been used by both anti-natalist and pro-natalist lobbies where the woman's 'womb' gets linked with state property and she is called upon to perform her duty towards the nation by either reproducing or restricting the number of offspring she produces.

Along with the population establishments, the private market has reaped benefits from contraceptive technology since the nineteenth century. It has always been an invisible force in deciding the kind of contraceptives that will be available in many of the developing and resource-poor countries. It has been established that contraceptive technology has been a lucrative business. Yet there are few population institutions (private and government) that have invested adequately in the field of contraceptive research and manufacture, as huge funds are required to develop a safe and effective contraceptive. Further, they are to be tested on healthy women and stringent laws are to be followed during human trials. Pharmaceutical companies have shied away from investing time required for the patents and the money required for manufacturing contraceptives. There also exists a fear of incurring huge losses in the event of damage and liability in expensive lawsuits. The consequence of this has been the

emergence of a 'birth control mafia' with funding coming from private foundations and multilateral agencies and governments. The marketing of these drugs gets licensed out to pharmaceutical companies and research is conducted by institutions supported by the private institutions or multilateral agencies. Over the years these establishments have focussed mostly on the promotion of contraception within the Third World market. Facilitating this is the paranoia of overpopulation that has been simultaneously created. This paranoia has been used effectively to prioritise population as the problem rather than discuss development issues or problems related to overconsumption of resources by the First World countries, and indeed the rich globally. Fund raising, media and advocacy are methods through which these organisations spread their influence among policy makers and elites in the recipient countries.

Over the decades investment for contraceptive technology has been on women-centric and provider-controlled contraceptives which have been promoted under the guise of 'expanded choice' and 'unmet need' for contraception. This language of 'meeting the unmet need' has rationalised the provision of provider-controlled contraceptives through family planning programmes of developing countries or to marginalised communities. Safety, ethics and efficacy of contraceptives are seen to have different meanings for the different groups talking about these issues. This is seen in the case of Depo-Provera and Norplant which have been declared as safe inspite of the severe side-effects that it causes in women.

These contraceptives have largely being used in Third World countries and among women of colour with the justification that they don't have to be taken on a regular basis. The organisations and pharmaceutical companies of the population establishment have been criticised for bringing out information that camouflages or underplays the side-effects of these contraceptives. These organisations believe in helping women to control their fertility through any means possible and presenting them with a 'basket of contraceptives' to choose from. They do not believe in ensuring women good quality of life, rather just a life free from child birth. This 'basket of choices' is limited to Third World women as drugs that are denied approval by FDA in the US for reasons of safety are administered to them. This attitude that the Third World women need to be 'only' free of child birth while disregarding concerns

of safety and efficiency for them is highly problematic as *any* drug, however harmful, can be included in the 'choice' basket. This also gives legitimacy to donor agencies that fund research and NGOs to promote harmful products through 'social marketing' It is like punishing the poor and Third World women for their poor health conditions. Thus research priorities are to modify provider-controlled contraceptives such as injectables and implants without changing their basic nature. Also, importance is given to undertake trials in developing countries where there have been gross ethical violations due to weak regulations.

The recent neo-liberal period has resulted in 'recolonisation', increased discrimination of poor and marginalised, increased maternal and infant mortality, failing health systems, and the shedding of responsibilities by governments. New versions of neo-Malthusianism were reborn as theories of environmental degradation and environmental conflict, the solution to which was of course to increase contraceptive prevalence rates.[1] These theories were used to implement stringent immigration laws and racist policies. The neo-liberal world, with increasing power to markets, has also resulted in a reduction of tolerance of the 'Other'. Restriction of abortion facilities and an increased demand to control the fertility of immigrants and of women of colour in the West, are only some examples of the consequences of strengthening of neo-Malthusian ideas in neo-liberal times.

Neo-liberal policies have imposed a double burden on Third World women and the poor within First World countries. It has used the language of choice as an easy alibi to justify the 'coercive' measures used by the governments and international organisations by promoting harmful contraceptives in the name of 'efficiency'.[2] These measures are also strengthened by the weak regulatory bodies within developing countries that are coaxed into accepting the norms set by the developed countries. Women's education and empowerment have been used as means through which birth

[1] Hartmann, Betsy.2006. "Liberal Ends, Illiberal Means: National Security, 'Environmental Conflict' and the Making of the Cairo Consensus"; *Indian Journal of Gender Studies*.2006.13:195.

[2] Silliman, Jael and Anannya Bhattacharjee (eds).2002.*Policing the National Body: Race, Gender and Criminalization*, South End Press, Massachusetts.

control measures could be promoted, and in this the population establishment was supported by the liberal feminist position.

Liberal feminists have historically aligned with the eugenicists and neo-Malthusians either believing in the ideology of 'pure race' or to avail of the funds offered to them by these groups.[3] More frequently they have made strategic alliances by staying silent over the ideas of these groups while pushing their agenda of gender equality. This collaboration between the liberal feminists, the neo- Malthusians and the eugenicists has helped in achieving reproductive rights within the framework of population policies rather than as an end in itself. This concept of reproductive rights has been critiqued, arguing that rights have never been a dynamic concept but instead has remained inert. It has narrowed down to a materialistic view of reproductive freedom which can be delivered in the form of contraceptive services through family planning programmes or the private market.

The feminist movement has over the centuries fought for the autonomy of women but largely this movement got restricted to the white bourgeoisie women whose struggle for birth control and abortion services were based on the principle of 'individual choice'. But feminists of Colour and Black feminists have problematized the concept of 'choice' propagated within the 'mainstream' feminist movement. They argued that contraception as a technology presented within the package of choice failed to take into account the power differences that existed between men and women in the society, and indeed between some women and others, and thus concealed the social context in which individuals make choices. They argued that such a view did not take into account the ways in which the state exercises control over populations regulates bodies of women through stringent policies, places a restriction over reproduction, sexuality, and gender. These expressions of rights and freedom are not situated within the structure and context within which the society functions.

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[3] Gordon, Linda.2007.The *Moral Property of Women: A History of Birth Control Politics in America,* University of Illinois Press, United States of America.

Women's groups, health advocates, and groups fighting against the population lobby are opposed to long- acting contraceptives. The information they bring out is based on questioning the development paradigm and criticising the reductionist approach taken by researchers when conducting trials. They have raised issues of safety and efficacy and above all have drawn attention to the hazards to women's health posed by these contraceptives. Contraceptives which are provider-controlled, they point out, are frequently used coercively. They argue that women's empowerment is not to be viewed in a utilitarian fashion as a means to population control; rather it is an end in itself that will ensure enhancement of women's place within society. Contraception in this paradigm falls within the larger framework of women's health rather than 'just' reproductive health.

This view among women's organisations demanding a holistic approach to the health of women has resulted in them demanding that EC does not become a substitute for provision of health care services for women. Another area where EC has been opposed by these organisations is the unholy private public partnership between the manufacturers of ECs, international NGOs and the government, resulting in these contraceptives being distributed to women in rural areas of India, Pakistan and Bangladesh without proper information for use as an 'emergency'. This becomes especially dangerous if the women suffer from an ectopic pregnancy after its consumption. In the absence of access to quality health facilities, the use of ECs may not always be beneficial given both their failure rate and side-effects. Providing women with choices is useful for women but it is necessary to do so within the framework of women's health rather than agendas of gaining profit and making laws. There are also voices against the concentration of contraception research and products focussing on women reinforcing the patriarchal norms that contraception is women's responsibility.

On one hand some sections of the women's movement are struggling against the powerful influences of the population establishments. There is another group which opposes this establishment and these are the fundamentalist and the anti-choice groups. There is of course no coming together of these two groups as they differ fundamentally in their visions of justice. The latter groups are patriarchal in nature

and do not believe in women's autonomy or provisioning of conditions appropriate for improving women's health. Rather, these anti-choice, anti-abortion groups have insisted that restriction on women's reproduction is immoral, aganist the will of God and amounts to the killing of the foetus. Although these arguments lack scientific evidence or logical reasoning, these groups have become extremely powerful within the birth control debate. These groups have influenced opinions regarding abortion and emergency contraception through aggressive media management, articles and publications that justify their views and oppose the 'birth control mafia' and also the feminists. Central to these groups is the idea of human rights of the foetus or embryo as they recognise life to exist from the moment of conception. They are opposed to many methods of contraception and above all to abortion. On the one side fundamentalists, and on the other side profit maximizing drug companies and INGOs, both use high sounding language of choice and rights in regards to women while exploiting women's bodies. The population control establishment provides women of Colour and Black women with abortion facilities and EC pills through state-run family programmes even if in developing countries like India it is neither the best nor the safest way to promote safe sex. Simple and safe barrier methods are not given research priority nor are condoms promoted as part of family planning but only for HIV/AIDS.

Choice has become a narrowed down concept to mean a technological 'quick fix' for providing contraceptives as a solution to the health problems of women and to annihilate the poverty of the developing countries and environmental problems of the world. Influenced by a powerful political and corporate sector this technology has imbibed their profit-making values while reducing women to mere reproductive beings. This limited view fails to consider the societies in which women's choices are dictated by men or by societal norms or indeed by the powerlessness induced by neo-imperialism. It remains unsuccessful in considering the desires of women to have choice regarding the type of contraceptives without having to choose from the only choices presented to them by the state or by the market. By reifying choice, it rendered it not only hollow, but mocked the poor who could not exercise such choices. The language of rights and choice that is co-opted into all the documents brought out by the 'birth control mafia' weakens the voices and protests of the

feminist movement. The call for Reproductive Justice needs to gain strength not just for safe contraceptives but improving overall health of women and go beyond the rhetoric of 'choice'.

BIBILIOGRAPHY

A History of Birth Control Methods Report.2006.Available on http://www.plannedparenthood.org/- As Accessed on 13th June, 2010.

A New Vision for Advancing an Understanding of Reproductive Health, Reproductive Rights and Reproductive Justice: Available on http://www.sistersong.net/documents/ACRJ_Reproductive_Justice_Paper.pdf: As Accessed on 10th December, 2009.

A Saheli Report.1997.*Quinacrine - The Sordid Story of Chemical Sterilisations of Women*. New Delhi, Saheli Women's Resource Centre.

A Saheli Report.1999.*Enough is Enough-Injectable contraceptives Net-En: A Chronicle of Health Hazards Foretold*. New Delhi, Saheli Women's Resource Centre, Sama-Resource Group for Women and Health.

About Population Reports- Available on http://info.k4health.org/pr/about.shtml- Accessed on 9th December 2009.

Ackerman, Todd.2006. "Emergency Contraception Science and Religion Collide"; *Annals of Emergency Medicine*; 47(2).

Akhter, Farida .1992.*Resisting Norplant-Women's struggle in Bangladesh against Coercion and Violence*, Dhaka, Narigrantha Prabartana.

Ali.K.A.2002. "Faulty Deployments: Persuading Women and Constructing Choice in Egypt"; *Comparative Studies in Society and History*,44(2):370-394.

Allyn, David.2001.Make *Love, not War: The Sexual Revolution*, an Unfettered History, New York, Routledge.

Anthony Comstock's "Chastity" laws- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_comstock.html- As Accessed on 5th June, 2010.

Arathi P M.2006. "Aborting Gender Justice: Legislating Abortion "Unpublished MPhil Dissertation submitted to Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

Archer, David, Christine A-Philput and Margaret E.Weber.1996. "Management of Irregular Uterine Bleeding and Spotting Associated with Norplant®" ; *Human Reproduction,* 11(2).

Bandarage, Asoka.1997.*Women, Population and Global Crisis: A Political Economic Analysis*, New Jersey, Zed Books,

Barrett, Geraldine and Rosalyn Harper.2000. "Health professionals' Attitudes to the Deregulation of Emergency Contraception (or the problem of female sexuality)"; *Sociology of Health & Illness*, 22(2).

Benagiano, Giuseppe, Alessandra Pera and Francesco and M.Primiero.2000. "The Endometrium and Hormonal Contraceptives"; *Human Reproduction*, 15(1):101-118.

Blumenthal, Paul, Jane Johnson, and Felicia Stewart.2000.The Approval of Mifepristone (RU486) in the United States: What's Wrong With this Picture? – As Available on http://www.medscape.com/viewarticle/408923- As Accessed on 24th July,2010

Bond, Christine.2008. "The Over-the-counter Pharmaceutical Market –Policy and Practice"; *Eurohealth*; 14(3).

Brodie, Janet Farrell.1994. *Contraception and Abortion in the 19th Century*, USA, Cornell University Press.

Brunton, Jennifer and Margaret.Beal.2006. "Current Issues in Emergency Contraception: An Overview for Providers", *Journal of Midwifery & Women's Health*, 51(6).

Bryason, Valerie .1999. *Feminist Debates: Issues of Theory and Politics Practice*, London, MacMillan Press Ltd.

Chapter 1, Human Rights, Women's Rights, and Reproductive Freedom: The Evolution of Ideas- Presented at the AdaptingtoChangeCoreCourse.1999.- Avaliable on http://info.worldbank.org/etools/docs/library/48442/m1s5dixon.pdf: As accessed on 12th May 2010.

Cheng, L.et.al.2000. "Contraception: Once a Month Administration of Mifepristone Improves Bleeding Patterns in Women using Subdermal Contraceptive Implants Releasing Levonorgestrel", 2000. *Human Reproduction*, 15(9).

Chez, Ronald and Janet Chapin.1997. "Emergency Contraception-The Pill's little known Secret Goes Public"; *Lifelines*.

Cirillo Vincent.1974. "Birth Control in Nineteenth-Century America:A View from Three Contemporaries"; *The Yale Journal of Biology and Medicine* ,47: 260-267

Clarke, Adele and Theresa Montini.1993. "The Many Faces of RU486: Tales of Situated Knowledges and Technological Contestations"; *Science, Technology, & Human Values*, 18(1) :pp. 42-78

Coeytaux, Francine and Barbara Pillsbury.2001. "Bringing Emergency Contraception to American Women: The History and Remaining Challenges"; *Women's Health Issues*, 11(2)

Committee on Contraceptive Development, National Research Council and Institute.1990. *Developing New Contraceptives: Obstacles and Opportunities,* Washington.D.C, National Academies Press.

Compton Foundation: Available on http://www.discoverthenetworks.org/funderprofile.asp?fndid=5371&category=79-As accessed on 20th May 2010

Condit, Deirdre.1994." Writing Reproduction: Reproductive Technologies and Motherhood Examined"; *Policy Sciences*,27(2-3):287-294

Connelly, MatthewJames.2008. *Fatal Misconception: The Struggle to Control World Population*, USA, Harvard University Press.

Contraception or Deception?.2006-As Available on http://www.cwfa.org/articledisplay.asp?id=1559&department=CWA&categoryid=life- As accessed on 5th April 2010

Contraception Pill Strictures Are Eased by a Judge.2009. Available on: //www.nytimes.com/2009/03/24/health/24pill.html?_r=2&scp=2&sq=plan%20b&st=cse-As accessed on 2nd April,2010

Contraception: As Available on: www.nichd.nih.gov- Accessed on 13th January, 2010

Contraceptive Research, Introduction, and Use: Lessons from Norplant.1998.http://www.nap.edu/openbook.php?record_id=5946&page=108 - As Accessed on January 20th, 2010.

Corea, Gena. "Depo-Provera and the Politics of Knowledge" in Patricia Hynes, (ed).1989.*Reconstructing Babylon: Essays on Women and Technology*, London. Earthscan Publications Ltd.

Costa, Tonia.et.al .2007. "Naturalization and Medicalisation of the Female Body: Social Control through Reproduction"; *Interface*, 3.

Council for International Organizations of Medical Sciences (CIOMS) and World Health Organization (WHO).2002. *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, Geneva.

Davidoff, Frank and James Trussell.2006. "Plan B and the Politics of Doubt"; *Journal of American Medical Association,* 296 (14):1775-1778.

Davis, Angela.1981.Women, *Race & Class*, USA, Vintage Books.

DeJong, Jocelyn.2000. "The Role and Limitations of the Cairo International Conference on Population and Development"; *Social Science & Medicine*, 51:941-953.

Depo Provera /Norplant- Available on http://www.faqs.org/health/topics/51/Depo-Provera-Norplant.html: Accessed on 14th May, 2010.

Depo Provera Attorneys- Available on-http://anattorneyforyou.com/legal/depo-provera.htm -As accessed on January 25th, 2010.

Depo Provera Contraceptive Injection Medroxyprogesterone Acetate Injectable Suspension, USP-Available on-http://media.pfizer.com/files/products/uspi_depo_provera_contraceptive.pdf - As accessed on 15th January, 2010.

Depo Provera Contraceptive Injection Medroxyprogesterone Acetate Injectable Suspension, USP -As Available on www.**pfizer**.com/files/.../uspi_**depo_provera**_contraceptive.pdf As accessed on 15th Nov, 2009.

Depo Provera Fact Sheet.2007: Available at http://www.cwpe.org/node/185: As Accessed on 20th April, 2010.

Depo Provera Osteoporosis and Depo Provera Bone Mass Density Loss- Available on http://www.monheit.com/depo-provera/index.asp - As accessed on January 20th, 2010.

Depo-subQ Provera 104- Available on-http://www.path.org/files/RH_depo-subq_brief.pdf-As accessed on 17th April, 2010.

Doyal, Lesley.1995.*What Makes Women Sick: Gender and the Political Economy of Health*, New Jersey, Rutgers University Press.

Doyle, Laura.2004. "Long Arm of Eugenics"; *American Literary History*, 16(3).

Dr. Charles Morrison and Kim Best.2004.Hormonal Contraception and HIV: An Update- http://www.fhi.org/en/RH/Pubs/booksReports/hcandhiv.htm- As accessed on 25th May 2010

E, Alison.et.al.2007. "Acceptability of Contraceptive-Induced Amenorrhea in a Racially Diverse Group of US Women"; *Contraception* 75,450– 453.

EC in the News- Available on http://ec.princeton.edu/news/index.html-As accessed on 15th February, 2010.

Editorial- "Depo-Provera's Black Box: Time to Reconsider?" 2005; *Contraception*, 72:165– 167.

Editorial.2009. "Emergency Contraception: Have We Come Full Circle?"; *Contraception*, 80: 1–3.

Ellertsona, Charlotte et.al.2002. "Information Campaign and Advocacy Efforts to Promote Access to Emergency Contraception in Mexico"; *Contraception*, 66: 331–337.

Emergency Contraception- Available on http://www.nlm.nih.gov/medlineplus/ency/article/007014.htm As Accessed on 25th March, 2010.

Emergency Contraception-Available on-
http://www.cps.ca/ENGLISH/statements/AM/ah03-01.htm#effects As accessed on 1st April, 2010.

Emergency contraceptives in India: Beyond the Magic Bullet-Available on http://www.thefreelibrary.com/Emergency+contraceptives+in+India:+beyond+the+magic+bullet.-a0119853760-Accessed on 10th May, 2010.

Eugenics after World War II-As Available on http://www.eugenics-watch.com/roots/chap10.html- As accessed on 20th June, 2010.

Expanding Services for Injectables- Available on-
http://info.k4health.org/pr/k6/published/k6.pdf: As accessed on 18th April, 2010.

Fairhursta , Karen.et. al. "Emergency contraception: Why Can't You Give it Away? Qualitative Findings from An Evaluation of Advance Provision of Emergency Contraception".2004, *Contraception*, 70:25–29.

Fau´ndes, A, V.Brache, F.Alvarezb.2003. ''Emergency Contraception—Clinical and Ethical Aspects''. *International Journal of Gynecology and Obstetrics*; 82: 297–305.

Fau´ndes, Ani´bal.et.al.2007. ''Emergency Contraception under Attack in Latin America: Response of the Medical Establishment and Civil Society", *Reproductive Health Matters*;15(29):130–138.

FDA Warning Letters-Available on
http://www.pharmcast.com/WarningLetters/Yr2002/November2002/WomensCapital120302.htm- As accessed on 29th April,2010.

Feminism and Women's Right: Available on
http://www.cato.org/pubs/articles/feminism-women-rights.pdf: As accessed on 12th April, 2010.

FFPRHC Guidance.2006. "Emergency Contraception", *Journal of Family Planning and Reproductive Health Care,* 32(2): 121–128.

Forum for Women's Health.1995. "Contraceptives: Our Choices, Their Choices" in: Karkal, Malini.ed.1995.*Our Lives Our Health*. New Delhi.

Franklin, Sarah and Robbie Davis-Floyd.2001. "Reproductive Technologies", *International Encyclopedia of Women*, New York, Routledge.

Franks, Angela.2005.*Margaret Sanger's Eugenic Legacy: The Control of Female Fertility*. North Carolina, McFarland & Co, Jefferson.

Fried, Marlene.2006. "The Politics of Abortion: A Note"; *Indian Journal of Gender Studies*; 13: 229

From Norplant to Contraceptive Vaccine- As Available on- http://www.assatashakur.org/forum/afrikan-wholistic-health/16646-norplant-contraceptive-vaccine.html- As Accessed on 20th May,2010

From Right-Wing to Pro-Choice: The Shifting Goalposts of "Abortion Neutrality" .2009. Available on http://www.religiondispatches.org/archive/politics/2088/from_right-wing_to_prochoice:_the_shifting_goalposts_of_%E2%80%9Cabortion_neutrality%E2%80%9D_-As accessed on 12th April,2010

Funding the Eugenics Movement- Available on http://www.eugenics-watch.com/roots/chap12.html- As Accessed on 9th June, 2010.

G.D. Searle Develops the Pill-As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_searle.html- As Accessed on 5th June, 2010

G.I. Serour.2006. "Ethical guidelines on Conscientious Objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health". *International Journal of Gynecology & Obstetrics*;92(3).

Gainera, Erin et.al. 2003. Bringing Emergency Contraception Over the Counter: Experiences of Non-Prescription users in France, Norway, Sweden and Portugal, *Contraception*, 68:117–124.

Gangoli, Geetanjali.1998. "Reproduction, Abortion and Women's Health"; *Social Scientist*, 26(11-12): 83-105.

Ghosh, Bhaswat.et.al 2009. "Ectopic Pregnancy Following Levonorgestrel Emergency Contraception: A Case Report", *Contraception,* 79:155–157.

Global Teamwork in Developing a Contraceptive Implant.1990.*Choice and Challenge*, New York, The International Development Research Centre in collaboration with Population Council.

Goodson, Patricia. 1997. "Protestants and Family Planning"; *Journal of Religion and Health*, 36(4).

Gordon, Linda.1984. "Voluntary Motherhood: The Beginnings of Feminist Birth Control Ideas in the United States" in Leavitt, Judith Walzer (ed).1984. *Women and Health in America: Historical Readings*, Madison, University of Wisconsin Press.

Gordon, Linda.2007.The *Moral Property of Women: A History of Birth Control Politics in America,* United States of America,University of Illinois Press.

Greer, Germaine.1984.Sex *and Destiny-The Politics of Human Fertility*, London. Secker and Warburg.

Griffin, Leslie.2006.Conscience and Emergency Contraception; *Houston Journal of Health, Law & Policy*, 6(299).

Gupta, Amit Sen. Research for Hire.2001.Available on http://www.issuesinmedicalethics.org/094di111.html: As accessed on 2nd May 2010

Gupta.J.A.2000.New Reproductive Technologies, Women's Health and Autonomy-Freedom or Autonomy?, New Delhi. Sage Publications.

H. E. Mons. Jean-Louis Tauran.2000.The Defence of life in the context of International Policies and Norms. Available on-http://www.vatican.va/roman_curia/secretariat_state/documents/rc_seg-st_doc_20000211_tauran-acdlife_en.html: As accessed on 11th February, 2010.

Hardee, Karen .et.al.1997. "Three Countries' Experience with Norplant Introduction"; *Health Policy and Planning*, 12(3):199-213.

Hardon, Anita.1994. "The Development of Contraceptive Technologies: A Feminist Critique"; *Focus on Gender*, 2(2).

Hartmann, Betsy .1995. *Reproductive Rights and Wrongs: The Global Politics of Population Control*, Boston, South End Press.

Hartmann, Betsy.2006. "Liberal Ends, Illiberal Means: National Security, 'Environmental Conflict' and the Making of the Cairo Consensus"; *Indian Journal of Gender Studies*.2006.13:195.

Hendrixson, Anne.2004. "Angry Young Men, Veiled Young Women", *The Corner House*, Briefing 34.

Hickey, Martha and Catherine d'Arcangues.2002. "Vaginal Bleeding Disturbances and Implantable Contraceptives"; *Contraception*, 65, 75–84

Himes, Norman.1936.Medical *History of Contraception*. New York, Gamut Press Inc,

History of the International Planned Parenthood Federation: Available on http://www.ippf.org/en/About/History.htm- As accessed on 16th June,2010

Hormonal Contraception and HIV: Science and Policy-Available on http://whqlibdoc.who.int/hq/2006/WHO_RHR_06.4_eng.pdf-As accessed on 30th May,2010

http://pop.org/ As accessed on 29th March 2010

http://webcache.googleusercontent.com/search?q=cache:http://www.cecinfo.org/publications/newsletters/Update_Highlights10.96-10.97.rtf-Emergency Contraception Update Highlights: 10/96 to 10/97

http://www.aiims.ac.in/aiims/events/Gynaewebsite/ma_finalsite/drmittal.html-As Accessed on 4th April, 2010

http://www.plannedparenthoodnj.org/library/topic/emergency_contraception/brief_history_of_ec: As Accessed on 25th April,2010

http://www.who.int/reproductivehealth/topics/family_planning/ec/en/ As Accessed on 21st March 2010.

Illich, Ivan.1975.*Medical Nemesis--The Expropriation. Of Health*, London, Calders and Boyer.

Implantable Progestogen Contraceptives: Monitoring for Unintended Pregnancies2005- Available on- http://apps.who.int/medicinedocs/en/d/Js8117e/3.1.html- As accessed on 20th May, 2010.

Increasing Contraceptive options providing Depo-subQ Provera 104™ in the Uniject® device: Available on http://www.path.org/projects/uniject-dmpa.php: As accessed on 20th April, 2010.

Indian Docs Worry Emergency Contraception Misused: Available on http://www.womensenews.org/story/reproductive-health/081016/indian-docs-worry-emergency-contraception-misused: As Accessed on 25th March, 2010.

Injectable Contraceptive Use Rises in Madagascar-Community-Based Distribution Boosts Rural Access to Family Planning- Available on http://search.fhi.org/cgibin/MsmGo.exe?grab_id=108735485&extra_arg=&page_id=1303&host_id=1&query=injectables&hiword=INJECTABLES+INJECTABLE+- As Accessed on 30th May,2010.

Injectable Contraceptives for Women .1999-Available on - http://www.gfmer.ch/Endo/Lectures_11/Arcangues.htm:Injectable Contraceptives for Women-As accessed on 15th March, 2010.

International Consortium for Emergency Contraception.2003.*Repeated Use of Emergency Contraception: The Facts* (Policy Statement.), New York.

Kallianes, Virginia and Phyllis Rubenfeld. 1997. "Disabled Women and Reproductive Rights"; *Disability and Society*, 12(2).

Karkal, Malini. "Reproductive Rights and Reproductive Health of Women". In: J.P.Singh (ed).1998. *Studies in Social Demography*, New Delhi, M.D.Publication Pvt Ltd.

Kaunitz et. al .2009. ''Subcutaneous DMPA vs. Intramuscular DMPA: a 2-year Randomized Study of Contraceptive Efficacy and Bone Mineral Density''; *Contraception*, 80:7–17.

Kesseru E, Larranaga A, Parada J. 1973. " Postcoital Contraception with dl-norgestrel"; *Contraception;*7:367.

Klein, Renate and Lynette J. Dumble.1992. "RU 486/Prostaglandin Threats to Safe Pregnancy Termination"; *Reproductive and Genetic Engineering: Journal of International Feminist Analysis*, 5(2).

Kulczycki, Andrzej.2007. "Ethics, Ideology, and Reproductive Health Policy in the United States"; *Studies in Family Planning,* 38 (4).

Lift Ban on Emergency Contraceptive Ads: Panel-http://lite.epaper.timesofindia.com/getpage.aspx?articles=yes&pageid=11&max=true&articleid=Ar01104&sectid=9edid=&edlabel=TOIPU&mydateHid=04-03-2010&pubname=Times+of+India+-+Pune+ +Times+Nation&title=Lift+ban+on+emergency+contraceptive+ads%3A+Panel&edname=&publabel=TOI As accessed on 2nd April, 2010.

Lingam, Lakshmi.Reproductive Technologies and Violation of Women's Bodies in Lingam, Lakshmi (ed) .1998. Understanding Women's Health Issues: A Reader, New Delhi, Kali for Women.

Liskin,L , Blackburn, R., and Ghani, R. 1987. "Hormonal Contraception: New Long-acting Methods"; *Population Reports*, Series K, 3.

London, Leslie.2002. "Ethical Oversight of Public Health Research: Can Rules and IRBs Make a Difference in Developing Countries?"; *Health Policy and Ethics Forum*,92(7)

Lorber, Judith. The Variety of Feminisms and their Contribution to Gender Equality-Available on http://www-a.ibit.uni-oldenburg.de/bisdoc_redirect/publikationen/bisverlag/unireden/ur97/kap1.pdf:As accessed on 14th May, 2010.

Lupton, Deborah. "Foucault and the Medicalisation Critique". Petersen, Alan and Robin Bunton (eds).1997.*Foucault Health and Medicine*. Routledge, London and New York.Ch.5

Lynn P Freedman.1996. "The Challenge of Fundamentalism"; *Reproductive Health Matters, 8.*

M.E. Khan.et.al.2008.Introduction of Emergency Contraceptive Pills in the Public Health System of Pakistan, A South-to-South Collaboration Frontiers in Reproductive Health, Population Council. Pakistan.

Madry. Jr, John and Russel.J.Thomsen "Testimony on Intrauterine Devices" in Tone, Andrea. 1997. *Controlling Reproduction: An American History*, United States of America, Scholarly Resources Inc.

Mainstreaming Emergency Contraception -A Report on the Compton Foundation's Emergency Contraception Initiative — 2002-2007 – As available

http://www.comptonfoundation.org/ec_initiative.html-As accessed on 8th May 2010.

Malat, Jennifer.2000. "Racial differences in Norplant use in the United States"; *Social Science & Medicine*, 50:1297-1308.

Margulies, Lazar.1975. "History of Intrauterine Devices"; *Bulletin of New York Academy of Medicine*, 51(5).

McCain, John and Washington Women's Liberation. "Testimony on Oral Contraceptives" in Tone, Andrea. 1997. *Controlling Reproduction: An American History*, United States of America, Scholarly Resources Inc.

McLeod, Carolyn.2010. "Harm or Mere Inconvenience? Denying Women Emergency Contraception"; *Hypatia*; 25(1)

Medicalisation: Available on: www.ucel.ac.uk/shield/docs/rlo_spec**medical**sation.doc- Accessed on 13th April,2010

Meirik, Olav.et.al .2003. "Implantable Contraceptives for Women"; *Human Reproduction Update*, 9(1): 49-59.

Ministry of Health and Family Welfare Government of India.2008.Guidelines for Administration of Emergency Contraceptive Pills by Health Care Providers. Family Planning Division, New Delhi.

Mintzes.Barbara, Hardon.Anita and Hanhard.Jannemieke.1993.*Norplant: Under Her Skin. The Women's Health Action Foundation*, Netherlands, Women and Pharmaceuticals Project, and WEMOS.

Mohammed, Sharif, Ismail Hossain, M. E. Khan, Moshiur Rahman and Mary Philip Sebastian .2005.*South East Asia Regional Training Manual Emergency Contraceptive Pills*. USAID, Population Council and Frontiers of Reproductive Health, New Delhi.

Muia, Esther et.al. 1999. Emergency Contraception in Nairobi, Kenya: Knowledge, Attitudes and Practices among Policymakers; *Contraception*, 60:223–232.

Nayyar, Anjali.2000. "Increasing Access to Emergency Contraception in India"; Health and Population- Perspectives and Issues, 23(3): 123-133

Nelson, Jenifer.2003. *Women of Color and Reproductive Rights Movement*, United States of America, New York University Press.

New Emergency Contraception Drug Stirs Old Arguments: Available on http://www.ourbodiesourblog.org/blog/2010/02/new-emergency-contraception-drug-stirs-old-arguments:As accessed on 29th March 2010.

Noé Gabriela et.al.2010. "Contraceptive Efficacy of Emergency Contraception with Levonorgestrel given before or after Ovulation"; *Contraception,* 81(5):414-420

Norplant – Available on www.popcouncil.org/what/norplant.asp -As Accessed on 10th October, 2009.

Olav Meirik, Ian S.Fraser and Catherine d'Arcangues1.2003. "Implantable contraceptives for Women"; *Human Reproduction Update for the WHO Consultation on Implantable Contraceptives for Women*,9(1): pp. 49-59

Ollila, Eeva.1999.*Norplant in the Context of Population and Drug Policies.* STAKES National Research and Development Centre for Welfare and Health, Finland.

Our Beginnings –Available on-http://www.cecinfo.org/about/history.htm As accessed on 1st January, 2010.

Owen, Susan and Caudill, Sally- Contraception and Clinical Science- "The Place of Women in Reproductive Technology", Parrott, Louisselle Roxanne and Condit Celeste Michelle (eds).1996. *Evaluating Women's Health Messages-A Resource Book*, Sage Publications

Paddock, William C.1998. The Emasculation of the Population Movement; *Population and Environment: A Journal of Interdisciplinary Studies*, 19(5).

Parke.Chris.2005. "Adolescents and Emergency Contraceptive Pills in Developing Countries"; *Family Health International*, WP05–0.

Parsons, Claire 1990. "Drugs, Science, and Ethics: Lessons from the Depo-Provera Story"; *Reproductive and Genetic Engineering- Journal of International Feminist Analysis,* 3.

Persleva, A.et.al.2002. "Emergency Contraception: Knowledge and Use Among Danish Women Requesting Termination of Pregnancy"; *Contraception*, 66:427–431.

Petchesky R P .1980. "Reproductive Freedom: Beyond "A Woman's Right to Choose"; *Signs,* 5 (4): 661-685.

Piramal Healthcare Acquires "i-pill", a Leading Emergency Contraceptive Brand from Cipla Available on http://www.fiercebiotech.com/pressreleases/piramal-healthcare-acquires-i-pill-leading-emergency-contraceptive-brand-cipla#ixzz0pihOC1u1 As Accessed on 10th April, 2010.

Planned Parenthood cut Sweetheart Deal with Producer of 'Emergency Contraceptive' Plan B.2005. As Available on-http://www.lifesitenews.com/ldn/2005/aug/050825a.html As accessed 3rd April, 2010.

Population Reports .2006. "Expanding Services for Injectables: How Family Planning Programs and Providers Can Meet Clients' Needs for Injectable Contraceptives": Available on http://info.k4health.org/pr/k6/published/k6.pdf- As Accessed on 10th, December 2009.

Priyaranjan.2007, "Setting the Agenda for Neo-Eugenics: An Exploration", Unpublished, MPhil Dissertation submitted to Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

Progestogen-only Contraceptive Use during Lactation and Its Effects on the Neonate: As Available on- http://whqlibdoc.who.int/hq/2009/WHO_RHR_09.13_eng.pdf- As Accessed on 20th December, 2010.

Pruitta L, Sandi and Patricia Dolan Mullen.2005. "Contraception or Abortion? Inaccurate Descriptions of Emergency Contraception in Newspaper Articles", 1992–2002; *Contraception*; 71:14– 21.

Qadeer, Imarana.1998. "Reproductive Health: A Public Health Perspective"; *Economic and Political Weekly*, 30(41):2675-84

Rao, Mohan.1994. "An Imagined Reality: Malthusian, neo-Malthusian and Population Myth"; *Economic and Political Weekly*, 29(5).

Rao, Mohan(ed).2004.*The Unheard Scream- Reproductive Health and Women's Lives in India*, New Delhi, Zubaan-An Associate of Kali for Women.

Rao, Mohan.2004.*From Population Control to Reproductive Health- Malthusian Arithmetic*, India,Sage Publications Pvt.Ltd.

Rao, Mohan.2006. "Cairo Door Ast? Population Policies and their Context in India after ICPD"; *Indian Journal of Gender Studies*, 13(247)

Rao, Mohan.2006. "Introduction: Taming the Beast"; *Indian Journal of Gender Studies*; 13; 163.

Ravindra R P.1999. Reject the Injectables- Available on http://www.issuesinmedicalethics.org/072ed047.html- Accessed on 5th January, 2010.

Regional Consortia- Available on http://www.cecinfo.org/worldwide/regionalConsortia.htm- As accessed on 5th April, 2010

Ross, Loretta.2006.Understanding Reproductive Justice, Sister Song Women of Color Reproductive Health Collective – Available on-www.SisterSong.net- As accessed on 15th December, 2009.

Ross, Loretta.et.al. "Just Choices: Women of Colour, Reproductive Health and Human Rights" in Silliman, Jael and Anannya Bhattacharjee (eds).2002.*Policing the National Body: Race, Gender and Criminalization*, Massachusetts, South End Press.

Roy, Somnath and Anupam Basu.2002.Emergency Contraception (A Second Chance for Preventing Unwanted Pregnancy and Unsafe Abortion) And Use of Regular Contraceptives- A Guide For Medical Practitioners and Medical Officers; Department of Communication, National Institute of Health and Family Welfare, New Delhi.

RU-486: A dangerous drug- As Available http://www.ru486.org/ru1.htm- As accessed on 17th June,2010

S O G C- Clinical Practice Guidelines.2003.Emergency Contraception, 131.

S. Anandhi.2006.Indigenous Malthusian: Birth Control Debates in Early Twentieth Century: http://www.cwpe.org/node/46: As accessed by 10th June,2010

Safety of Levonorgestrel-Alone Emergency Contraceptive pills-Available on http://www.who.int/reproductivehealth/publications/family_planning/HRP_RHR_10_06/en/- As Accessed on 23rd

Saheli Women's Resource Centre.1998.*Target Practice: Anti Fertility Vaccine Research and Women's Health*, New Delhi.

Sama-.2003.*Unveiled Realities-A study on Women's Experiences with Depo-Provera, an Injectable Contraceptive,* Sama-Resource Group for Women and Health .India.

Sarkar, N. N. 2008. "Barriers to Emergency Contraception (EC): Does Promoting EC Increase Risk for Contacting Sexually Transmitted Infections, HIV/AIDS?"; *International Journal of Clinical Practice*, 62 (11):1769–1775.

Satyamala, C.2000.*An Epidemiological Review of the Injectable Contraceptive-Depo-Provera.* India. Medico Friends Circle and Forum for Women's Health.

Schiappacasse, V, S. Diaz .2006. "Fulfilling Women's Reproductive Intentions Access to Emergency Contraception"; *International Journal of Gynaecology and Obstetrics*, 94: 301—309.

Scudder,Laurie.2008. Are There Contraindications to Switching From Intramuscular to Subcutaneous Depo-Provera?- Available on http://www.medscape.com/viewarticle/584971: As Accessed on 19th May,2010.

Segal, S.J.1999. "Liability Concerns in Contraceptive Research and Development"; *International Journal of Gynecology & Obstetrics*, 67(2)

Sen, Gita and Carmen Barroso. 1996. "After Cairo: Challenges to Women's Organizations", Workshop on Reproduction Health, Rights and Women's Empowerment. Center for Development Studies. Sept 4-14.

Sen, Amartya.1981.Poverty *and Famines: An Essay on Entitlement and Deprivation*, UK, Oxford,

Sexton, Sarah and Nicholas Hildyard.2005. "Managing Resources, Managing People: The Political Uses of Population" – Available on http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/Surrey.pdf- As accessed on 15th June, 2010.

Sharing Responsibility Women Society and Abortion Worldwide-Available on http://www.guttmacher.org/pubs/sharing.pdf- As Accessed on- 13th May 2010.

Sheffer-Mimouni, Galit et.al.2003. "Ectopic Pregnancies Following Emergency Levonorgestrel Contraception"; *Contraception,* 67:267–269.

Sherman, Christy. 2005. "Emergency Contraception: The Politics of Post-Coital Contraception"; *Journal of Social Issues,* 61(1): 139-157.

Should sale of emergency contraceptives be restricted?- As Available on http://www.dnaindia.com/speakup/report_should-sale-of-emergency-contraceptives-be-restricted_1324171- As Accessed on 18th June,2010

Silliman, Jael et.al.2004.*Undivided Rights-Women of Color Organize for Reproductive Justice*. Massachusetts, South End Press.

Simelela.N.2006. "Women's Access to Modern Methods of Fertility Regulation"; *International Journal of Gynecology and Obstetrics*, 94:292-300.

Simond, Wendy and Charlotte Ellertson.2004. "Emergency Contraception and Morality: Reflections of Health Care Workers and Clients"; *Social Science & Medicine*, 58: 1285–1297.

Simon-Kumar, Rachel.2007. "Neo-liberal Development and Reproductive Health in India : The Making of the Personal and the Political"; *Indian Journal of Gender Studies*,14: 355 -385 .

Singh, Jyoti Shankar.1998. *Creating a New Consensus on Population*, United Kingdom, Earthscan Publications Ltd.

Sivin, Irving.et.al.1998. "The Performance of Levonorgestrel Rod and Norplant Contraceptive Implants: A 5 Year Randomized Study"; *Human Reproduction*, 13(12):3371-3378.

Sobol, Richard.1991.*Bending the Law: The Story of the Dalkon Shield Bankruptcy*, United States of America, University of Chicago Press.

SOGC Clinical Practice Guidelines.2006. "Canadian Contraception Consensus-Update on Depot Medroxyprogesterone Acetate (DMPA)", 174.

Soloway, Richard Allen.1978. "Neo-Malthusians, Eugenists, and the Declining Birth-Rate in England, 1900-1918"; *Albion: A Quarterly Journal Concerned with British Studies*, 10(3).

Solter, Cathy.1999. "Comprehensive Reproductive Health and Family Planning Training Curriculum Module 6: DMPA Injectable Contraceptive", *Medical Services Pathfinder,* USA.

South- East Asia Advisory Committee on Health Research Twenty- First Session- Available on http://repository.searo.who.int/bitstream/123456789/5544/2/sea_achr_21_inf.18.Pdf: As accessed on- 21st April, 2010.

Srinivas, K Ravi.; Kanakamala, K .1992. "Introducing Norplant: Politics of Coercion"; *Economic and Political Weekly*. 27(29): 1531-1533.

Stanworth, Michelle, "Reproductive Technologies and the Deconstruction of Motherhood" in Michelle Stanworth(ed) .1987. *Reproductive Technologies: Gender, Motherhood and Medicine*, Cambridge, Polity Press.

Statement on Norplant, Anti-pregnancy Vaccines and RU486, Presented at the 6th IWHM, 3-9 November 1990, Quezon City, Philippines.

Study on 2 Monthly Injectable Contraceptive Norethisterone Enanthate (200mg)- Available on http://www.mohfw.nic.in/dofw%20website/Final_Net-En_Report.pdf- As Accessed on 15th December 2009

Tabah, Leon .1984. "Preparations for the 1984 International Conference on Population"; *Population and Development Review*, 10 (1): 81-86

The Boston Pill Trials- As Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_boston.html- As Accessed on 5th June 2010

The Catholic Church - As Available on- http://www.pbs.org/wgbh/amex/pill/peopleevents/e_church.html- As Accessed on 5th June 2010

The Corner House: Briefing 27.2002. The Origins of the Third World: Markets, States and Climate Markets, Available on http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/27origins.pdf: As accessed on 15th June, 2010.

The Development of Synthetic Hormones- As Available on- http://www.pbs.org/wgbh/amex/pill/peopleevents/e_hormones.html- As accessed on 5th June, 2010.

The Facts About Emergency Contraception-Available on ://www.arhp.org/publications-and-resources/clinical-fact-sheets/facts-about-ec Accessed on 10th January,2010

The International Consortium for Emergency Contraception-Available on http://www.cecinfo.org/index.php -As accessed on 1st January, 2010.

The Pill and Informed Consent - Available on http://www.pbs.org/wgbh/amex/pill/peopleevents/e_informed.html- As Accessed on 5th June 2010.

Tirelli, Alessandra Angelo Cagnacci and Annibale Volpe.2008. "Levonorgestrel Administration in Emergency Contraception: Bleeding Pattern and Pituitary-Ovarian Function"; *Contraception*, 77:328–332.

Tone, Andrea. "A Medical Fit for Contraceptives" in Wyer, Mary.et.al. (eds).2008.*Women, Science and Technology: A Reader in Feminist Science Studies*, New York, Routledge.

Tone, Andrea.1996. "Contraceptive Consumers: Gender and the Political Economy of Birth Control in the 1930s"; *Journal of Social History*,29(3):485-506

Tone, Andrea.2000. "Black Market Birth Control: Contraceptive Entrepreneurship and Criminality in the Gilded Age"; *The Journal of American History*, 87(2): pp. 435-459

Tone, Andrea.2002. "Making room for Rubbers: Gender, Technology, and Birth Control Before the Pill"; *History and Technology*, 18 (1): 51–76

Tone, Andrea.2006. "From Naughty Goods to Nicole Miller: Medicine and the Marketing of American Contraceptives"; *Culture, Medicine and Psychiatry.* 30: 249–267.

Trussell, James, Eleanor Bimla Schwarz and Katherine Guthrie.2010. "Research Priorities for Preventing Unintended Pregnancy: Moving Beyond Emergency Contraceptive Pills"; *Perspectives on Sexual and Reproductive Health*, 42(1).

Trussell, James, Elizabeth G. Raymond, 2010. "Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy" –Available on http://ec.princeton.edu/questions/ec-review.pdf: As accessed on 5th April, 2010.

Trussell, James.1997. "Breaking the Silence on Emergency Contraception"; *Lifelines*, 15.

Tummino v. von Eschenbach (NY): Available on http://reproductiverights.org/en/case/tummino-v-von-eschenbach-ny:: As accessed on 10th May,2010

Turshen, Meredeth.2007. "What has Happened in Africa since Cairo?"; *Indian Journal of Gender Studies*,14:387

U.S. Medical Eligibility Criteria for Contraceptive Use.2010.*Morbidity and Mortality Weekly Report*, 59.

UBINIG.1990. "Research Report Norplant, The Five Year Needle: An Investigation of the Norplant Trial in Bangladesh from the User's Perspective"; *Reproductive and Genetic Engineering: Journal of International Feminist Analysis*.3 (3).

UBINIG.1993. "The Population Issue: A Third World Women's Perspective"; *People's Perspectives*, 1.

UNFPA. 2002. Donor Support for Contraceptives and Condoms for STI/HIV Prevention, New York

UNFPA.2007. Donor Support for Contraceptives and Condoms for STI/HIV Prevention, New York

United States District Court Eastern District of New York, Case 1:05-cv-00366-ERK-VVP, Document 282 Filed 03/23/2009.

Upadhyay, Ushma, Indu Adhikary, and Catherine Richey.2005. "New Contraceptive Choices"; *Population Report M*, 19.

Visvanathan, Nalini.2009. "Hormonal Contraception and HIV Disease Acquisition: A Limited Review and Reassessment of Findings", *Population and Development Program's Reviving Reproductive Safety Project (A Discussion Paper),* Hampshire College, Amherst.

Weisberg, Edith and Ian S. 2009. "Fertility Regulation Rights to Emergency Contraception"; *International Journal of Gynaecology and Obstetrics*; 106:160–163

Westley, Elizabeth and Anna Glasier.2010. "Emergency contraception: Dispelling the Myths and Misperceptions"; *Bulletin of World Health Organisation,* 88(4):241-320

White, Katherine Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights. Available on-http://www.questia.com/googleScholar.qst;jsessionid=MGgBGjZGdTFp5nrKPVk5vt7fnYwGZGr1j3WRSBhGCc5ppqm38hJG!-1212072275!-1754635462?docId=5001276118-As Accessed on 2nd May, 2010.

WHO Consensus Statement on Emergency Contraception. 1995. *Contraception*; 52:211-213.

WHO Family Planning Cornerstone.2007.A Global Handbook for Providers Evidence-based guidance Developed through Worldwide Collaboration. Geneva.

WHO/HRP.2005.*Technical Consultation on the Effects of Hormonal Contraception on Bone Health-Summary Report.* Geneva

Women's Global Network for Reproductive Rights.2004. "A Decade after Cairo: Women's Health in a Free Market Economy"; *The Corner House*. Briefing 31

Ziebland, Sue.1999. "Emergency Contraception: An Anomalous Position in the Family Planning Repertoire?"; *Social Science & Medicine*, 49.

Zubrigg, Shiela.1992. "Hunger and Epidemic Malaria in Punjab 1868-1940"; *Economic and Political Weekly*, 27 (4):2-26.