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Neo-Eugenics [1]: The Quinacrine Sterilisation of Women in India

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Introduction

There can be little doubt that the last two hundred years have seen advances in health which have seldom before been witnessed in human history. These include unparalleled advances in the expectation of life at birth, remarkable decline in infant and child mortality, a marked decrease in the birth rate and so on. The large majority of health professionals, as indeed social scientists and the lay public, assume that these improvements in human health occurred due to advances in medical technology. Thus it is that planners frequently measure advances in health provision by indices such as the number of doctors and hospital beds per thousand population. In other words, there is an ahistorical, unproblematised consensus, seldom if ever scrutinised, that science and technology in medicine offer a veritable cornucopia to humankind.

This extends to the field of family planning and the use of contraceptives. It is often forgotten that birth rates in the West declined in the absence of reliable contraceptive technology and indeed in the face of opposition by both the state and religion to their use. What factors together determined this historical decline of fertility in these countries are similarly forgotten as the growth rates of Third World populations are surveyed with alarm. A host of assumptions about the reproductive profligacy of the poor in these countries and the problems they are said to engender to economic development, health and the environment underlie the uncritical acceptance of solutions to these problems in the domain of contraceptive technology, most often directed at poor women. A concatenation of such factors together give birth to scientific scandals as the quinacrine sterilization of women now going on clandestinely in India.

It is not being contested that contraceptive technologies have not benefited women: neither is it being asserted that women in India are not seeking contraception. What is being attempted by discussion of the issue of quinaerine sterilization is to throw light on the web of factors which congeal into a certain kind of intervention into women's lives and question the scientific, or in public health terms, the epidemiological basis of this understanding.

I

Quinacrine was widely used as an anti-malarial in the thirties and forties before it was replaced by drugs such as chloroquine. Current interest in the drug stems from the novel use that has been found for it: as a method of non-surgical female sterilization. Issues of safety, efficacy and ethics have dogged the course of its "trials" around the world.

The method was developed in Chile by Dr. Jaime Zipper in the 1970s and tried out over the next decade and a half in three public hospitals involving 1500 women. For non-surgical sterilization, the method involves the trans-cervical application of pellets of quinacrine in the early phase of the menstrual cycle using a modified. Copper-T IUD inserted into the fundus of the uterus. While various schedules have been tried, the most common involves the insertion of seven pellets of 36 mg of quinacrine performed either once or twice.

The insertion of quinacrine into the fundus of the uterus leads to local inflammation. The scar tissue that follows the inflammation gives rise to tubal occlusion, and hence irreversible sterilization. In other words, this is a method of chemical sterilization, which has a barbaric history going back to the Nazi concentration camps. The victims in that grand eugenic design were jews, gypsies, communists and those deemed "unfit" by the science of eugenics. While the scientific credentials of eugenics were completely stripped by the work of Haldane and Muller, the ideas underlying such endeavours persist. They come to the fore in neo-eugenics endeavours: the women now being subject to this method of sterilization are poor women in a host of Third World countries where the Neo-Malthusian [2] chicken comes painfully home to roost.

The quinacrine insertions do not require anaesthesia or trained personnel and can be performed in areas with no access to health facilities. While these are listed as some of its operation advantages, given the nature of family planning programmes in many developing countries and the poor development of public health infrastructure, it is precisely these factors which endow this method with a high potential for abuse. Indeed that these are not merely Cassandra's fears is grimly brought home in a documentary on these trials in New Delhi entitled A Yellow Haze made by students at the Mass Communication Department of Jamia Milia Islamia. This documentary features an interview with a woman who, having approached a clinic for the insertion of a Copper-T, is sent back sterilized with quinacrine.

In Vietnam more than 31,000 women underwent quinacrine sterilization between 1989 and 1993 before the trial was called off following the recommendations of the WHO. A retrospective study of more than 1600 of the women was carried out

in 1994 but the report of this study has not yet been published. In India the Drug Controller permitted the Indian Council of Medical Research (ICMR) to carry out a trial with quinacrine in 1992. But much before the trial could be completed, the extremely high failure rate of the method compelled the ICMR to terminate these trials. Since then no institution wishing to conduct trials with quinacrine have approached the Drug Controller of India for his mandatory permission, thus rendering all of them illegal. Nor has the Government of India permitted the import of the drug into the country. Despite this, what is astounding is the scale and spread of this illegal procedure in so many parts of the country.

In June 1994, the WHO consultation on Female Sterilization Methods, reviewing the world-wide evidence of quinacrine sterilization to date, called for the conduct of four pre-clinical toxicology studies on quinacrine before approval of the drug for clinical testing on women. It categorically stated that human clinical trials should be stopped forthwith pending the outcome of these tests.

Family Health International (FHI), an NGO in the USA previously involved with Norplant trials on women in Bangladesh that raised serious ethical and scientific questions, decided to carry out these studies with funding from USAID. The rationale was that a safe and effective non-surgical method of sterilization would be cheaper than surgical methods of sterilization.

In September 1995, the FHl's publication Network indicated that three of four tests with quinacrine were positive, i.e. that quinacrine was mutagenic (causing mutations or changes in cells). While not all mutagenic substances are carcinogenic or cancer causing, more tests on laboratory animals would be necessary to exclude carcinogenicity. In addition to its potential carcinogenicity, the drug has also to be assessed for its embryotoxicity. In view of these findinds, the US government stopped the funding of these studies. Further, problems developed with the next step involving trials on rodents: problems with route of insertion, dosage, number of insertions, and the high mortality among rodents which have to be subjected to repeated anaesthesia during the course of the tests.
In Chile, meanwhile, there was an outcry in 1994 led by a broad-based coalition called Open Forum for Reproductive Health and Rights on the question of quinacrine trials. The group voiced four main concerns:

1. Unresolved issues of safety;

2. The WHO recommendation that clinical trials not be carried out till toxicology trials are satisfactorily completed;

3. The need for informed consent procedures that were lacking in the Chilean trials;

4. Scrutiny of the trial documents by an ethics committee to assess both ethical and safety standards.

The Chilean Ministry of Health withdrew its support to the trial in December 1994; the public hospitals were asked to review their internal ethical procedures. However, Dr. Zipper and his team are reportedly continuing the trials in private hospitals with the financial support of the US based NGO, The Centre for Research on Population and Security.

The Centre for Research on Population and Security is a two-man NGO run by two doctors, Dr. Elton Kessel and Dr. Stephen D. Mumford. They receive funding from right wing, racist, anti-immigration groups. Dr. Kessel is on record that as a patriotic American he is proud to receive funding from such sources as he believes that, should the US allow free immigration, it would soon be turned into a Third World country. In a published paper they also argue that population control in Third World nations is of paramount importance to US security interests. The Centre for Research on Population and Security is funding quinacrine research in India, Bangladesh and Chile, among other countries. In India it funds the quinacrine "trials" being carried out in Calcutta, Delhi, Baroda and Bangalore. Dr. Biral Mallik in Calcutta claims to have sterilized more than 10,000 women with quinacrine. Dr. Pravin Kini and Dr. Sita Bhateja in Bangalore have set themselves a target of 25,000 sterilization to be performed over the next two years. In New Delhi, Dr. Maya Sood of the Obstetrics and Gynecology department at the Lady Hardinge Medical College admits to having carried out a trial with financial support from Dr. Eiton Kessel. Reports indicate that trials are also going on in other cities in India -- and indeed are spreading to rural areas -- and that these are being carried out largely by NGOs and doctors in the private sector. The supply of drugs and equipment for all these trials in the country is being coordinated by Dr. J.K. Jain, former BJP member of the Rajya Sabha, who runs the Jain Medical Centre. Indeed Jain Studios, also owned by Dr. Jain, has made a promotional video film on quinacrine sterilizations that is being distributed all over the world by Kessel and Mumford.

What is motivating otherwise well-intentioned medical professionals, many of them eminent female gynecologists, into involvement in this entirely dubious enterprise is a lot of rhetoric about "reproductive health" and "choice" which is beguiling to those not initiated in issues in public health. Thus we are told hat quinacrine sterilization can liberate Third World women from the horrendous toll of maternal deaths. What is ignored is the entirely fallacious nature of the argument: what causes maternal deaths is the appalling health status of women in these countries and the absence of emergency obstetric care in the event of complications of pregnancy and delivery. Quinacrine -- or for that matter, other

methods of contraception -- does nothing to address these fundamental issues. Indeed in India mortality data indicates that even within the reproductive age group of women, causes due to reproduction account for merely 12 percent of all deaths: the major causes of death remain diseases of poverty, viz. infectious diseases and undernutrition.

II

The major factors, which have coalesced to make the quinacrine sterilization scandal possible, is not something inherent in the nature of science and technology. One major set of factors is the efforts at the "rolling back" of the state now accepted as part of the package of liberalization and globalization in our country. This has led to the undermining of public institutions, including those like the ICMR and the DCI which have played a crucial role in earlier years in not only conducting research, but in monitoring and regulating the kind of public health research that is being carried out in the country. Today a host of NGOs and private individuals, not competent or mandated to carry out research on human populations, willfully by-pass the institutions of the state and, with funding from private bodies in the West, carry out research like the quinacrine trials.

A second major reason is the euphoria created by the neo-liberal discourse on rights, including "reproductive health" and "reproductive choice", in international circles which find reflection in health policies in our country. What is elided in this discourse is that to talk of reproductive rights in the face of lack of rights to food, water, employment, incomes, access to education, health, and indeed survival, is to make a travesty of women's rights. Women in the Third World countries have, often enough in the past, paid the cost in terms of their health and well-being for the benefits by way of improved contraception which primarily accrued to women in the Western countries: for example the low-dose hormonal oral contraceptive pills were refined after trials with extremely risky high-dose combinations carried out in Puerto Rico. Similarly, it is not any woman in India who runs the risk of being sterilized by quinacrine without either her knowledge or informed consent, but women who are poor, lower caste, and perhaps from the minorities. Neither should it be forgotten that many of the votaries of this barbarous technique are women.

It appears that a structurally adjusted and weakened state is incapable or unwilling to take a stand to protect the health and well being of its poorer citizens. That this is happening in the field of women's health is not surprising: evidence from a host of countries in Africa and Latin America has revealed that among the poor, women bear a larger brunt of these policies.

Notes

1. 'Science' of Eugenics, based on selective breeding of humans, was pioneered in the nineteenth century for the so-called betterment of the human race. It was, however, scientifically discredited in the 1930s. For details on Eugenics and Neo-Eugenics, see Greer, G., 1984.

2. Neo-Malthusianism is a variant of the Malthusian doctrine, which holds population growth responsible for poverty. For details on Malthusianism and Neo-Malthusianism, see Rao, M., 1994.

References

1. Greer, Germaine. 1984. 'Sex and Destiny: The Politics of Human Fertility'. Secker and Warburg, London.

2. Rao, Mohan. 1994. 'An Imagined Reality: Malthusianism, Neo-Malthusianism and the Population Myth in Economic and Political Weekly, Vol.29, no.42, October 15.