Politics of Contraceptive Technology
Depo-Provera in New Zealand

sally washington

The development and dissemination of injectable contraceptives provides a good illustration of the politics of contraceptive research and its international dimensions. It is also an example of the capitalist patriarchal control over women's fertility. The article throws light on the $ six million clinical trial which was conducted in New Zealand by Upjohn, the sole manufacturer of the contraceptive. Needless to say a majority of women on whom the drug was tried were black and working class as well as Maori women. The New Zealand trial was extremely important to the manufacturers for several reasons and moreover there were several conditions in the country which made it convenient for Upjohn. Not surprisingly women's struggles against these trials have been determinedly put down.

IN the patriarchal mode of reproduction, women lose their social power at the moment of conception when the work of reproduction begins. There is no right time to become pregnant because in this mode, sex, procreation and the socially necessary work of parenting are inextricably linked and all occur under male control. (Trainer, 1986). In theory however, contraception allows individual women to plan when they will confront this process. Female control of fertility is therefore an essential condition of women's self determination and is an important site for gender struggles.

Women do not make real choices about when or whether to reproduce. It is a misnomer to talk about 'free choices' when the means of contraception (the pill, injectables, intra uterine devices [IUDs] etc) are not primarily developed according to women's needs, but are determined by the forces of the capitalist patriarchy mediated by the state, the medical establishment and the multinational drug corporations.

In this article I examine the patriarchal means of contraception to discover the real relations behind their development and dissemination. I shall use the example of the injectable contraceptive Depo-Provera as one of the most horrific examples of the capitalist patriarchal control of women's fertility, and one that has special relevance for New Zealand women. I shall also attempt to link this discussion to the current struggle by Indian women to have a similar (progestogen based injectable) contraceptive, Net-Oen, banned in their country.

A Patriarchal Industry

Men dominate the contraceptive industry at every level; in research and development, as manufacturers and suppliers, and as regulatory authorities. Male dominance means that the contraceptive cafeteria reflects patriarchal needs to control female fertility. Common features of 'modern' contraceptives, are that they control female rather male fertility. The form that their administration takes, is that birth control is a female responsibility. Virtually no research has gone into male contraception. The repertoire is currently limited to condoms and sterilisation, as patriarchy could not tolerate tampering too much with male fertility.

Birth control is also a commodity. The forces of patriarchy determine that contraceptives should be aimed at female fertility, but the detailed decision about which contraceptives will be developed are determined by the forces of capitalism. The bulk of research money pours into IUDs, the pill and methods of 'reversible' sterilisation including injectables, while barrier methods receive minimal investigation. Barrier methods have limited profitability whereas chemical methods are "amongst the most profitable of all pharmaceuticals" (Bunkle, 1983).

Chemical methods are presented as more 'effective' but the real reason why they are given such priority is because they are administered by medical professionals, not controlled by the women who use them. Chemical methods are typically dangerous so women must be kept ignorant of their functioning.

The patriarchal monopoly of contraceptives and contraceptive information means that women must either 'accept' whatever is developed and offered by patriarchy and risk dangerous side effects, or 'fall' pregnant and face a possible lifetime of domestic drudgery. The social conditions of our lives and the wider political system in which we live influence the extent of risk we will take as well as the awareness of that risk. In countries like India, a women's ability not to become pregnant often means better access to housing, schooling for their children and health services: all typical family planning incentives, (Balasubrahamanyam 1986).

While modern contraceptives appear to give women some choice about when they reproduce, the real structures at work are patriarchal and hence, do not serve women's needs. Capitalist corporations require that contraceptives maintain profitability, imperialist nations require effective population control weapons and the medical profession demands that contraceptives are monopolised so that only medical 'experts' can administer them. Under these criteria, Depo-Provera and its injectable cohorts are ideal contraceptives.

Depo-Provera in New Zealand

Depo-Provera works by inhibiting ovulation and is administered by injection once every three months. It is however, a temporarily irreversible drug which cannot be purged from the bloodstream once injected. Those women then, who suffer severe side effects from it must endure these for at least three months. Millions of women are using Depo-Provera worldwide which given its dubious safety record, amounts to a massive experiment on women, (Bunkle, 1985). Since the patent on DMPA, the progestogen used in Depo, expired in 1984, other brands of injectable contraceptives have flourished. One of these is Net-Oen. Given that the active agent in progestogen-based injectables is similar if not identical to Depro-Provera, it could logically be argued that the side-effects will also be similar. Certainly the means by which multinational corporations have 'tested' and disseminated their particular brands have been surprisingly similar.

America's Upjohn Corporation took over the development of Depo in the 1960s. The drug had been used in the 1950s

but had been cast aside because it caused disease of the uterus (Unity, 1982). In 1965 Upjohn researches began human experiments on Thai women using three monthly doses of Depo which were later increased to six monthly doses.

In 1969 Upjohn applied to the American Food and Drug Administration (FDA) for a licence to sell the drug as a human contraceptive. A year later, the seven year study on beagle dogs and the eleven year monkey study required by the FDA began. In New Zealand the Health Department approved Depo Provera for use as a contraceptive before the results of both studies were released. The results revealed increases in both benign breast nodules and breast cancer. Meanwhile, other unsuspecting women were participating in trials of Depo in Bangladesh as were black women in South Africa and what was then Rhodesia.

In 1974 the FDA allowed the 'restricted' sale of Depo for 'patients' who knew the drug could make them sterile; who were unreliable users of contraceptives; who could not use other forms of contraception; or who had a history of contraceptive failure. In 1978, after three Congressional Hearings the FDA rejected Upjohns's application to market the drug in the USA.

A year later, the rhesus monkey study revealed that two out of the twenty high dose animals had cancer of the uterus and three had breast lumps. But Upjohn's enthusiasm was not dampened by these results.

Many developed countries including Australia, Britain (temporarily) and the USA have banned Depo pending proof of its safety. Evidence is still being gathered from millions of female 'guinea pigs' who still use it: essentially the poor in Jamaica, Thailand, Mexico, Sri Lanka and New Zealand. In countries where it is banned for general use disadvantaged sections of the population are also using it, in particular: West Indian and Asian women in Britain, aboriginal women in Australia and Chicano and Black women in America. Similar trials of other injectables with less of an international reputation then Depo are also being conducted, such as the Net-Oen trials in India.

The carcinogenity of Depo has been the main issue in the debate over its safety. Other side effects are relegated to 'minor' or 'irrelevant' status, which women are expected to put up with. What are the effects of Depo use?

i) Long-term risks include:

a) anemia
b) diabetes
c) temporary or permanent infertility
d) uterine disease and permanent damage to the ovaries, pancreas, liver and adrenals
e) lowered resistance to infection because of its negative effects on the production and distribution of antibodies: particularly damaging to poor women.
f) child abnormalities: Depo is especially recommended for breast feeding mothers on the assurance that there are no negative effects on the production of breast milk. Yet Depo has been found in breast milk, and discovered in the fact tissues of breast fed children of Depo mothers. The drug also cannot be discontinued if a women finds she is pregnant which means it could act on the fetus for several months.
g) cervical, endometrial and breat cancer: Depo users have revealed three to nine fold increases above normal rates of cervical cancer (Neal, 1979).
h) A New Zealand study found that several women had serious anaphylactic reactions which were almost fatal (Bunkle, 1983).

ii) Immediate and short-term effects include:

a) abdominal discomfort
b) dramatic weight gain or loss
c) depression: progestogen is a well-known depressive drug.
d) loss or suppression of sexual desire and/or orgasm: Depo is used in two American clinics to chemically castrate rapists. Supressing libido is an ironic property for a contraceptive.
e) headaches, dizziness and nausea.
f) vaginal discharge
g) breast discomfort and abnormal growth
h) menstrual abnormalities are suffered to some extent by all women on Depo.

One respondent to a New Zealand survey was bled every day for three years and eventually had a hyserectomy, while about one Depo user a week is admitted to Auckland's National Women's hospital with uncontrollable bleeding. Yet Upjohn medical director, Norman McLeod, dismisses this by saying "Anyway, bleeding is more of a nuisance than a health problem and can be easily dealt with" (*The Press*, 1985) apparently by administration of controversial estrogen pills probably also produced by Upjohn.

Depro-Provera was not primarily designed to help women control the reproductive lives, so why do millions of women still use it? Probably the main reason why women still use drugs like Dempo, despite their dubious safety records, is that they are not aware of the risks or the alternatives. We assume that whatever medical professionals and 'specialists' prescribe has been adequately tested and proved safe. This assumption could be fatal.

Scientifc Evidence

The FDA ban on Depo effectively closed the US market to Upjohn and worse still meant the US 'aid' agencies could not supply it overseas. Upjohn has campaigned hard to have this situation reversed. The most effective strategy in this campaign has been to produce 'scientific evidence' that the drug is safe. It has spent millions a year ($ 6 million on a New Zealand study alone) on research designed to produce the desired results. Investigations into the safety of Depo have therefore centred on its carcinogenity (which is difficult to prove anyway) while its more immediate side effects have been ignored.

Upjohn's control of the information about Depo allows it to brush asise any evidence that questions its safety. In the first seven-year beagle study for example, Upjohn dismissed the findings that 18 of the 20 dogs receiving Depo died, by claiming that beagle dogs were especially prone to breast tumours.

The results of the rhesus monkey study were similarly dismissed by saying they were dose related. Upjohn's claim that Depo "is probably the safest harmonal contraceptive

drug available" is therefore totally unproven (Bunkle, 1983). So while medical practitioners may prescribe it in good faith, their decisions are based on mis-information produced and controlled by the company that stands to profit.

And profit it has. The first Reagan administration passed the Drug Regulations Act which rendered impotent the FDA ban on Depo sales to the Third World. Drugs judged unsafe for Americans can now be exported provided they are requested by the foreign government. Apart from Upjohn's profits, the assault on Third World women has other advantages:

"Population explosion, unless stopped would lead to revolutions: population control is required to maintain the normal operations of US commercial interests around the world... without our trying to help these countries with their economic and social development, the world would rebel against the strong US commercial presence. The self interest thing is the compelling element" (Ehrenreich, 1980).

Government applying for loans from organisations like the World Bank (with heavy US presence) are usually required to show that they are addressing their 'population problem'. Sterilisation programmes and campaigns of Depo-Provera and other injectables are pushed because they are immediately effective with long-term results.

Why New Zealand?

US imperialism concentrates Depo's three-way assault of racism, patriarchy and capitalism. Like other weapons in this armoury, Depo has been aimed at women in New Zealand.

In 1968, the New Zealand Health Department approved Depo for use as a contraceptive, before the study on its effects were complete and despite its ban in the US. Moreover, it is offered as "one of the many available choices" (Bonito, 1980) rather than approached conservatively.

There are several reasons why Upjohn has chosen to study women in New Zealand:

First, they reveal the highest rate of Depo use for a population whose social and ethnic composition resembles that of the US, where the company ultimately hopes to market the drug.

Second, the subsidised health system here is a great boon because it relieves the company from having to pay for any medical treatment required by women involved in the study.

Third, the ACC (Accident Compensation Corporation) Act absolves Upjohn of all damages suffered by the women. Drug companies have had to pay millions of dollars in the US in damages for the effects of drugs like Depo.

Fourth, since the New Zealand Medical Association monopolises and the state regulates the dissemination of contraception, the company does not have to seduce a wide variety of organisations.

That the power brokers—state and medical—are united in supporting the Upjohn study means the assault on New Zealand women will continue. But the Depo-Provera assault is not distributed evenly. There are definite targets.

In New Zealand, Depo is administered mainly to women who have the least access to contraceptive information; women for whom informed consent has little relevance. For example:

1) One survey revealed that 42 per cent of Maori women and 11 per cent of Pakeha (European) women had used Depo while another concluded that the injection was the only contraceptive method used by a higher proportion of Maori women than European women, (Bunkle, 1982; Trlin and Perry, 1981). This reveals racist attitudes on the part of white middle class medical practitioners who view Maori women as unreliable users of contraception.

2) Working class women—one study discovered that the injection had been used by a higher proportion of women without school certificates and by women whose partners were in the 'lower' status category (Trlin and Perry, 1981).

3) Maternity patients and breast-feeding mothers—one study found that some women were given Depo as routine medication before leaving the maternity hospital and were assured that it would not alter the milk supply. Many were not told what they were being given until it had been administered but being in unfamiliar surroundings and subject to hospital rules they were not in a position to resist or complain.

4) Mental patients and intellectually handicapped women are given Depo on the excuse that menstruation is a 'problem' for hospital staff. This totally ignores the fact that instead of losing their periods some women 'flood' while on Depo. In addition a women admitted to a psychiatric institution, perhaps suffering from some form of depression, "should not be subjected to a drug known to cause depression" (Clark, 1980).

Depo is also given to young women who are considered 'sexually irresponsible'; to immigrant women especially if they are of an 'undersirable' type (i e, non-European); and to post-abortion women.

But by far the largest group using Depo-Provera however, are Black and working class women. Health professionals say this is because these women like Depo and cannot or will not use other forms of contraception. The reality is that women do not make choices about their reproductive lives under conditions that they control.

Black and working class women are under great preassure to accept stronger and more dangerous methods of birth control because an extra child could have quite disastrous effects on the quality of the lives of existing family members. When family planning incentives and dis-incentives are institutionalised as they are in some countries like India these pressures are even greater.

In a capitalist society doctors set up in areas where they can earn most, which means that women living in working class areas see doctors who are typically overworked. Quite apart from any decision those doctors may make about the contraceptive competence of any individual woman, they simply do not have the time to explain various contraceptive methods adequately.

Women are dependent on those who control the goods and the information. One New Zealand study found that 82 per cent of Depo users should not have taken it had they known the evidence against it (Amas, 1984). In India a Net-Oen camp was disrupted when half the women left after hearing about the dangers of injectable contraceptive use (Nair and Balasubrahmanyam, 1985). Women appear to 'consent' to

using dangerous contraceptives but what appears as consent is really submission.

Their 'decisions' are largely determined by the material conditions of their lives including their access to abortion facilities, their ability to support another child and by the limited information they receive from the birth controllers.

Contraception is an important area for gender struggles because as long as men control women's fertility, female sexuality and the work of reproduction will be inextricable linked. What forms have women's struggles against injectable contraceptives taken and how effective have they been?

Women's Struggle Against Injectables

The campaign against Depo was an attempt by New Zealand women's health groups to have the Upjohn study stopped and Depro-Provera banned in New Zealand. By publicising the side-effects of Depo use it was hoped that women could resist being manipulated into participating in the study and or using the drug. But the feminists who campaigned against Depo have been verbally attacked, threatened with libel suits, or dismissed as 'emotional' and 'hysterical'. Upjohn was not about to waste the $ 6 million it had pledged for the study.

The study's essential aim is to produce data that will extend the Depo-Provera stranglehold. Not long after the study began Upjohn was claiming the success of its New Zealand study and claiming that it proved the drug's safety for use in America.

And while even statisticians and demographers criticised the study's protocol they have never been given the opportunity to back up their arguments with the data from the study because this has never been made public (*The Press*, 1983). Completed questionnaires go straight to Upjohn's New Zealand headquarters then directly, without being opened, to Michigan, USA, where data is stored on their company computer. Only Upjohn scientists have access to that data. The 'facts' that are concluded from the study will reflect the male-dominated and profit-oriented structures that created them. The opinions of lay women have no status alongside those of the country's medical experts. The $ 6 million Upjohn was prepared to pay for the study is equivalent to the entire budget of the New Zealand Medical Research Council and must have been an irresistible attraction to those experts.

For women's groups, the struggle was diverted to the more immediate and probably winnable Dalkon Shield crisis. The anti-Depo campaign essentially failed, alongside rumours that new injectables are being secretly trialed at our top medical institutions.

It is interesting for New Zealand women to see the successes of our India sisters in the struggle to ban Net-Oen in their country. Perhaps this is because in contraceptive camps women do not confront the drug or the administrators of that drug alone, but can stand together for a collective refusal as in the example of the Net-Oen camp described above.

But despite the success and failures there are several points that need to be remembered:

Women should struggle against all 'types' of contraceptives rather than certain brands. The adverse publicity created about Depo had no effect on the development, trials and dissemination of similar injectables marketed once the patent on Depo was lifted. The same was true of the Dalkon Shield debate: other potentially dangerous IUDs were left with their reputations intact.

It is also important that women share information across international boundaries and link our struggles so that getting rid of a dangerous contraceptive in one country does not mean that the problem is simply exported to more vulnerable women in some other country.

Perhaps the most effective strategy, and one that has ramifications for women outside the birth control arena, is to empower individual women or groups of women to stand up to the birth controllers. Empowering women means providing them with information to challenge the 'wisdom' of doctors, medical 'experts', technicians working in contraceptive camps and 'scientific evidence'. Information is power and both must be shared for women to take some control of their reproductive lives.

References

Amas, Raewyn, *Depo-Provera—voluntary choice?* unpublished undergraduate paper, Department of Women's Studies, University of Waikato, 184, p 3.

Balasubrahmanyam, Vimal. A Bizarre Medley of Carrots, *Women's Global Network of Reproductive Rights*, January-March 1986, p 7. Reprinted from *SHR*.

Bunkle, Phillida. National Women's Health Conference Report, *Broadsheet*, November 1982, p 10.

Bunkle, Phillida. Draft paper presented to ANZSEARCH (Australia and New Zealand Society for the Epidemiology and Research in Community Health), Wellington, New Zealand, May 1983.

Bunkle, Phillida. Calling the Shots? The International Politics of Depo Provera In Test Tube Women, ed Rita Arditti et al, Pandora, London 1983, p 168.

Bunkle, Phillida. As above p 179.

Bunkle, As above cites Upjohn Corporation p 169.

Bonita, Ruth. Contraceptive Research: For Whose Protection? *Broadsheet*, January-February, 1980, p 7.

Clark, Heather. Letter to *Broadsheet*, June 1980, p 3.

Ehrenreich, Barbara et al. Contraceptive Dumping, reprinted in *Broadsheet*, January-February, 1980, p 7.

Nair Sumathi and Vimal Balasubrahmanyam, *Manushi*, no 28, May-June, 1985, p 35.

Neal, Sue. Only Women Bleed, *Broadsheet*, December, 1979, p 13.

The Press. In Depo Provera, A Drug on Trial, July 8, 1983.

The Press. Depo Project will Involve 7,500 women in three samples, July 8, 1983.

Trlin A and P C Perry. *Manawatu Family Growth Study*, Management Services and Research Unit, Department of Health, Special Report 60, Wellington, 1981, p 25.

Unity. Dangerous Contraceptive Freely Prescribed. No 13, October 1982, p 6.