High Dose EP Drugs—II

The Socio-Political Dimension

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The EP drugs issue has brought into focus the sickness not only of the legal system, but of the medical system as well. How is it that we are fighting a case which should not have arisen at all in a sane society? In reality the very need for pregnancy testing is rooted in the maladies in the social situation and the inadequacies of the health system. Thus the movement against EP drugs and other such technologies must be woven into the wider political movement against a system which breeds, and protects such oppressive developments.

THE addition of high dose oesterogen and progesterone combinations to the long list of oppressive technologies for women is not recent. These drugs have been freely sold in the market for some time now, even though scientifically speaking—their use is not indicated. Its use however, has created such havoc that the victims, that is some of the women, could not bear it any longer. Their protests led to the banning of the drug. The ICMR had already recommended its ban as a drug for pregnancy testing and the court passed a judgment banning its sale. These steps by the authorities were brought to naught by the companies which used the loopholes in the legal system. They obtained the right to continue their business not because they proved the drug safe but because they argued that the Drugs and Cosmetics Act had no provisions to ban a drug (however lethal it might be)! Their victory over the petitioners (women), the referral of the case to the Drug Controller of India and the public hearings in the major cities have revealed a lot more about the sicknesses of not only the legal system but also the medical system.

This compels one to ask, how is it that we are fighting a case which should not have been there at all in a sane society? How is it that while life saving drugs are scarce, dangerous drugs are so easily available over the counter? How is it that the majority of those who flaunt the Hippocratic oath as a mark of their superior professional ethics, preferred to stay out of the controversy when the health of their clients was being jeopardised? How is it that for the sake of so called scientific advancement and the doctors' right to chose treatment for their patients, needy people are treated as guinea pigs whose lives seem to be of very little value?

When we ask ourselves these questions, it is not difficult to see that the issue is not confined to EP drugs but relates to the very nature of technology which is being propagated today in the area of population control. To give it scientific neutrality this area of research is called 'reproductive biology' and constitutes a part of the larger field of 'biotechnologies', all meant to intervene in natural biological and not social processes. They do however, become tools in the hands of some and thereby influence the social process in a way desired by only those sections who are in control. One, therefore, has to ask a very basic question, do the majority really need these technologies? And if they do, what should be the limits of their use?

In this age of modernity and high technology, such questions might sound backward, even anti-technology, but they are neither. Let us ask ourselves why do we need pregnancy tests? The reasons are simple enough.

1. These couples/women for some reason either do not want to have a baby or on medical grounds need to know their status so that adequate care may be given to them as in the case of pregnancy in diabetic or heart patients or in case of high risk mothers with high probability of congenitally malformed or diseased foetus.

2. Apart from these medical reason yet another reason for pregnancy testing is to make a timely choice for abortion if the sex of the baby is undesirable.

If the right of a women to avoid a pregnancy is accepted, then, why is it that despite years of research, in reproductive biology and contraceptive technology, despite millions of dollars that have gone into this research, we still do not have a contraceptive which is safe for the user, sure and cheap? The researchers have in fact sacrificed safety for surety and costs have never really mattered. A good example, is the use of NET-EN despite adequate evidence of its dangers, and the free distribution of oral pills despite their exhorbitant prices. Oral pills were accepted by the planners of the National Family Planning Programme for use in pilot projects for the benefit of rural women and Net-En was approved for marketing in India. All this because the focus had all through been, not on discovering or inventing safe technologics but on pushing those which fulfilled certain targets. Similarly, if we were serious about providing contraceptive or abortion services to women, these should have been an integral part of the most basic health services. This however, is not the case. Despite all the glib talk about health for all by 2000 AD and about full coverage of populations with minimum health services (Primary Health Care), the majority, specially the poor, still have no access to health services (GOI, 1983). People are much more familiar with targets, force, paycuts and withholding of increments for not getting 'cases' rather than with choices in family planning methods. They don't seem to know that the country's health services were in fact meant to provide these choices to them and all that goes along with making such a choice.

Yet another related issue is that a large number of women cannot avail even such services as are available, even if they want to. This is primarily because of the pressures exerted by the family and their own insecurity within that structure. Despite voluminous reports on the status of women, national celebrations of the international womens' year and huge amounts of money going down the drain into the so-called women's upliftment schemes, the status of women remains at a level where the majority have little say in matters as intimate as their own selves.

The problem of women who need the test for medical reasons or for failure of contraception is not very different.

Had they been given access to a good health service, the question of their becoming a prey to the greedy private practitioner, or the ill informed doctor would not arise. There are any number of safe and equally cheap pregnancy tests that the health service ought to be providing to women who really need it (*EPW*, 1987).

It is not difficult to see then that the medical establishment is not interested in safety for the user but in surety of contraception. It is not concerned with making services accessible to people but wants to catch them as targets for surer methods like sterilisation. It is not bothered about the poverty or backwardness of the people but is geared to control them.

The second reason for using pregnancy tests was the need to be selective about the baby's sex. A couple detects pregnancy, goes for amniocentesis and then opts for abortion if it is a female foetus. In Maharashtra alone, between 1982 to 1986 the number of clinics performing amniocentesis has increased from 10 to about 600. The estimated numbers of abortions done for expelling female fetuses in 1985 has been 40,000 (GOI, 1986). This pattern, frighteningly prevalent in most parts of the country, is yet another reflection of a social malady. Instead of provoking its professional ethics and fighting the evil openly, the medical profession chooses to keep quiet or fights against restrictions over the use of amniocentesis, in the name of freedom of the medical practitioners to choose the best for their clients. The medical researcher on the other hand continues to add to the list of oppressive technologies, techniques such as those used for sex pre-selection which promotes the practice of discrimination against female foetuses. At the same time they also make the obstetrician the complete controller who now diagnoses as well as dispenses and thus acquires godly powers!

These questions lead us to the reality that the very need for pregnancy testing in the majority of the cases, largely arises out of maladies located in the social situation as well as the inefficiency and inadequacy of the health service system. Focussing on this need and not its causes, finding technologies for satisfying this need without touching its causes, can at best be called a symptomatic approach to tackling deeprooted problems. Such technologies in fact not only divert attention from the real nature of the problem but also provide cover for the system's wider failures. Accepting them and using them for controlling female fertility amounts to accepting an out-right neo-malthusian strategy for the problems of population.

EP Forte is not the only drug which falls under this group of reactionary technologies. When in 1984 women protested against amniocentesis the government had expressed much concern at the loss of female foetuses and the exploitation of women by "clandestine private practioners". In a seminar organised by the Additional Secretary and Commissioner of Family Welfare in December 1986 at Nirman Bhavan, the steps suggested to tackle the problem included (1) Legal reforms, specially in the Medical Termination of Pregnancy Act 1971, (2) Social awareness through educational programmes and upliftment of women (3) Restricted permission for doing amniocentesis to public institutions (4) More than one doctor's recommendation for such a test. The government's representatives were very sympathetic to these ideas but they argued that the legal system could not be changed. This was perhaps because the MTP Act provides for abortion in a cases where contraceptions has failed and there is no way in which this could be disproved. It is well known that MTP has become a technology in use for the family planning programme and it is no wonder that the government is not inclined towards making this explicit. At the same time it is impossible to introduce stringent measures within the legal system without making the conditions under which abortions take place more restricted and explicit. The government's reluctance to change the law is projected as the 'helplessness' of its legal system. It is ironical that a government which passed the Muslim Women's Bill despite all the opposition and social presures should plead helplessness and invoke 'social awareness' to put an end to the misuse of amniocentesis.

Yet another example is the wide range of technologies used in Family Planing Programme starting from IUD, tubectomy, oral contraceptives, abortions and laparoscopy. All of these were considered for family planning and within the programme, acceptance and desire for family planning were simply taken as issues of availability of technology. The programme for a long time refused to take into account the major socio-economic dimensions of family. This very narrow approach to the problems of population is obviously not an un-intended accident. The waxing and waning attraction towards compulsion at one time and incentives at another time is in itself an indication of the limited range of options within which given technologies are expected to be effective. It also reflects the direction and nature of the overall developmental policies.

The latest in the barrage of technology is the case of Indo-US Vaccination Action Programme (*EPW*, 1987, correspondence). In the health programmes for mothers and children as well as the general population, vaccines have been in use since independence. Despite the availability of these well known technologies, the diseases against which they are effective continue to kill and maim. The only exception is smallpox, a disease that continued for decades despite the use of vaccines in this country. Finally, when it was contained, it was not only because there was a vaccine, but because a better understanding of the epidemiology of smallpox developed over time and provided an alternative strategy.

Suddenly, however, the faith of a set of experts in vaccines has been revived and they have signed a collaborative scheme with the US. Will they now test better vaccines on the Indian population? Even if we believe the argument that only vaccines needed in India will be tested like the cholera vaccine (or rabies and pneumonia vaccines etc.), we have to answer a very basic set of question. Firstly, what is the use of giving effective cholera vaccine to a people who are to perish in drought, without food and drinking water? Even if cholera is to be fought, have we shown that it is possible with the use of vaccines alone, rather than together with the provision of drinking water, food rations and sanitation? Over and above all this, do we have an understanding of the dynamics of morbidity and mortality caused by these diseases and their load and extent to be able to predict costs, set priorities and do some kind of monitoring? With obvious contempt for even the rhetorics of 'scientific rationality' vaccine technology is being glorified. This is not because what it prevents is our priority health problem but because

there is a technology which creates the aura of action and concern for the suffering of people without really touching the cause of that suffering.

These examples illustrate that again and again the system clutches at technologies which promise relief from suffering without really changing some of the social constraints.

Therefore, in the case of EP Forte and its widespread usage, it would be wrong to blame the lack of continuing education on non-availability of information to doctors. These may be peripheral reasons, the main reason being the underlying ideological bias of the 'scientific rationality' which is taught, accepted and propagated within the medical establishment. It is because of this ideological regimentation (where all technology available must be accepted and used and ill health should be seen as a medical problem alone), that the medical profession at large has failed to stand up together and speak in the interest of its clients. A good number in the profession have in fact taken advantage of the trend to make their own profits in the shape of money, position and security. This has been possible because they have been backed by those interested in actively or passively propagating technologies like EP Forte. The drug companeis who use these doctors, also paralyse the legal system which invariably finds itself 'helpless and incapable' of banning killer drugs. The control machinery has become ineffective and is listening to the 'impressions' and 'personal experiences' of the so called scientists (the senior medical practioners) rather than to the meticulously collected objective evidence presented by those who are demanding a ban on the use of EP Forte.

Where the inappropriate usage of EP Forte (and other medical technologies) can be traced to maladies at so many levels, then the issue is not of fighting against just one drug, one test or one technique. The issue is of weaving this protest into the wider political movement against a system that breeds, nurtures and protects oppressive technologies and ignores those technologies which could be better utilised in the interest of the people.

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