

DifferentTakes

Maternal Mortality, Population Control, and the War in Women's Wombs: A Bioethical Analysis of Quinacrine Sterilizations

By Judith A. M. Scully

Quinacrine hydrochloride is a drug that was developed in the late 1920s to prevent and treat malaria. In recent years it has achieved notoriety as a female sterilization agent. As a result of a worldwide sterilization crusade, launched by American MD Elton Kessel and public health doctor Stephen Mumford, approximately 104,410 women in nineteen countries have already been subjected to quinacrine sterilizations.

Quinacrine causes permanent sterilization by creating scar tissue in the fallopian tubes. Although the long-term side effects are not yet known, quinacrine sterilizations are associated with a number of serious

short-term side effects, including burning and irritation of the vaginal walls, cervical stenosis (a narrowing of the cervical opening), uterine adhesions, excitation of the central nervous system, toxic psychosis, and perforation of the uterus.ⁱ The risks associated with fetal exposure to quinacrine are also unknown.

Because of the known side effects of quinacrine and concerns about its long-term effects, many major family planning organizations and foreign governments, as well as the World Health Organization, oppose its use for sterilization. Quinacrine has not been adequately tested or approved for use as a sterilization agent anywhere in the world. Despite this fact, Mumford and Kessel have paid for the manufacture of quinacrine in Switzerland, arranged for its distribution, and mobilized a network of doctors, nurses and midwives to administer it.ⁱⁱ Together, these two U.S. doctors have distributed quinacrine in nineteen countries including Bangladesh, Chile, China, Colombia, Costa Rica, Croatia, Egypt, India, Indonesia, Iran, Morocco, Pakistan, the Philippines, Venezuela, Vietnam, the United States, Malaysia and Romania.

The process, history, and political motives of the quinacrine sterilization campaign suggest that it is one of several examples of human experimentation where poor women, particularly women of color, have been used as guinea pigs in the name of advancing reproductive technology. When one looks at this issue in combination with the history of sterilization as a form of population control, it is difficult to simply discard the quinacrine campaign as an unfortunate but necessary occurrence for the advancement of gynecological science.

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The Politics of Quinacrine Sterilization

Mumford and Kessel appear to be driven by several different goals in their sterilization crusade: the need to reduce maternal mortality in developing countries in order to save women's lives, the desire to control or reduce the population in Third World countries in order to secure world peace, and the need to prevent immigrants from flooding United States borders in order to prevent chaos and destruction.

Assuming for the sake of argument that Mumford and Kessel are motivated by a desire to "do good," the question becomes how effective the quinacrine experiment is at achieving its allegedly "beneficent" goals.

MYTH #1: Chemical Sterilization Will Reduce Maternal Mortality Because Fewer Women Will Become Pregnant

Mumford and Kessel's analysis regarding the relationship between sterilization and maternal mortality is fatally flawed. It assumes that all women at risk of maternal death in developing countries—i.e. pregnant women—do not want to be pregnant and that they do want to be sterilized. Missing from this analysis are the many women who consciously choose to be pregnant or those who would deliberately reject sterilization as an acceptable form of contraception. Several other forms of contraception are arguably more beneficial than quinacrine sterilizations because they have a higher effectiveness rate in preventing pregnancy and/or providing protection against HIV and other sexually transmitted diseases.

Studies indicate that maternal mortality is caused by unhealthy lifestyles, poor nutrition, a lack of access to health care in general and less access to prenatal care specifically. Prescriptions to reduce maternal mortality would be most effective if they

addressed at least one of the root causes of the problem. Quinacrine sterilization, however, does not address any of these causes, making it a questionable solution to maternal mortality.

MYTH #2: Chemical Sterilization Will Limit Immigration to the United States and Prevent Destruction of Third World Countries

Embedded in Mumford and Kessel's quinacrine campaign is the desire to limit immigration to the U.S. and population growth in the Third World, a desire which represents a political rather than a medical objective. The Wall Street Journal reported these views of Mumford:

Describing quinacrine as "essential to population-growth control," he says he sees it as a means of reducing the potential number of immigrants to the U.S. from developing nations. "This explosion in human numbers, which after 2050 will come entirely from immigrants and the offspring of immigrants, will dominate our lives. There will be chaos and anarchy," says Mr. Mumford, who relies in part on anti-immigrant forces in the U.S. for financial backing.ⁱⁱⁱ

In the same article, Mumford goes on to cite not only the supposed influx of immigrants as a reason for sterilization, but also a Third World "population bomb" that would pose a significant threat to U.S. national security.

In light of their decidedly anti-immigrant, population control politics, Mumford and Kessel's quinacrine campaign gains new political significance. In this campaign women are being treated as a means to achieve lower Third World population rates, not because it is in the best interest of the women to have fewer children, but because it will allegedly benefit the world and "American culture." This type of philosophy subjugates women's interests to a political agenda which is steeped in xenophobia, racism, and classism.

Quinacrine: A Bioethical Analysis

One way of addressing the abuse of women and the political motivations of the quinacrine campaign is through a bioethical analysis. The Nuremberg Code, the Helsinki Declaration and the International Ethical Guidelines for Biomedical Research Involving Human Subjects all place great emphasis on three commonly accepted principles of bioethics: the principles of beneficence and non-maleficence, distributive justice, and autonomy. *The beneficence and non-maleficence* principle requires that the risks of research must be reasonable in light of the expected benefits, that the research design must be sound, and that the investigators must be competent both to

conduct the research and to safeguard the welfare of the research subjects. *Distributive justice* requires the equitable distribution of both the burdens and the benefits of participation in research. This principle dictates that no one group—socio-economic, gender, racial, ethnic, or geographic—should bear the burden or be denied the benefits of research. The *autonomy* principle requires that, only after all the risks and the alternative treatments have been explained in simple language capable of being understood by the individual, can an individual consent to participation in an experiment. In addition, the process of obtaining consent must be free of deception and coercion. In bioethical analysis, all three of these principles are important to resolving the ethical problems presented by human experimentation.

It is necessary to point out that many of the quinacrine sterilizations that have already been performed were done without regard to an established research agenda. Mumford and Kessel claim that quinacrine is not a “new drug,” because it was originally used as a malaria treatment and that its safety has already been established.

By removing quinacrine from the “experimental” category, Mumford and Kessel believe that they are free to ignore all guidelines governing human experimentation. Consequently, many of the women who have been subjected to quinacrine sterilizations are not being monitored for either long-term or short-term effects, are not being provided with any type of follow-up care, and are not being informed that there are potential unknown risks associated with quinacrine sterilizations.

In those cases where women are clearly being treated as if they are “subjects” of a

medical study, the lack of informed consent, combined with unreliable research design and inadequate follow-up, make it highly unlikely that the results of this “research” will be valid. Without valid results, research using human subjects is not only valueless but probably unethical as well.

The haphazard and questionable nature of quinacrine “experimentation” is particularly troubling in light of whom the campaign is targeting. Most, if not all, of the women subjected to quinacrine sterilizations are disadvantaged: they are low income rural and urban women with very little education living in developing countries. Kessel and his associates argue that using a riskier sterilization method is justified because women’s lives in developing countries are more at risk, not only in pregnancy but in general. One of Mumford and Kessel’s medical associates in Bangladesh framed the issue as follows:

The developed world’s cautious standards of medical ethics and safety have no place in the lives of women for whom repeated pregnancies bring nothing but deprivation and danger. ... As it is, they’re going to die, so what do the long-term complications of quinacrine matter?^{iv}

Women in developing countries are deemed to be expendable because they will die from malnutrition, malaria, some form of cancer or from pregnancy. Rather than improve health care systems, these social strategists call for the alteration of women’s bodies. From their perspective, the problem is not the system, it is the women themselves. From a bioethical perspective, the concentration of the quinacrine campaign on women in developing countries presents a clear conflict with the principle of distributive justice.

In addition to putting women’s bodies at risk, the quinacrine campaign poses a clear threat to the autonomy of women in developing countries. It has been reported that many of the women who were sterilized did not know what was happening to them. For example, in 1989, after Vietnam’s family planning program had performed more than thirty thousand quinacrine sterilizations, it was reported that women working at the Hoa Binh Rubber Plantation were involuntarily sterilized. Similar problems regarding the failure to adequately inform women about the quinacrine procedure and to provide follow-up care arose in India as well. These stories illustrate that deception and coercion were used as part of the process in recruiting women to be chemically sterilized. These are clear examples of experimentation that lacks respect for autonomy.

Even if autonomy were respected, the quinacrine experiment would still be unethical. As Robert Burt points out in connection with the Nazi experiments, "the consent of the experimental subjects would not have justified the experiments"^v because obtaining consent in clinical research is not the only requirement for ethical validity. The principles of beneficence/non-maleficence and distributive justice must also be considered. In the case of quinacrine, none of the principles of bioethics have been sufficiently respected.

In November 2000, the FDA approved a clinical trial of quinacrine by Dr. Jack Lippes at the Children's Hospital of Buffalo, in Buffalo, New York. Although the FDA trial may provide an environment more conducive to respecting women's rights to obtain information and follow-up care, it is a double-edged sword. The problematic research previously conducted in developing countries will be shielded from criticism by this new found FDA "legitimacy." The women in developing countries who were ill-informed and ill-treated could be forgotten and swept under the proverbial rug. The history of abuse and lack of justice involved in the quinacrine experiments should not be tolerated or forgotten.

Unless we take a closer look at the ethical dimensions of the quinacrine campaign, the devaluation of women's lives in both developing and developed countries will continue. Health professionals and legal activists should emphasize the lack of ethics involved in the quinacrine campaign in order to set the standards for acceptable objectives and procedures in future experimentation.

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Endnotes

ⁱ Abnormal menstrual bleeding, backaches, fever, lower abdominal pain and headaches have also been reported. In addition, if the quinacrine sterilization is not properly performed, incomplete blockage of the fallopian tubes could occur, thereby causing an ectopic pregnancy - a life-threatening emergency, particularly in areas with no emergency medical facilities for surgery.

ⁱⁱ Private funding from the Leland Fikes Foundation and the Scaife Family Foundation have made it possible for Mumford and Kessel to provide quinacrine free of charge to researchers, clinicians, and government health agencies worldwide. Mumford and Kessel's gifts of quinacrine are also made possible through the financial support of individuals such as Sarah G. Epstein and Donald Collins, both board members of the Federation for American Immigration Reform (FAIR), a conservative, anti-immigrant organization.

ⁱⁱⁱ Freedman, Alix. "Two Americans Export Chemical Sterilization to the Third World." *Wall Street Journal*. June 18, 1998, A1.

^{iv} Ibid

^v Robert Burt, *The Suppressed Legacy of Nuremberg*, Hastings Center Report 26:30-33; Sept.-Oct. 1996.