Ravindra, R.P.: Reject the Injectables (Unpublished Article). p 1-3.

Reject the Injectables

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The recent attempts to incorporate injectable contraceptives (ICs) and other long-acting contraceptives (LACS) in the National Family Welfare Program (NFWP) are based on a premise, which is totally unscientific, unethical and unjust.

Let us examine the 'scientific' basis of permitting the mass use o f ICs: that the 'benefits outweigh the risks'.

Known risk factors: 'Menstrual chaos' is intrinsically linked with the use of all LACS. In the largest multi-center trial of the I.C. 'Net-En', conducted by the ICMR, the cumulative discontinuation rates due to menstrual disturbances were 21.2 per cent (+ 1.3%) for the first year and 43.5 per cent (+ 1.9%) for the second year (1)

The corresponding figures for the other injectable product, 'DMPA', from a similar but wider WHO study were 33.3 per cent to 75 per cent and 49.5 per cent to 91.3 per-cent (2). 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 (3). If the majority of women using these products under 'controlled' conditions (where medical support is supposed to be available) drop out within one to two years, how can 'researchers' label these side effects as 'minor and insignificant'?

Weight gain (five-kg or more) is another important reason cited by researchers for discontinuation of ICs. by women. The multi-center Net-En study reports that 22.6 per cent of all participants registered such weight gain. An Indian study (4) strongly supporting the mass use of ICs reported 38.7 per cent incidence of this 'minor' side effect.

The less frequent side effects include dizziness, headache, backache, depression and 'loss of libido' (5). Incidentally, the last-reported side-effect was considered a 'major' factor while deciding the fate of the only male contraceptive developed internationally, but was largely ignored in matters related to female contraceptives.

Long-term safety not ensured: The long-term effects of ICs on several important organs such as the liver, processes such as the metabolism, and its immuno-

suppressive effect and possible teratological effects have not been studied. In the absence of conclusive data on safety, the use of ICs on millions of women of reproductive age, spread throughout this vast country, would be hazardous.

While the efficacy and prolonged duration of action of ICs have been proved, it remains basically a provider-controlled method. Even during controlled trials, cases of gross violation of medical ethics have been documented. So, when introduced in a target-oriented insensitive, bureaucratic NFWP set-up, its potential for misuse can well be imagined.

Contraindication of ICs include cancer of the breast or an undiagnosed breast lump, all genital cancers, while special problems requiring medical assistance include abnormal liver functions, and history or evidence of cardiovascular disease. How can these conditions be diagnosed in a primary health center where basic amenities for primary care are often not available? Who will provide the women the much-needed medical support and referral system? Given the history of mass sterilization camps and other misadventures of the 'population lobby', there is no guarantee that even if ethical and scientific guidelines are drawn, they would ever be followed. In a country where the majority of women of reproductive age are anemic, how can the effects of heavy and prolonged bleeding on their health be ignored?

The global scenario has undergone major changes after the controversy on ICs in the 1980s. The paradigm has shifted from 'population control' to 'family welfare', and from 'women as targets' to 'reproductive rights'. The emphasis is on strategies and communication, rather than on devices. Medical ethics is central, and informed consent today means much more than a thumb impression on the dotted line. The series of consultations between women's and consumers' health advocates, researchers and international agencies has underlined the need to emphasize 'woman-friendly' rather than 'provider-controlled' methods, and for respecting women's experiences.

Attempts to bulldoze ICs into the NFWP run contrary to the spirit of such a dialogue. While the relatively advantaged first world women are clamoring (and receiving) safer barrier contraceptives, women of color and third world women are being targeted for hazardous ICs, keeping in mind their vast market potential. It is time that all people concerned with medical science, ethics-and women say NO to injecting the ICs in our National Family Welfare Program.

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