

DECEPTIVE CONTRACEPTIVE

by Hyejo Jun

Unfold the white pamphlet. Words divided into five sections: Method, How it Works, Advantages, Disadvantages, and Special Notes. Fifteen rows of Methods divided into four categories of Hormonal or Chemical, Barrier, Abstinence, and Sterilization. The information the pamphlet confers is reassuring because with these resources, one can have more control over the decisions regarding body and health. As citizens of a nation and members of a health community, it is a right to be provided with such knowledge and a responsibility of the government and the institutions that function by its law to protect and insure this right. Sadly, this is a fragile ideal and one that has been broken on many occasions. The Dalkon Shield mess that began with the introduction of the contraception to women in the early 1970s proved to be an appalling example of the withholding of crucial information and a product's misuse, especially in which it was targeted towards a certain population of women. Through an application of the term "biological citizenship" coined by Adriana Petryna in *Life Exposed: Biological Citizens after Chernobyl*, how the health of women was compromised and how their bodies were ultimately under a system of control through a lack of knowledge will be brought to light.

In her ethnography, Adriana Petryna eloquently discusses the aftermath of the biologically disastrous Chernobyl incident in which millions of Eastern Europeans were exposed to harmful radioactivity. She is especially concerned with the subsequent interactions between the survivors and the bureaucratic, medical, and scientific institutions in claim-making. Petryna uses biological citizenship, defined as the way in which "the damaged biology of a population has become the grounds for social membership and the basis for staking citizenship claims," as a vehicle to explore the relationship between the sufferers who demand but have selected access to compensation and recognition and the nation-state, who has the regulatory power to deny or accept claims based on their idea of an ideal sufferer.¹ From that relationship, a nation-state finds legitimacy and citizens find legitimacy in their bodies and of their experiences within the nation-state. In exposing a connection between biology and identity, biological citizenship is citizenship based on biology in its literal connotation. If there was an ideal sufferer in Chernobyl, delineated by medical, scientific, and legal criteria that both acknowledged biological injury and compensated for the suffering, then there was also an ideal citizen in terms of biological makeup in

the Dalkon Shield controversy.¹ And in that controversy, those who failed to meet the requirements of ideal were subject to "biopower," a concept by Michel Foucault that is essentially a mode of control.² Therefore, citizenship based on biology was a means of subjecting to control those who were not ideal through a system of biopower.

The general use of contraceptives has long been a part of women's history, and due to its function as something which curbs reproduction, the desire to control reproduction has also been embedded in the minds of many women for some time. Lisa Baker, in her article *Control and the Dalkon Shield*, notes how a woman's body has consistently been a site of regulation and "conceptualized as a locus of practical cultural control."³ Unfortunately, women have compromised their health in trying to avoid pregnancy by resorting to possibly dangerous contraception methods.⁴ Why is it the case that women are the ones to negotiate their health in order to regulate reproduction? More importantly, have women and their bodies always been subjects of biopower? Who or what power structures are responsible for the "subjugation of [women's] bodies?"³ It can then be said that women, citizens of a particular biological sex, are less than ideal and experience the unfolding of biopower, and as long as contraception was available, reproduction considered as needing to be checked, and a woman's body deemed a site of regulation, women have had little autonomy in controlling their lives and their ability to (re)produce life. The highly publicized Dalkon Shield, an intrauterine device (IUD) which was reported to be the "superior modern contraceptive," and the push for its use by the shield's creators and supporters was essentially a strategy of biopower and affected more than four million women around the world.⁴

Of the four million women who were exposed to the harms of the Dalkon Shield, women of certain biology or situated at a certain level of biological citizenship were especially targeted and impelled to use the shield. Professionals at this time believed it was imperative to curtail the growing population of the world to limit the economic and social problems inherent in overpopulation, thus risks involved in the use of contraception were justified.⁴ The majority of the blame was placed on poor minority women and many felt underprivileged women would benefit most from IUDs such as the Dalkon Shield. This conviction lies underneath the controversial, overarching discourse of eugenics, the careful controlling of reproduction based on

the worth of a person for the sake of “the improvement of the ‘race of man’” and the belief that humanity would be weakened by the rapid population growth of the inferior.⁵ Eugenics is an endpoint in the spectrum of what Rayna Rapp, author of *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*, calls stratified reproduction by which some people are empowered to reproduce and others are disempowered. Middle to upper-class White women were encouraged/empowered to reproduce, or were not as urged to use contraception as women of lower economic status and minority background, who were discouraged/disempowered to reproduce. Because reproduction involves a sense of future, progress, and a reiteration of social identities and citizenship, it is seen with the objective of mobilizing towards the ideal: affluence and white skin.² Whilst women in general may have already experienced less than ideal biological citizenship because they were women, poor and non-White women faced an even less than ideal biological citizenship, placing them under harsher surveillance and regulation of their reproductive capacities.

One form of biopower utilized by the participating power structures in regulating reproduction was the outright coercion of women into using the Dalkon Shield. Dr. Hugh Davis, creator of the shield, conducted clinical trials of the contraception in a Baltimore public clinic on mainly poor, Black women, some of whom never gave consent. Under pressure from countries such as the United States in return for international aid, many developing nations implemented programs for controlling reproduction and population growth of its citizens. In Indonesia, women were “indoctrinated” by political authorities who offered four kilograms of rice to women who used the shield. These women were deemed angels (aspari). Bangladeshi women were awarded with money and wheat for using the shield, and disturbingly, administrators were given cash bonuses for exceeding the predetermined number for IUD “insertion and sterilization”.³ In these cases of coercion, women found themselves severely limited in their choice of contraceptive method and limited in the agency over their own lives and procreative bodies. Even in protest, a woman possessed little autonomy – a marginalized, poor, Black woman who had a shield inserted without her consent and spoke in dissent, was told by the doctor that he knew what would be best for her.³ While women of a particular biological group were unacceptable because they did not fulfill the ideals of biological citizenship, the use of the Dalkon Shield was in a sense an alternative route to acquiring advancement of biological citizenship status. Whether or not this was the woman’s intention and whether or not it would actually be recognized by the agents of biopower underscore the delib-

erate manipulation involved.

Undoubtedly, women across all socioeconomic strata used the shield, but White, middle to upper-class women’s biological citizenship were not as compromised because they were closer to “ideal”. The encouragement, rather, enforcement of its use by a more specific category of women - poor and non-White - contributed to the quietly terrorizing aspect of biopower, in which it is in the interest of those acting as agents in the use of biopower to further the lives of some at the expense of others based on the biased notions of biology.²

Paul Farmer, in *Infections and Inequalities: The Modern Plagues*, argues that poor African women suffer from HIV/AIDS as “a result of structural violence: neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency.”⁷ Many women were not aware of Dr. Davis’s financial stake in the success of the Dalkon Shield.⁴ Farmer continues that “structural violence is visited upon those whose social status denies them access to the fruits of scientific and social progress.”⁷ The Dalkon Shield can hardly be said to be a fruit of progress, but some women received an imbalanced proportion of the harmful effects on health and were controlled more strictly because of their biology, place in society, and ultimately, their citizenship.

The other subtle but more extensive form of biopower, in its controlling effect on all of the women who used the Dalkon Shield, was the willful prevention to accurate information about the contraceptive. Formal citizenship guarantees every citizen rights and protections awarded by the ruling institution for having lived under its law and regulation.² One of these rights is a citizen’s right to truth. However, women have been confronted with compromised citizenship, specifically biological citizenship, and structures of power have taken advantage of women in these precise moments of concession and manipulated their reproductive lives. In the embedded power dynamics of knowledge production and distribution, the ruling institutions determine what is knowledge, which knowledge is authorized, and which knowledge shown be known, supporting Michel Foucault’s belief that power and knowledge are intimately connected and cannot be separated from one another.⁶ At a time when a high dosage of hormones in oral contraceptives and the resulting birth control pill scare of the 1970s deterred their use by women looking to curb their reproductive capacity, IUDs enjoyed the promotion of its advantages as an inexpensive, safe, and successful method of birth control.⁴ This was misleading knowledge and jeopardized the health and control over one’s body but presented as truthful by the agents of biopower: Dr. Hugh

Davis, A.H. Robins Company, which eventually bought the rights to the shield, and the governments that allowed the distribution of the faulty contraception. The endorsement of the Dalkon Shield as effective was an obstacle to a citizen's right to knowledge.

When concerned with knowledge, it is important to think about the way in which knowledge is made and acknowledge that knowledge has a site of production.⁶ Rayna Rapp richly described the cytogenetic laboratory as a site of knowledge production not only in determining the physical karyotype of the fetus, but the subsequent knowledge extracted from the results. In laboratories where knowledge created is purported to be objective, there is a "continuous construction of stable interpretations" even with ambiguous material, which leads to a variety of social interactions between the technicians to decipher the ambiguity.⁵

The production of product knowledge about the Dalkon Shield was situated in two locations: the research laboratory where clinical trials of the shield were conducted by Dr. Hugh Davis, and in the actual distribution of the knowledge pertaining to the Dalkon Shield by Dr. Davis, the government, the clinic, and society as institution. The fundamental problem with these sites of production was that the knowledge imparted was erroneous and detrimental to the health and well-being of the women who used the shield. Clinical trials of the Dalkon Shield were done on a relatively small number of women, some without consent. When results of the study were reported in the *American Journal of Obstetrics and Gynecology*, they were deemed a success in reducing pregnancy rate while maintaining high retention rate of the shield. Dr. Davis, however, failed to mention to the medical community and more importantly, the women who trusted in safety of the shield, that only 1.25% of the women endured the shield for the entire 12 months of the study and spermicidal foam was applied during the first four months to prevent pregnancy.³ Disturbingly, "for women to 'accept' and to 'retain' IUDs, it was often necessary for them to endure months of pain and heavy bleeding."⁴ There was also evidence to indicate that A.H. Robins was aware that the shield had a tendency to wick. Wicking allowed bacteria to travel up the tailstring of the shield from the vagina into the sterile cavity of the uterus, and increased the risk of infections, damage as serious as pelvic inflammatory disease (PID), and death.³ Even when the sale of the Dalkon Shield was taken off the market in the United States, the U.S. Agency for International Development bought and distributed the shields to women in particularly poor countries of Asia, Africa, and Central America as described earlier without an adequate amount of inserters and instruction, and without sterile packaging.³ The knowledge produced and made available to the global

community about the safety of the Dalkon Shield was severely lacking and caused ill-effects to a countless number of women, illustrating the tension between health and rights. Had women been given the truth about the shield, women in control over their reproductive bodies would not expose themselves to such harm. Without that knowledge as a right promised by the formal citizenship, women's bodies were placed under a system of biopower.

Adriana Petryna portrayed pain and suffering as "experiences that are...to some extent made into social instruments. That is not to say they are any less authentic, but that new determinations and values are being attached to them."¹ Institutions of power in the Dalkon Shield mess used lack of knowledge as a tool of control. The women who suffered under its use employed the social instruments Petryna described and began to claim files against A.H. Robins Company as reports of infections, other bodily harm, and deaths related to the use of the shield accumulated. In 1976, over 600 lawsuits were pending; by 1986, over 300,000 claims were made by women globally. However, relative to the total number of women who were terrorized by the Dalkon Shield, that number is scant.⁴

In the realm of claim-making, to which Petryna applied her concept of biological citizenship as aforementioned, the tension between health and rights is made clearer: filing a claim aims to redress the suffering of the women while simultaneously promoting more suffering.² Women who spoke out against the Dalkon Shield were interrogated about their "lifestyle, dress, practices, and conformity to standards of hegemonic femininity and sexuality" in order to deposit the blame of injury on the women themselves. "The discrediting and embarrassing of Dalkon Shield survivors through constant references to their sexual and hygienic practices" led to the eventually low number of claims and suits made to A.H. Robins Company.³ A woman's effective citizenship, which is the capacity to activate the rights and protections offered through formal citizenship by making claims to the state or institution utilizing biopower, was severely limited.² The noxious effects to their health continued to be unrecognized and women were left with few tools of remedy.

Many women unfortunately believed that the Dalkon Shield was an effective and safe method of contraception. However, women's reproductive health around the world was compromised due to attacks on their formal, effective, and biological citizenship. Perhaps controlling reproduction for women will always involve a compromise. Until the underlying foundations of society are radically overturned, it is everyone's duty to minimize the compromise women have to make regarding their health and reproduction and provide all the knowledge available

for women to make informed decisions. Women will not have to participate in the use of biopower as subjects, but as agents of control over their reproductive bodies and counter the notion of a woman's body as a site of relentless compromise.

References

1. Petryna, Adriana. *Life Exposed: Biological Citizens after Chernobyl* (Princeton: Princeton University Press, 2002), 5.
2. Pinto, Sarah. Lecture. ANTH 148 Medical Anthropology. Tufts University, Medford, MA. 9 Nov. 2006.
3. Baker, Lisa. "Control and the Dalkon Shield," *Violence Against Women* 7 (2001), 1305.
4. Grant, Nicole. *The Selling of Contraception: The Dalkon Shield Case, Sexuality, and Women's Autonomy* (Columbus: Ohio State University Press, 1992), 16.
5. Rapp, Rayna. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* (New York: Routledge, 2000), 36.
6. Pinto, Sarah. Lecture. ANTH 148 Medical Anthropology. Tufts University, Medford, MA. 31 Oct. 2006.
7. Farmer, Paul. *Infections and Inequalities: The Modern Plagues* (Berkeley: University of California Press, 1999) 79.

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