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Journal of Medical Ethics blog

Zika, Gandhi and the CDC

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Guest Post by Agomoni Ganguli Mitra

56

Three pieces of news over the last weeks particularly troubled me. In the first, and perhaps most radical of them all, Latin American governments began to urge women not to become pregnant over the next couple of years, as a public health measure to restrict the number of children born with microcephaly, potentially caused by the Zika virus currently plaguing the region. The second came from the Indian Minister of Women and Child Development, Maneka Gandhi, one of the highest ranking officials in the current Indian government. For years, India has struggled with non-medical sex-selective abortion (and female infanticide) in such significant numbers, that the sex-ratio for infants in certain regions has become heavily skewed. Despite sex-determination being illegal since 1994, the practice has continued with the complicity of physicians and clinics, and in some cases without the consent of the pregnant women themselves. At a conference in early February, Gandhi suggested that an alternative to the current, ineffective policy of criminalising those who provide ultrasounds and sex-selective abortions, would be to register and monitor *every* pregnant woman in the country to ensure that female foetuses are brought to term and female infants are not killed shortly after birth. The last and most recent piece is perhaps the least shocking of them all, if only because we almost take it for granted that women's health and lifestyles choices are seen to be closely related to their ability and inclination to produce babies. The US government's Centre for Disease Control and Prevention (CDC), in a bulletin patronisingly subtitled *Why Take the Chance?*, has suggested that women should think carefully before mixing sex and alcohol intake, if they are trying to get pregnant, or (and this is what makes it particularly problematic) could unknowingly be pregnant.

On the face of it, these are three very different sets of circumstances, geographical, political and social contexts, and in applied ethics, context is crucial to rigorous analysis. And yet I am struck by how, ironically, these policies and policy proposal fail to be contextualised within broader considerations of reproductive rights and justice by policy makers. Underlying all three events is a blatant naivety, if not wilful ignorance about the circumstances in which women make reproductive choices (when they make them at all), and a nonchalant paternalism about controlling women's rights and freedoms, as if it is evident that such "public health" measures can be suggested with full impunity, as long as they come under the cloak of protecting the health and well-being of (potential) children. *Plus ça change…*

Never mind that the link between Zika and microcephaly hasn't been conclusively established. Never mind the mind-boggling logistical implications of registering and monitoring each and every pregnancy in a country of 1.3 billion people, where the State is currently unable to bring to justice those who are currently flouting the ban on sex-determination. Never mind that the implications of what the CDC recommends seems to be that women of reproductive age should consider either giving up alcohol altogether (since according to the same bulletin, half of the pregnancies in the US are unplanned) or that all women of reproductive age should consider serious measures not be become pregnant if they wish to drink – especially in a country where access to affordable contraception and healthcare remains politically fraught.

There seems to be, on the part of state officials, a staggering lack of recognition and humility with respect to the role public policies currently play in impeding women's reproductive freedoms and wellbeing. The Latin American governments could have possibly responded to the Zika emergency by taking a hard look at current regulations around access to contraception and abortion in this (predominantly Catholic) region, and by opening a dialogue with the Church in order to revisit political and social norms around access to contraception and abortion. The CDC could have separated their concern about alcohol abuse in pregnancy as part of a wider debate on alcohol abuse by men and women and its potential dangers, including intimate partner violence, or as one commentator has suggested, contextualised it along with recommendations about men's reproductive health. The Indian government Ministry of Women and Child Development could have taken this opportunity to revisit corruption in the judiciary and law enforcement, or its recent failure to bring those responsible to justice on the matter of sex-selection.

None one of these proposals came with suggestions to ensure that women are not further criminalised for their reproductive choices, measures to increase women's reproductive freedoms and wellbeing in general, or steps towards conferring additional responsibility to actors who happen to be involved, and sometimes in more privileged positions with regards to these choices (religious leaders, partners, families, health care providers, law enforcement officials). The UN has now asked the Latin American governments to revisit their laws on contraception and abortion, Gandhi and her ministry were forced to do some political backtracking in response to the outrage from activists, and the internet backlash to the CDC proposal has been swift (see this, this, and this, for example). However, it seems unlikely that in the wake of these events, there will be a wider debate

regarding reproductive health and freedom in any of these contexts.

What should the response be from the bioethics community? Firstly, a trend that I particularly welcome as an early career researcher in medical ethics and bioethics is the increased popularity and understanding of social justice issues in health and healthcare debates, and a recognition that women and girls' health, flourishing and wellbeing are heavily influenced by policies in other areas. But often, these approaches remain confined to those who are particularly concerned with social and health justice topics. I would welcome further academic attention to cultures – professional, institutional, societal, economic – to ensure that policy changes are eventually translated into practice and social norms. Finally, for those of us who tend to be kept awake at night worrying about global justice concerns, the cases above further show that the global bioethics discourse does not necessarily need a final answer to the statist-cosmopolitan divide before we can consider whether bioethics concerns are truly global, nor does it require a breakdown of borders through trade, mass exodus, pandemics, and climate change in order to be relevant. In bioethics, more than ever, the local, is also the global.

We recommend

Zika virus: management of infection and risk
Shazaad S Y Ahmad et al., BMJ Support Palliat Care, 2016

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New Guidance From DoH On Abortion Provision
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bearp, JME blog, 2016

Zika: should I be worried about it?
James McIntosh, Medical News Today

Zika Virus: Treatment and Prevention
Lori Smith BSN MSN CRNP, Medical News Today

Mosquitos and Zika: the insect behind the outbreak

James McIntosh, Medical News Today

WHO: Zika epidemic requires 'research-guided' public health interventions
Neil Osterweil, Family Practice News, 2016

Zika virus: CDC investigating more possible cases of sexual transmission
Catharine Paddock PhD, Medical News Today

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