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Birth Control Pills.

FDA approved without proper testing in 1960. A great success \because of ease of use. Within two yrs about 1.2 million American f used it & by 1973 the no. rose to about 10 million. Although no more increase in use, it is the most widely used contra. in the U.S. & the world.

First idea about dangers from a f Barbara Seaman's book in 1969. Medical literature spoke of side effects in 1962 but warning 'of no consequence' also only in 1970. Since 1978 FDA requires that comprehensive info. be given. Most researched contra.

The Pill stimulates pregnancy and so some of its negative effects are like early pregnancy.

3 kinds of pills:

(a) Combin. pills: both E & P for all 21 days - Inhibits ovulation. Presence of P thickens mucus & does not allow uterine lining to develop.

(b) Progestin-only pills: Do not stop ovulation & so not as effective.

(c) Sequential Pill: E for few days, then combn of both for remaining days. Less effective than combination pills but more dangerous also. Taken off the market by FDA in 1976.

COMBINATION PILLS:

Theoretical pregnancy rate is 0.5% but actually it is about 2%.

Reversibility is ~~not~~ been studied but no conclusion drawn from the study.

Symptoms of severe problems: (if persists for more than 2 to 3 cycles. it is severe)

- pain or swelling in the legs (thigh or calf)
- headache
- blurred vision (loss of sight)
- chestpain or shortness of breath
- abdominal pain

Who should definitely not use the pill:

- > If you have any disease or condn with poor blood circulation or excess blood clotting
- > Hepatitis or other liver disease.
- > Undiagnosed abnormal genital bleeding
- > Cancer of the breast or reproductive organs
- > Pregnancy.

Who is strongly advised not to use:

- > Migraine headaches
- > Diabetes, prediabetes or family history
- > Gallbladder disease
- > Sickle cell anaemia
- > ♀ over forty
- > Impaired liver fn. in the past year
- > Long leg casts or major injury to lower leg.
- > Smokers (15 or more per day).

Who should probably not use:

- > Lactation: It may dry up or reduce nutrition of milk. Effect of E or P not known.
- > Weight gain of 10 pounds while taking the pill.
- > ♀ who don't have regular periods.
- > Cardiac or renal diseases.

It may not be wise to use the pill when suffering from:

- depression • hair loss related to pregnancy
- asthma • epilepsy • uterine fibromyomata
- acne • varicose veins • history of hepatitis but normal liver functions for at least 1 yr.
- a woman who is a DES daughter.

Negative effects.

- Cardiovascular disease responsible for most pill related deaths.
- Betn 5 - 7% ♀ develop hypertension. Not known if problem goes on discontinuing the Pill. Problem increases with longer use.
- Not clear cut results about link betn using of Pill and diff types of cancers.
- ♀ pregnant while taking pill or within 3 months of discontinuing higher risk of birth defects in children. Also higher rate of jaundice in mothers who took the pill before the pregnancy.
- 5% ♀ develop migraine or other severe headaches
- One in 4 ♀ more irritable, anxious or depressed
- Decrease in libido
- Nausea & fatigue as in early pregnancy.
- Many problems like vaginitis, U.T.I, breakthrough bleeding in early use of Pill. Body gets used to new hormone levels slowly.
- Gum inflammation. Need more care of teeth.
- An increase in viral infections suggests that Pill may affect body immunity.

There are also many other effects to which the pill has been linked but for which there is no conclusive proof.

- pleurisy - suppression of bone growth - arthritic symptoms - visual disturbances - ulcers in the mouth - bruising - antagonism with TB drugs
- abdominal cramping - changes in thyroid fn.
- photodermatitis - hair loss - excessive hair growth - benign growths of muscular tissue
- autophonia an ear or nasal disorder etc.

- Pill alters nutritional requirements. Increased requirements for Vit C, B₆, B₁₂, B₂ & folic acid.
- Carbohydrate metabolism adversely affected
Water metabolism also altered.

Should use pills with 50 µgm or less of E.

PROGESTIN ONLY PILLS

Theo. rate is 1 to 1.25%.

Actual failure rate is 2.5%.

Contraindications: Those who absolutely should not take is same as for the combination pills. Full. women are strongly advised not to take: diabetes, acute mononucleosis, irregular periods, past history of ectopic pregnancy.

Side effects: These were made to reduce the E-related effects. Some are still reported:

headaches, change in weight, cervical erosion & change in cervical secretion, jaundice, allergic skin rash, chloasma, depression, gastrointestinal disturbances & breast changes, increased risk of ectopics.

Common complaint is that menstrual bleeding is very irregular in amount, duration of flow and length of cycle.

Diaphragm

Invented in the nineteenth century.

Popular until the 60's.

In 1960s almost one third of couples in the U.S. using it but by 1971, Planned Parenthood said only 4% of its clients used this method.

Reduced use \because of pill & IUD.

Now back again to diaphragm.

Research on barrier methods very minimal.

\therefore out of a total 30.2 million dollars spent in 1976 on contra. research, the U.S. spent only 50 thousand dollars on barrier research.

(Ref. 5 pg. 259. OBOS).

D. comes in various sizes 50 - 105 mm.

Fit according to size of vagina.

Has to be used with spermicide. Cream or jelly are the actual contra. D. is only to hold it in place.

Failure rate 2% if fit properly & used carefully & with proper understanding.

In practice, however, it is 10%. \because of not using it every time & not using spermicide.

2% could be because D moves under certain condns

Wrong size D can cause problems

Also some f get recurrent yeast infections if D not stored safely.

In case of a severely displaced uterus, or protrusion of bladder into vaginal walls - do not use Ds.

How to use : well illustrated.

D. can be used for ~ 2 years if cared for.
Costs (then) about 12\$.

Adv.

D. with cream or jelly reduces chances of getting trichomoniasis or gonorrhoea infections in the vaginal canal. It increases protection against PID & cervical dysplasia & may help clear up adenosis.

Condom

Egyptian men wore condoms in 1350 B.C. as decorative cover for their penises.

Condom was popularised for protection against conception & STDs in the 18th century.

Usually unrolls to about $7\frac{1}{2}$ " & has a $1\frac{3}{8}$ " dia. rubber ring around it at one end.

Failure rate of 2% if properly used - 10% otherwise.

Adv.

Method of birth control that gives some protection against gonorrhoea & syphilis when used in every instance of vagina to penis contact it also prevents partners from infecting & reinfecting each other with infections such as trichomoniasis or herpes.

If man ejaculates too soon, this lack of direct contact would extend the period for stimulation.

Since condom catches semen, it does not allow semen to wet the woman. She can then immediately go out after intercourse.

Condoms are available in only one size and have a shelf life of 5 years if kept away from heat.

Cervical Cap. ~~Contraceptive~~ sponge.

Idea is thousands of years old. In ancient Sumatra, ♀ molded opium into cuplike devices to cover their cervixes.

Used in some European countries. Not widely or easily available in the US although it was studied in early 20th century. By mid-60s U.S. companies had completely stopped producing it.

It is $1\frac{1}{2}$ long, thimble shaped & covers the cervix.

This rubber cap comes in 4 diff. sizes from 22 mm to 31 mm in dia.

Theoretical failure rate of 2% but actual failure rate up to 13%.

How to use given at length in OBOS.

Many ♀ cannot use cap but existing sizes may not fit all women.

If you have cervical erosions or lacerations, cap should not be used. since it does not allow free flow of cervical secretions which may cause some irritation.

If cervix is long or irregular in shape, cap not to be used. Also vagina can be so long that cervix can't be reached.

Efforts on to make caps to actually fit the cervix.

Disadv.

It may cause an unpleasant odor if not removed fairly often.

Some ♀ dislike idea of trapping cervical secretions for as long as the cap is used.

Contraceptive Sponge.

Investigations to develop a sponge began a few years ago \because \uparrow moved away from Pill & IUD, recognition from medical establishment that \uparrow are seeking alternatives, a slight increase in public & private funds for research in barriers. In 1983, FDA approved the sponge.

As of early 1984, 400,000 \uparrow in the U.S. had used the sponge. A study had shown 16.8% actual failure rate for sponge as compared to 13.2% for the diaphragm.

Sponge is made of polyurethane. One size $2\frac{1}{4}$ " in dia. & $\frac{3}{4}$ " thick.

Covers the opening of cervix where it traps sperm. Held in place by walls of \uparrow 's vagina & "dimple" covering the cervix. Also slowly releases the spermicide.

How to use also given in OBOS.

No long term studies done on safety of material used. About 2% of \uparrow using the sponge have reported allergic reactions. Some sponges have shredded while they are in place.

Adv.

Effective for about 24 hours.

Comes in one size so need not be fitted.

Does not leak.

Disadv.

Some \uparrow notice unpleasant odor after intercourse.

2-3% \uparrow in clinical trials report expelling the

sponge esp in bowel movements.

Some ♀ such as those with a prolapsed uterus
cannot wear it.

Jellies & creams.

To be used with D or cervical cap & can be used for extra protection with a condom.

In 1981 a study linked its use with birth defects.

No further corroborating studies.

Some brands sold in U.S. at one time showed a presence of Hg. Discontinued since.

Can be problems of leakage, allergy or reaction to smell and taste

An adv. is that it can increase protection against gonorrhoea and trichomoniasis.

Foam

When used alone it has a theoretical failure rate of 3 to 5% but an actual failure of at least 15%. Using it with condoms can give about 100% protection.

Using it is quick - requires about 30 seconds
Less drippy than cream or jelly.
Helps prevent STD.

Foam irritates some vaginas & penises leading to pain, itching or sensation of heat.

IUD.

Centuries ago when camel drivers in the middle East went on long journeys, they would insert pebbles into the uterus of a female camel to keep her from becoming pregnant.

A foreign body in the uterus seems to prevent pregnancy most of the time.

IUDs became popular in the 60s & today about 60 million ♀ use more than a 100 types

In theory it has a failure rate of 1.5%.

Actual failure rate is 4%.

There is suspicion that aspirin or antibiotics may interfere with IUD effectiveness.

A major drawback is expulsion. After 1 year of use betn. 5 & 20% ♀ have expelled their IUDs sometimes even without knowing it.

Usually expelled in first 3 ~~mo~~ months esp. during menstruation. So check for it. Signs are unusual vaginal discharge, cramping or pain spotting, longer string, feel the IUD in cervix or vagina. Male partner may feel pain or irritation during intercourse.

Serious complications can lead to impaired fertility.

Warning signals:

late period or missed period
abdominal pain

increased temp., fever, chills

noticeable or foul discharge

spotting, bleeding, heavy periods, clots etc.

Who should absolutely not use an IUD:

♀ who are pregnant & ♀ with active pelvic infection including known or suspected gonorrhoea. (70% of gonorrhoea is asymptomatic)

Who is strongly advised not to use

Abnormal pap smears • endometritis

abnormal pelvic bleeding

acute cervicitis • gynaecological malignancy

difficulty of access to emergency treatment

disorders of blood coagulation

history of ectopic pregnancy

impaired response to infection (in diabetics or ♀ taking steroids)

high risk of infections, recent or recurrent PID
sickle cell anaemia.

Who should probably not use:

anemia; bicornate uterus; cervical stenosis;

desire to get pregnant in future; endometrial

polyps; endometriosis; leiomyomata; past history

of severe vaso-vaginal infection; severe menstrual

cramps or bleeding; small uterus; valvular

heart disease.

Complications & Negative effects:

> PID are betn. 3 & 9 times more likely to occur in IUD users.

> Also infected miscarriage or septic abortion esp. during second trimester.

> Increased menstrual bleeding, cramps, backache

Betn. 5 & 15% remove IUD in 1 year \therefore of bleeding & cramping.

> IUD can get embedded in uterine lining - This continues contra. effect but complicated while removing. Might need D & C. Could lead to hysterectomies.

> Perforation of uterine wall. If IUD perforates totally it could go & perforate or get embedded in other organs. No symptom other than smaller or absent string.

> If pregnant with IUD, safer to have it removed. It could also be ectopic in 5% cases.

> Cu in Cu-T etc. could cause allergic reactions.

When to get an IUD: controversial. Either immediately after menstruation - easier to insert but increased exposure to infections. Best time is betn. periods & at least 6 weeks after childbirth or abortion.

Tying of the tubes.

Most abused method of contra.

Used coercively against black, poor women all over the world. Also used many a times on 'so-called mentally retarded ♀.'

So certain regulations & guidelines laid down.

- Obtaining voluntary, informed, written consent
 - No threat of withdrawal of welfare etc.
 - Explaining side effects & sharing info. on other available contra. methods.
 - Waiting for 30 days after consent given.
 - Prohibiting obtaining of consent while person is in labour, before or after abortion, or under influence of drugs & alcohol.
 - Prohibiting hysterectomies for sterilisation in federally funded programmes.
 - Moratorium on govt. funding to sterilisations of persons under 21 who are declared legally incompetent or are institutionalised.
 - Auditing sterilisation programmes in the ten states where most of these operations are performed
- (Ref. 27, page 260 OBOS)

Complications & -ve effects:

- Complications due to anaesthesia.

Cardiac irregularity, cardiac arrest, infection, internal bleeding & perforation of a major blood vessel are few of the effects.

- Laproscopic techniques may involve internal burn injuries or punctures to other organs, skin burns, puncturing of the intestine, perforation of uterus & CO₂ embolism (which can

cause death.

- Some ♀ experience problems after the operation including heavy irregular bleeding & increased menstrual pain which may require repeated D & Cs & in some cases even hysterectomies

Not reversible. Even if possible it is too expensive. Lead to misconception that it is reversible and yet access to reversible only with certain sections of society.

Vasectomy.

Much simpler procedure.

Leaves genital system unchanged. No change in hormones. Absolutely no problems of any kind.

It should also be considered irreversible.

Science in India

A changing Profile.

edited by S. U. Mukherji B. V. Subbarayappa.

Indian National Science Academy New Delhi 1984.

Page 32.

Medical Sciences.

In 1911 the Government of India created the Indian Research Fund Association to promote scientific medical research in India. This Association for over 30 years sponsored schemes of research on malnutrition, malaria, typhoid, plague cholera, leprosy and kala-azar. The work of the Association was taken over by the Indian Council of Medical Research in 1949.

Society and Science. A Journal of Nehru Centre Vol. 2. NO. 1 (Jan/March 1979).

Reprint of Relevance of Archaeology. D. P. Agarwal.

The Relevance of Archaeology in transforming society.

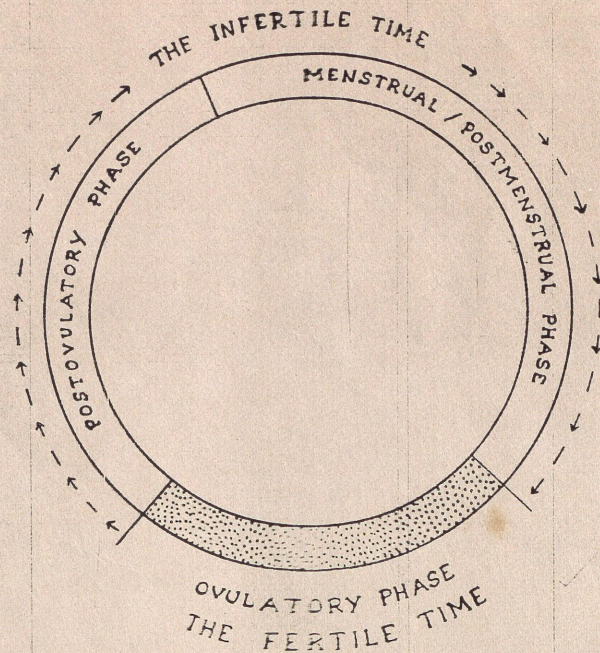
D. P. Agarwal. Page 2.

Man woman competition.

As only an immature brained infant was delivered by the human female, it remained dependent for 5-6 years, where as most of the other mammals need only a few months to become independent. Monkey infants remain helpless only for about an year but as they cling to their mothers, unlike human ones, they do not impede mother's mobility (Pfeiffer 1932). Thus the mobility of the human female was not only reduced by the enlargement of her hips but also by the necessity of looking after infants for a longer time. The infant had to depend for protection & food on its mother and an immobilised mother on an adult male. This was ~~the~~ perhaps the first division of labour bet. the two sexes and may have been the beginning of pairing and family.

page 3. Animals indulge in intercourse during 'heat' (estrous) which, being instinctive & beyond voluntary control, could be dangerous for the safety of the human infant during its period of dependence. The natural selection has freed humans of the estrous - and man is unique amongst mammals in this freedom. Females become receptive to sex during most of the time which reduced the male aggressiveness & increased the emphasis on personal preferences; now man & woman could choose their partner for intercourse, as also the time. Thus man's love for an individual female is rooted ultimately in the freedom from his estrous.

TABLE 2



Infertility is continuous from the beginning of the postovulatory phase through the end of the menstrual/postmenstrual phase.

ous through the postovulatory and the menstrual/postmenstrual phases.

It is important to note this continuous phase of infertility because study after study has shown that there is absolutely no chance for conception once a woman has entered the postovulatory phase of her cycle.¹ Conception becomes likely only when she enters the ovulatory phase of the *succeeding* cycle, when the cervical mucus secretions change into a solution that not only is hospitable to sperm but actually aids their survival.

Determining the Infertile Time: One method gives you the highest possible assurance that the postovulatory infertile phase has begun. Thus, it offers you reliability equivalent to the Pill or tubal sterilization. What is involved? Only this: monitoring your basal body temperature every morning.

Every woman's waking temperatures change throughout her cycle. They are lower at the beginning of the cycle; they are about a half a degree higher during the last two weeks. *When a woman's waking temperatures have reached a sustained high level, she is infertile.* Pregnancy cannot take place once a woman has entered the high temperature phase of the cycle.

Explaining Your Temperature Rise: Why does your temperature rise in the final two weeks of your cycle? What causes it?

Here is what happens: After the egg cell is released, the ovarian follicle that originally contained it begins to manufacture the hormone *progesterone*. Progesterone does three things:

1. Causes a woman's basal body temperature to rise,
2. Dries up cervical mucus, and
3. Suppresses all further ovulations for the rest of the cycle.*

But please recognize that you *cannot* pinpoint the day of ovulation from a review of your temperatures. *The only*

*Progesterone has another essential task if conception takes place: It helps prepare the uterine lining for the implantation of a tiny embryo. If conception has occurred in that particular cycle, the follicle will continue to produce progesterone to sustain the pregnancy.

In fact, one way of discovering if you are pregnant even before the doctor can tell is to note whether the high level of progesterone is sustained in your body for seven days beyond the expected beginning of the menstrual period. So if your waking temperature remains elevated for a full week beyond its usual elevated duration, you have 99 percent assurance that pregnancy has been achieved.

x. The philosophical understanding about this ^{role} male and its philosophical on is observed as measure role in history of science. The body of knowledge, ~~reality~~ ^{its} day to day reality has never. It can be seen in Archaeologist D.P. Agarwal's view point on human evolution, or as Evelyn Keller ~~states~~ in her book on Gender & science the alchemist view point about this biological sexual ~~reality~~ ^{reality} of sexes.

The natural selection has freed humans of the estons.

and man is unique in this freedom. female became receptive to sex during most of the time which reduced the male aggressiveness & increased the emphasis on personal preferences ~~now~~. As Keller puts it in her book on reflections on gender & science (page 53) The alchemists were not feminists. In many ways, they shared in the general contempt for women of their time but for them women's procreative powers remained a matter of reverence, awe and even envy. as she quotes from paracelsus How can one be an enemy of woman - whatever she may be? The world is peopled with her fruits and that is why god lets her live so long, however loathsome she may be. (ed Jacobi 1954 p 26).

AL

Is it possible to discover safe contraceptive? what are the criteria of arriving at such contraceptives?

The concept of contraception its needs and requirements. is important to examine at first level.

The population control, which leads to fertility control, the question here is ~~the~~ becomes a grave in magnitude because of the change in mortality rates and the life expectancy ~~is~~ limits increasing. The 'development' has given this opportunity. The developing countries becomes the target of this control, population control and if one wants to control population then the fertility control. The fertility of married couples which is a target, all other sexual expressions may be leading to fertility are not to be tackled or not crucial. The patriarchal institutions of monogamy are strengthened by this control, The norms put by monogamous, ~~a~~ man centered social, cultural and economic society. The control of reproduction. control of fertility.

4 The sexual expression of humans which is having basis in animal world but is more liberated than animals, the sexual urge of humans is not restricted to reproduction, not directly related to 'estrous'. The attitude of the sex ~~for~~ reproduction and as entertainment was shown sarcastically by one of the TV serial, where the stoile in co. the fertility of all the worker's wives increasing almost 100%. The developing countries sexual expression is considered by developed countries to that expression. The unemployment, poverty and ~~the~~ ~~con~~ such situations the need of sexual expression increases many fold that is the attitude the perspective on which the control of fertility is ~~made~~ becomes a need, the socio-economic variations because of the dependence

on agriculture and the variation in the socio-economic cultural expressions within the nations is not considered important to be tackled differently. The tribal societies which are still cut off from the world, or the caste based traditions ~~are~~ still the need of working hands is not a prime important factor as far as world population policy is concerned. The need to control population is to control fertility.

The socio-cultural variations are considered in the aspects like depriving the users of such methods from information, their inability to understand and the belief system existing is ~~was~~ becomes a issue of their their ignorance and the primitiveness to understand the new aspect of ~~its~~ the method, the fertility control is important, and the ignorance and primitive character of the user becomes the otherside so ~~at~~ the consent, evolving understanding & stating the need, arguing the perspective becomes immaterial to the extent the consent is also not taken or as ethical value becomes important.

When PSM had shown a slide show on women's menstruation and women's ~~de~~ body in the discussion the one of the doctor doing research on injectable contraceptive casually mentioned, Rs 300, the intensive which prevents women from working, and search of work ~~it~~ becomes ~~was~~ important because she earns for the month. The monkey was attraction of the grave which is suspended bet. the

persons, women who were injected contraceptive. The ~~other~~ draggery in the lives of such women is not important to understand. You people is it not important why she opts out for such studies. her life is so bad so she opts out for such trials. Because it helps her in preventing the birth of an one more child. The interviewed women do not seem to be in this category but the issue of the experiment state is not important to volunteers.

The matters which are considered to be very sensitive to talk about are totally out of their hands ~~because~~ & in hands of such authorities who will monitor them to see the efficacy of the contraceptive, aren't they pregnant etc. The whole issue of efficacy of contraceptive method becomes a sole and prime important in such trials. Because the ~~most~~ right focused objective is to control the fertility. The ~~in~~ another important area becomes the ~~#~~ long lasting effect of maintaining the efficacy. The basis of such contraceptive ~~& the~~ ^{on} which understanding evolved and innovation and manipulations in it becomes a side problem. The objective is the efficacy not the method ~~on~~ & its ~~the~~ principal on which method has evolved.

The search of the origin of such methods leads to evolving understanding of such Research, ~~with~~ & methods of research. The Research is aimed at the efficient and long lasting control of fertility. The control fertility ~~to~~ bounds are extended to a longer control because the fertility span of the women is almost 30 yrs.

the fertility span becomes important criteria. In the developing countries especially India the ~~modern~~ practiced marriage age is 14 just onset of menstruation. The legal age is 18. But in socio cultural norms prevalent in society the women is looked upon as burden and liability. The ability of women to reproduce is looked upon as threat to the society. So it has to be properly controlled that ability to reproduce is the norms so the Research orientation is that crowd of women who are in institution of which are legalised, or identified as normal.

To control that fertility is research motive and the span should be long enough to ~~cover~~ cover maximum years of the fertile years of women. The question and demand can be turned on to socio-cultural status, the ignorance and drudgery of women's life is also considered to effectively argue about non combersome method of such as Implant which are effective for 5 yrs.

Research Method is a complex area, because the criteria are overruled and become flexible, in such research, because the immediacy of the problem ~~has~~ takes overedge to all values ~~and~~ on enter which ~~effice~~ efficacy is based. Safety is such criteria. the animal trials on primates are done in some cases, ~~the imp.~~ results adverse findings can be ~~be~~ overlooked because ~~hum~~ it is not comparable to human body. The humanbeings in the developing world and developed world also are different because of their socio-economic and cultural set ups. The ban, proved contra indicative of contraceptive methods can be used in developing ~~wa~~ ~~the~~ part of universe.

Infertility : medical & social choices

- Office of technology assessment (OTA)

Ch.1 Summary, policy issues and options for congressional action

- How big a problem is infertility
- What factors contribute and can it be prevented?

(Table 1-1 pg 7 : Prevention of infertility)

- How is infertility diagnosed and treated.

(Box 1.A : Infertility's emotional toll pg 8)

- Who assures quality of infertility treatment?
- How much does infertility cost?
- What ethical issues are involved.
- What does the law say? . . .

- Policy issues and options for congressional action

The issues • collecting data on reproductive health

• preventing infertility • information to inform and protect consumers • providing access to infertility services

• reproductive health of veterans (?) • transfer of human eggs, embryos & sperm • recordkeeping • surrogate motherhood and • reproductive research

Ch.2 Introduction

- Defining infertility (medical defn)

(Table 2-1 Some landmarks in RT of animals & humans) pg 36

- Is infertility a disease?

- Parents, children and families

- The human reproductive process (figures of female and male reproductive systems) . . .

Ch.3 Demography of infertility

- National survey of family growth data

- Infertility services (Fig. 3.2 showing use of services by males and females from 1966 to 1984 in U.S.)

- Summary.

Ch. 4 Factors contributing to infertility

- Infection (STDs & other infections)
- Hormonal disturbance
- Endometriosis
- Varicocele (varicose vein of the testes)
- External factors - Contra (of all kinds) • Abortion
• environ. and drugs • smoking.
- Genetic and chromosomal abnormalities.
- Cancer
- Iatrogenic factors (by physicians or by treatment)
- Misc. - Unexplained.

(Table 4.4. pg 74 Iatrogenic causes of fertility)

Ch. 5 Prevention of infertility

- Prevention strategies
 - ✓ (Table 5.1 pg 86 prevention of infertility)
- STDs
- Maternal age ~ Iatrogenic infertility
- Education
- ✓ - Research needs (pg 90)
- A strategy for prevention

Ch. 6 Diagnosis of infertility

- Patient history
- Physical exam
- Techno. for evaluation of repro. status

Ch. 7 Treatment of infertility

- Medical treatments (pg 117-122)
- Surgical treatments (125 - male infertility)
- A.I.
- Cryopreservation
- Risks of infertility treatments ...

Ch. 8. Infertility services & costs -

Ch. 9. Quality assurance in research & clinical ~~care~~ ^{care} centre

- Role of professional societies in assuring quality.
- Distinguishing therapeutic from exptal. treatments . . .

Ch. 10 Reproductive health of veterans

(Veterans' Administration - largest health care delivery system in the U.S.)

Ch. 11 Ethical considerations

- Context of the ethical debate.
- The right to reproduce
- Moral status of the embryo.
- Parenthood and parent child bonding
- Research initiatives & rights of patients
- Truth telling and confidentiality.
- Intergenerational responsibilities.

Ch. 12 Constitutional considerations

- Freedom to procreate
 - Restrictions on freedom of procreation.
 - Prohibiting commercialisation of non vital RT.
- (pg 229 - Commercial sperm bank's list of sperm donor characteristics)

Ch. 13 Legal considerations

- Str. of applicable law.
- A. I. H. - A. I. D.
- I. V. F.
- G. I. F. T.
- E. T.
- Restricting or regulating sale of gametes or embryos . . .

Ch. 14 Legal considerations : surrogate motherhood.

- Finding & choosing a surrogate mother.
- Requiring consent from husband of surrogate mother.
- Recordkeeping & confidentiality.
- Typical contract provisions.
- The surrogate gestational mother . . .

Ch. 15 Frontiers of RT.

- IVF .

(Box 15.A pg 294. A look back).

- GIFT .

- Uterine lavage to retrieve a fertilised ovum
- Freezing embryos
- Freezing eggs .
- Micromanipulation of sperm into ova .
- Sexing sperm cells , embryos
- Genetic screening of gamete donors

Appendixes :

- A. Sites offering IVF in U.S.
- B. Self administered pre conception questionnaire
- C. Fetal research laws possibly affecting IVF.
- ✓ D. Feminist views on R.T.s. (pg. 326 - 328)
- E. International developments .
- F. Religious perspectives .
- G. OTA survey of surrogate mother matching services
- H. List of Contractor documents .
- I. Acknowledgements .
- J. Glossary and acronyms & terms .

Alison Jaggar in 'Feminist Politics & Human Nature'
Harvester, Brighton 1983 p. 41.

As soon as one takes into account the facts of human biology, esp. reproductive biology, it becomes obvious that the assumption of individual self sufficiency is impossible. Human infants resemble the young of many species in being born helpless, but they differ from all other species in requiring a uniquely long period of dependence upon adult care. This care could not be provided by a single adult; in order to raise enough children to continue the species, humans must live in social groups where individuals share resources with the young and temporarily disabled. Human interdependence is thus necessitated by ^{human} biology, and the assumption of individual self sufficiency is plausible only if one ignores human biology.

Ravikala → Blouse

Andhra lowercaste.

Pandaga → Festival / celebration.

The Sexual cycle.

From Female cycles Paula Weideger Women's Press (1938)

Reproduction represents the highest aspect, and menstruation, the lowest, is in its service.

We are species in which sexual behavior is furthest removed from hormonal control. We are also the species that has demonstrated the greatest facility for conjuring up emotional constraints that are fully, as limiting and confining as any physiological constraint might be.

Given for photo at RWS (27/8/90).

SIGNS vol. 15 # 3 page 475 - 499.

Failures of volition - Female agency & infertility in historical perspective

Margarete J. Sandelowski

Mother Machine

- Referring to scientists as 'men' (#5)

- Eugenics ^{I. AID} inherent in all the techniques. (Ch. 1)

"Overpopulation" instead of "propagation of the unfit" Methods to avert - sterilisation / birth control.

-ve eugenics : ↑ tools

+ve " : AID, IVF-ET, cloning etc.

- A.I.D.

threatening to men i.e. basis of patriarchal descent

- Sperm banks - men before going in for vasectomy

- to preserve germ cell from hazards

- then ^{for} choice of sperm.

Clear cut eugenic nature of sperm freezing
AID. ~~for~~ sperm bank for both population control and infertility.

→ Check out statements from news item about sperm bank recently come.

Eugenics ↔ biological determinism.

Chapter 2.

- Relative slow implementation of AID

- Slow development of sperm banks not because of "fear" of new techno. but "

AID recognised as threat to the patriarchal family & male dominance.

- History of AID pg. 35 onwards!

AID viewed in alarm

2 reasons. ① threat to patriline descent

② provides ♀ a means of rebellion

- Legitimacy a concept not for ♀.

- Adultery related to introducing a false strain of blood in husband's family.

- Grieving the loss of genetic continuity is one of the difficult issues. = AID

Ch 3.

Socialising of the sperm.

II E.T.

Ch. 4. Watching an ET on a cow

Ch. 5 ET in animals

- Cattle are intrinsically worth the meat or milk they produce

The procedure:

- Synchronisation of estrus of recipient & donor
Adjusted by hormone treatment. (LH/FSH) => superovulation.

- Ova recovery: slaughter or removal of oviducts or flushing out as done now.

- Embryo evaluation

- ET. thro' cervix or surgery.

+

- Freezing of embryos } Req'd quality, at the
- Twinning } req'd. time - also
- Sexing } inter-species ...

Ch 6 ET in humans

- ET means ectopic pregnancy for donors & recipients → flushing could push the embryo into the tube.

recipient: also has risk of pelvic infection

- synchro. of cycles artificially: exposure to hormones

- risk of VD due to AI with sperm of husband

- donor also risks pelvic infection

- rec. carrying foreign genetic make up "unknown risks"

AID ↔ being compared with ET.

Embryo evaluation - could be used for sex selection

& genetic screening even in normal pregnancy

All these for whose benefit?

Would this remain mandatory in future too?

No exact prediction possible for anybody.

When babies are consumer products, who oversees quality control?

III IVF

ch 7

- Man made ovulation

• First attempts to get eggs by hysterectomy at ovulation

• Fertilisation including maturation tried outside first

• Ovulation to be controlled.

First: Pergonal - a human menopausal gonadotrophin or hMG. to stimulate growth of follicles

Then - hCG (III¹²⁵ to LH) - ripening & ovulation.

"assumed the role of hypothalamus"

∴ check estrogen levels & then give second hormone

pg. 109: describes cycle

III: laparoscopy.

No info on how human tests carried out

i.e. how the subjects were chosen.

Early human trials: without verifying safety of IVF in primates before attempting on women.

- IVF not for blocked tubes but mainly for low sperm count of men.
- Cross betn. humans & animals
- Eugenic selection in the name of helping the infertile. The tools could be
 - > egg donation
 - > sperm donation - sex selection
 - choice of donor controlled
 - > both sperm/egg donated
 - embryo adoption
 - > sterilisation & RT relation of control
 - > embryo freezing
 - > embryo screening
 - > G.E.

Ch. 8 Doctor induced infertility

IVF justified as natural right to bear babies

- Reasons :
- > interest of nation
 - > continued sterilisation abuse
 - > Not all IVF patients childless
 - > No right if not done under condn of patri.
 - > 'deserving & appropriate' & chosen

IV Related Technologies :

Ch. 9 Informed consent

- ♀ not told of exptal. nature - being coerced emotionally and invisibly.
- human experiments or therapy
- Other than this too, choice very much constructed through the messages gathered over a large period of time.
- Scientists working towards helping ♀ fulfill their biological destiny.
- As feminists how we understand & resolve the anguish of an infertile ♀
- Torture of other testing & treatment prior to coming into IVF programme.

- Ruining of one's sexual life
- Finding right time for ovulation
- Emergency egg collection
- Fertilisation - Implantation
- Statistics of success pg. 179.
- Experiences

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Ch 10 Sex determination

- Sex preference in all cultures
- Even dominant with ♀♀. How does one understand choice? Choice is intrinsically connected with power to choose, a power systematically undermined by patriarchal values. - Connors 1981 p. 206
- Raymond, 1981 p. 209
- Techniques used for sex det. & sex preselect.
 - Preselection > Separation
 - > Discrimi. against X on Y in ♀'s body
 - > Timing of intercourse
 - > Antigen-antibody reaction
 - > NRT: ET, IVF, Cloning

Ch 11 Surrogate motherhood

- Available for whom
- Desire to nurture a child for its own sake is not their prime motivation. They only want a child that meets certain specifications
- Pressure forcing infertile ♀♀ to go in for surrogate
- Surrogacy more for husband to have a child
- Sperm donors & womb donors comparable. Compare with tears & eye. (Andrea Dworkin) Can collect tears but can't take out eye
- Surrogate's free will over her body! surrogate motherhood called reproductive prostitution
- Andrea Dworkin (1983) - individual will / choice
- Woman's economic status pushing her into this. Also involves exploitation of her emotional structure

.. Its being said that \forall love to be pregnant
Dr. Janice Raymond: "... Our motivation to choose differently is also being controlled "

- Contradictory arguments of psycho. stress on losing child in abortion & surrogacy
- Surrogates \leftrightarrow wet nurses
- AID and Surrogate motherhood
weaken patriarchy strengthen men

Ch. 12 The artificial womb

- Woman's body & womb dangerous \therefore
- > Humans only mammals to walk upright. Hence pregnancy painful. Can get rid of it only in womb.
- > 150/1000 embryos die in 1st month \Rightarrow hostile environ.
- > hazardous environment today. So artificial wombs safer
- > Labour is dangerous for babies
- Other reasons: therapeutic; eugenic; moral (abortion); psychological - for men to confirm paternity; benevolent (save \forall all the problems related to pregnancy).
- Some technical details of man made womb

Ch. 13 Cloning

- Technique still requires egg & probably the uterus. Can be used by \forall too.
- David Rossnik's book: 'In His Image'
- Philosophy revolves around idea of immortality. Organs from one's clones.
- Desire to control birth - also that to control death.
- cloning offers eugenics (highest degree)
- Uses > preselection of sex > avoid genetic disease > people with certain qualities for certain tasks (wills of clones ignored) > create supermen e.g. Einstein

- + > child for sterile couple
- > colonise a distant planet
- > preserve family likeness.
- Other uses of cloning to study the cell development
- Cloning in plants & animals.

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V Bigger picture

Ch 14 Breeding brothels

- Breeders: only role to some women
- Professional breeders where ♀♀ do not want to produce generally & where population declining
- Motherhood a new branch of female prostitution
- New social institutions to reflect men's total control over female reproduction: reproductive brothel
- "nonvaluable ♀♀": looked upon as breeders for embryos of valuable women.
- brothel with 3 major activities.
 - > getting eggs: not only from living women but also from ovaries of dead ♀♀ or female embryos.
 - > manipulating eggs:
 - twin the embryos. Use eggs for clones.
 - remove female component - add 2 sperms. G.E.
 - Fertilise in lab. using culture from various parts
 - sex selection.
 - > transferring embryos. - could use even brain dead ♀. Finally artificial wombs would make perfect mother machine.

Ch 15 Reproductive continuity

- Earlier mother goddess. Early man, primitive man & Christian man have all tried to make ♀s procreative power their own.
- self mutilation - castrating, donating parts or subincision
- Couvade - fake childbirth / labour to misguide evil spirits
- Initiation ceremonies; baptism
- Even psychological studies about men's envy

- The politics of reproduction - Mary O'Brien (1987)
- No philosophy of birth comparable to labor, sexuality & death (existentialists) (Marx) (Freud)
- For ♀♀ birth continuous process. For men alienating. No sense of unity with natural processes so appropriation of child by men thro' ideologies of male supremacy and a host of social str. s
- Marriage and patriarchal family
- RTs offer thro' > AI & sperm banks
 - > sex preselection > clones
- Claim over maternity weakened, over paternity stronger. Making motherhood more intellectual.
- Maternity also in question like paternity
- Getting men to carry babies
- Taking away all functions from the ♀♀. Changing ♀ into a man-like being. Her cyclical periodic nature is obliterated with hormones to give her the linear biology of a man.
- Earliest form of worship 'mother goddess'. Matrilineal descent. → patrilineal descent with the knowledge: Male gods
- Babylonian text → Bible. Semen prime life gives
- Discovery of egg in 1827
 - ↳ role taken only as nutritive
- 1875 → 1879: role of egg & sperm in fertilisation
- Even later sperm idolatry continues. Also view of ♀ as vessel for life that man created → as obvious in patriarchal obstetrics as in patriarchal religion.
- 'Labour & Delivery' dept. of Ob/gyn now called 'fetal ICU'!

Ch 16 Reproductive Control

- Ob. & gyn. from men's desire to conquer control the innermost part of nature.
- Attack on midwives
- Midwives termed 'unsafe' but later the doctors leading to infections and disorders.
- Greater & greater control through hospitals of childbirth.
- Breast feeding vs bottle milk.
- Obs. → gyn. & hence surgery on repro. organs to deal with envy of female procreative power
- Knowing role of ♀ egg in producing the child, recreating the myth of single parenthood, not thro' religious or scientific theory but thro' technology.
- Controlling nature - ♀, animals & plants all.
- Control over outer space as well as inner space - i.e. genes, cells, chromosomes = GE.
- Today ♀'s bodies manipulated out of compassion to increase their options & their freedom.
- Impact on ♀ as a class obscured, "rights" of individual women emphasised.
- Soon language for women will be the same as that used for animals.
- Men trying to mfg life better than that which women can give birth.

pg 314 "Now men are far beyond the stage at which they expressed their envy of ♀'s procreative power thro' couvade, transvestism, subincision. They are beyond merely giving spiritual births in their baptismal font wombs, beyond giving physical birth with their electronic fetal monitors, their forceps, their knives. "Now they have laboratories".

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Afterword : Crystallisation

- Opposition coming from ♀♀.
- Can ask for regulation as in case of environment.
- If we can compare the perceived good for the few in the biomedical technologies, with the larger harm to the many, and demonstrate that there is greater harm than good, then we can argue that there has to be a regulatory framework to prevent that harm.
- Need to clearly articulate values we uphold & demo. how the techno. impair well being of ♀♀ & of animals too.
- Pain of infertile ♀♀ being used for research not primarily intended for the infertile.
- So break silence against all odds.
- Not easy to speak. lot of confusion. We are supposed to be confused. 'confusion is a tool of oppression.'

Chronology of development of NRTs from

1870s → 1980s.

Books . . .

1. "Woman controlled conception"

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- Presentation of technical info.
- Personal accounts of ^{experiencing} these technologies.
- Statements by other people on the debates.

(1) Safe contraceptive

(2) ^{Does} Technology give choice?

(3) Infertility treatment

(4) Childlessness

(5) Yes or no to techno. How to decide

(6) Reproductive right & choice.

(7) Evolution of patriarchal control over women's procreative power.

(8) G.E. & biotechnology

(9) Traditional methods of controlling reproduction.

(10) Birth control & F.P.P.

(11) Eugenics

Technical info. into boxes

Technical info. on

- (1) O. C.
- (2) Injectables
- (3) Implants
- (4) I. U. Ds.
- (5) Barriers
- (6) A. F. Vaccines
- (7) RU-486.
- (8) A. I.
- (9) E. I. T.
- (10) I. V. F.
- (11) GIFT etc.
- (12) Cloning.

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After noon session

Debates:

1. Safe contraceptive ♦
2. Infertility
- 3 why all contraceptive research on women.
- 4 why we are raising the issue of development in technology related to genetic engineering & biotechnology in case of ~~repro~~ human reproduction why we have not raised similar ^{only} questions related to plant & animal reproduction & hybridizations etc.
- 5 ~~Abortion~~ is an invasive R.T. ^{to} Genetic engineering? & to
- 6 Why NO to MRTS, then in the light of it, How we perceive abortion
Abortion is an invasive R.T. and other old R.TS.

Introduction - Pse FINRRAGE (initiative by FASDSP)

- FINRRAGE → Jaipur "health"

- Perspective - Need for info. & our stand.
- Our responsibility as a city based group.
- Hence workshop.

Expectations from workshop: why this group called.

- Help in prepn of material.
- Material mainly for info

- techniques	} both nec.
- ~~Debate~~ Debate on technical info. How presented gives an understanding of ideology.

So technical details → context of basic princi.
involved in each of them. ^{Details} ~~How~~ of technique
not to be stressed.

Structuring of technical info:

No separation betn. practice & technique
Not divided as fertility / infertility

↓
locked as 2 sides of same coin

Issue is control over reproduction

Views this control - ① Menstruation cycle
② Other methods?

Some Recent Articles on Health and Related Subjects

Health and Medicine

Status of the Drug Industry in India; Haseeb A Drabu,
January 25, 1986

The Drug Charade; S Srinivasan, January 18, 1986

Controlling Tuberculosis; N H Antia, January 4, 1986

An Alternative Strategy for Health Care: The Mandwa Project;
N H Antia, December 21-28, 1985

Maternal and Infant Mortality; Malini Karkal, October 26, 1985

How the Other Half Dies in Bombay; Malini Karkal, August 24,
1985

✓ Infant Mortality in India: Levels, Trends and Determinants;
Leela Visaria, August 10, 17 and 24, 1985

Mortality Toll of Cities: Emerging Patterns of Disease in
Bombay; Radhika Ramasubban and Nigel Crook, June 8, 1985

Treatment Failure in Indian National TB Programme; Kashyap
Mankadi and Klass van der Veen, May 25, 1985

✓ Famine, Epidemics and Mortality in India: A Reappraisal of
the Demographic Crisis of 1876-78; Ronald Lardinis,
March 16, 1985

✓ Health Hazards of Cotton Textile Workers; Bharat Dogra;
February 16, 1985

Breast Feeding: Collage of Danger Signals; Vimal Bala-
subrahmanyam, August 25, 1984

Breakdown of Public Health System; D Banerji, June 2-9, 1984

Family Size, Levels of Living and Differential Mortality
in Rural Areas; Some Paradoxes; N Krishnaji, February 11,
1984

Ban on Dangerous Pain-Killers; Padma Prakash, June 25, 1983

Drug Trials: Charade of 'Informed Consent'; Vimal Bala-
subrahmanyam, June 18, 1983

✓ Impact of Social and Economic Development on Mortality:
Comparative Study of Kerala and West Bengal; Moni Nag,
Annual Number, 1983

- National Health Policy and Its Implementation; D Banerji,
January 22, 1983
- New Patterns in Health Sector Aid; Roger Jeffery, Septem-
ber 11, 1982
- Little Girls and Death in India; Pranab Bardhan, September 4,
1982
- Bangladesh's New Drug Policy; John Cunningham, August 21, 1982
- Health for All: A Review and Critique of Two Reports; Malini
Karkal, February 13, 1982
- Leprosy Control and Eradication; Padma Prakash, November 28,
1982
- Choice of Best or Cheapest Drugs? A Note on Regulating Drug
Supplies; Mahesh S Patel, August 22, 1981
- Health for All: A Reaffirmation; N H Antia, August 15, 1981

Nutrition

- Protein and Energy Requirements; P V Sukhatme, November 2,
1985
- Bashing Nutritionists: The Small-but-Healthy Hypothesis;
Sol Chafkin, May 18, 1985
- ✓ Ideology and the Poverty-Line Debate; Sheila Zurbrigg,
December 3, 1983
- ABDf Undernutrition, Energy Requirement and Adaptation: A Physio-
logist's Point of View; L Garby, November 26, 1982
- Estimation of Nutritional Intake; Rajaram Dasgupta, July 9,
1982
- RDAs: Their Limitations and Applications; K T Achaya,
April 9, 1983
- Measurement of Undernutrition: Biological Considerations;
C Gopalan, April 9, 1983
- ✓ Malnutrition of Rural Children and Sex Bias; Amartya Sen
and Sunil Sengupta, Annual Number, 1983
- We Are Eating Better; K T Achaya, January 1-8, 1983
- Measurement of Undernutrition; P V Sukhatme, December 11, 1982
- Poverty and Undernutrition in Rural India: A Cross-Sectional
Analysis; Rajaram Dasgupta, September 25, 1982

✓ Nutritional Norms and Measurement of Malnourishment and Poverty; Jaya Mehta, August 14, 1982

The Poor as a Social Stratum: Some Economic Criteria for Studying Poverty; V M Rao and M Vivekananda, July 3, 1982

Administrative Constraints on Rural Development: A Field View of the Applied Nutrition Programme; Amal Roy and Vanita Venkatasubbaiah, Review of Agriculture, June 26, 1982

Some Nutritional Puzzles; C Ashok and Mahdavi Kulkarni, April 24, 1982

✓ Rural Energy Scarcity and Nutrition: A New Perspective; Srilata Batliwala, February 27, 1982

Calorie Norm Controversy; V M Rao and M Vivekananda, February 13, 1982

On Measurement of Undernutrition; V M Dandekar, February 6, 1982

✓ Measurement of Poverty and Undernutrition; D Banerji, September 26, 1981

✓ On Measurement of Incidence of Undernutrition; What is a Consumer Unit?; N Krishnaji, September 12, 1981

Measurement of Poverty; V K R V Rao, August 29, 1981

On Measurement of Poverty; P V Sukhatme, August 8, 1981

Measurement of Incidence of Undernutrition; Santi K Chakrabarti and Manoj K Panda, August 1, 1981

On Measurement of Poverty; V M Dandekar, July 25, 1981

Some Nutritional Puzzles; V K R V Rao, July 11-18, 1981

On Measuring the Incidence of Undernutrition; P V Sukhatme, June 6, 1981

On Measuring the Incidence of Undernutrition; N Krishnaji, May 30, 1981

Family Planning

✓ Towards a Women's Perspective of Family Planning; Vimal Balasubrahmanyam, January 11, 1986

✓ Two Decades of Sterilisation, Modernisation and Population Growth in a Rural Context; Stanley A Freed and Ruth S Freed, December 7, 1985

Case for Injectable Contraceptives?; Sujit K Das and Pijus Kanti Sarkar, October 5, 1985

Case for Injectable Contraceptives; Iris Kapil, May 11, 1985

Family Planning and the Emergency: An Unanticipated Consequence; Alaka M Basu, March 9, 1985

Retreat on DepoProvera; Padma Prakash, December 8, 1984

Problems Concerning Tubectomy Operations in the Rural Areas of Punjab; Joyce Pettigrew, June 30, 1984

Fertility Decline in Kerala: The Social Justice Hypothesis; P G K Panikar, March 31, 1984

Use of Laparoscopy for Sterilisation; Padma Prakash, March 17, 1984

Excess Female Mortality in India; Tim Dyson, March 10, 1984

Mass Use of Injectable Contraceptives; Vimal Balasubrahmanyam, March 3, 1984

Fertility Differentials in Kerala and West Bengal: The Equity-Fertility Hypothesis as Explanation; Moni Nag, January 1, 1984

Breast-Feeding and Family Planning Policy; Vimal Balasubrahmanyam, December 10, 1983

Amniocentesis: The Debate Continues; Leela Dubey; September 17, 1983

Amniocentesis Again; Dharma Kumar, June 11, 1983

Female Infanticide and Amniocentesis; Roger Jeffery and Patricia Jeffery, April 16-23, 1983

Fresh Focus on 'Natural' Family Planning; Vimal Balasubrahmanyam, April 2, 1983

Misadventures in Amniocentesis; L S Vishwanath, March 12, 1982

Misadventures in Amniocentesis; Leela Dubey, February 19, 1983

Male Utopia or Nightmares?; Dharma Kumar, January 15, 1983

Hormonal Pregnancy Tests: One More Year's Havoc; Padma Prakash, August 28, 1982

Where Have the Women Gone? Insights from Bangladesh on Low Sex Ratio of India's Population; Lincoln C Chen, March 6, 1982

Preliminary Demography of 1981 Census; Tim Dyson, August 15, 1981

To be issued and read later

1. The Politics of Women's Biology - Ruth Hubbard
Rutger's Univ. Press (1990).
2. Now or Later? The timing of Parenthood in adult Lives.
Pamela Daniels and Kathy Wengarten.
3. Food for Feminist thought. the Sociological Review August 1988
Nichie Charles & Marion Kerr. VOL. 34. NO. 3.

Population Reports.

Population information Program

ATTN: POPLINE

The Johns Hopkins University

624 North Broadway

Baltimore, Maryland 21205, USA.

Oral contraceptives series A

A-6 Oral contraceptives in the 1980

Intrauterine devices series B.

B-4 IUDs An appropriate choice for many women.

Barrier methods series H.

H-5 Spermicides.

H-6 Update on condoms.

H-7 New developments in vaginal contraception.

Drug action groups → criticism for contraceptives, drug long acting and chemical interference. The demand of the people or persons using is in contradiction to ~~it~~ this understanding. The side effects which is in use of

C. E. D

- R. D42a. 155 ✓ Campaign against Depo. London. Page 35, Page 1
- B. D42a. NI ✓ Imperialism & control of ♀'s fertility Samathi Nair
- R. D42b. 564 ✓ Men: New focus for F.P. programs. P.I.P.
- R. D42b. 261 ✓ Men & F.P. - Worldwatch paper 41.
- R. D42b. 307 ✓ Development of Nonplant. - Segal Sheldon, London.
- R. D42b. 371 ✓ Barrier methods of Contra. IPPF.
- J. D42b. 89EPW1 308 Health: Contra. Research EPW.
- ✓ B. D42c. P1 ✓ Abortion & ♀'s choice Rosalind Petchesky
- ✓ B. D42c. S1 ✓ A Savage enquiry: who controls Wendy Savage
- R. D42c. 41 ✓ 1 childbirth
- The abortion question Schon Goddrige.
- R. D42c. 304 The childbirth picture book
- R. D42c. 305 " universal " " "
- R. D42c. 330 Sex Predet. A. ♀ & ♂ Jalna Hanmer.
- R. D42c. 392 New Right vs ♀'s rights. ♀ organised for reproductive choice
- R. D42c. 476 ✓ Sexist & racist implications of NRTs Maria Mies
- R. D42c. 479 Monograph on hazards & complications of contra. sterilisation, abortion amnio. CREST.
- R. D42c. 488 The silent scream, Richard Glasow.
- R. D42c. 665 Abortion: a collection of clippings Boston's ♀'s health collective.
- J. D42c. 89EPW 2277 Abortion right: shocking decision EPW.

→ Paper presented at XI World Congress of Sociology N.D. Aug. 18-22, 1986.

Nandita to get:

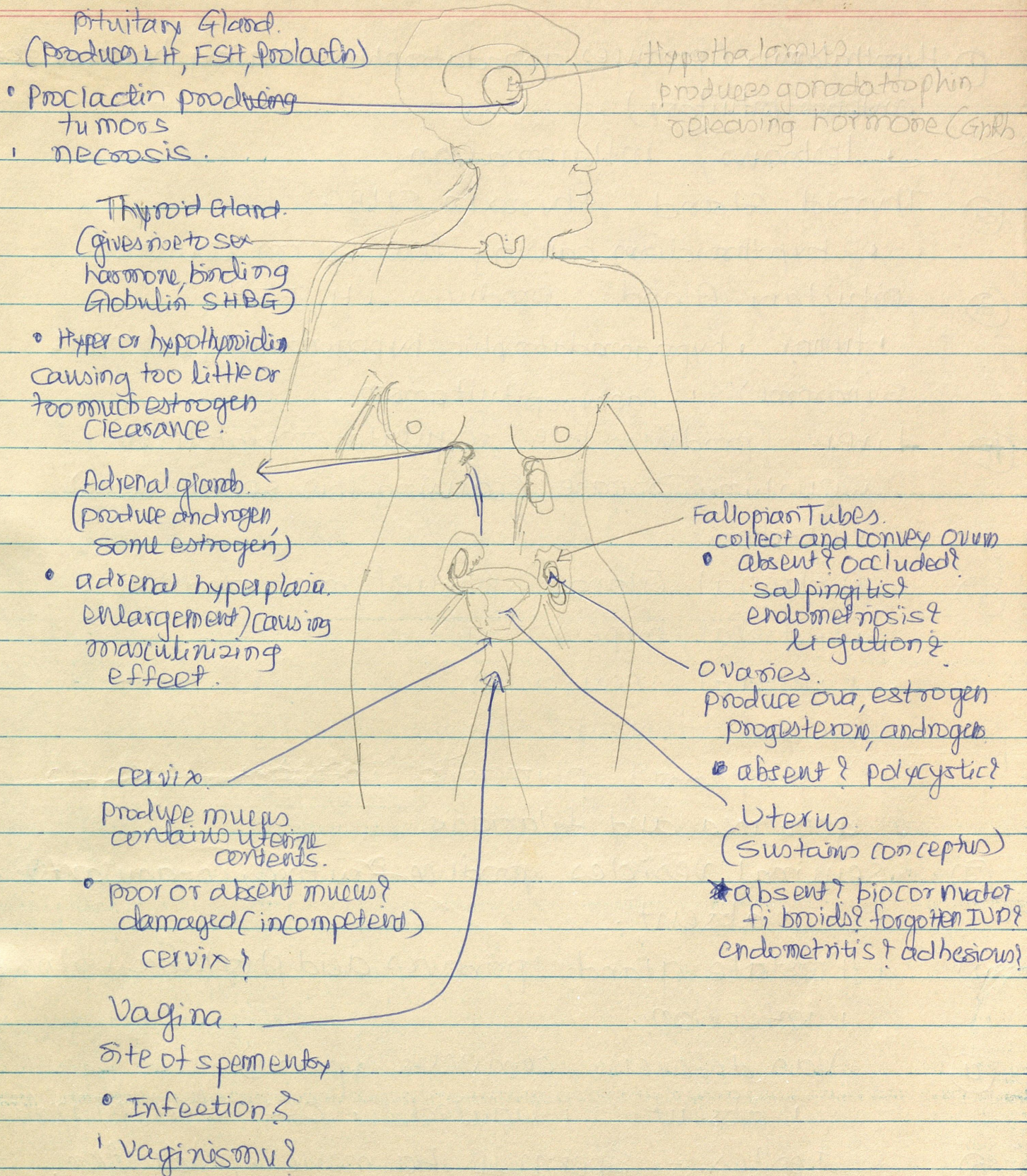
1. Abortion & ♀'s choice Rosalind Petchesky.
2. Contra. techno. 1984-85 Hatcher et al.
3. Reproductive rights & wrongs Betsy Hartmann
4. The Hidden malpractice Gena Corea.

SNDT

1. Mainstream 22 #24. Vimal B. When motherhood becomes a curse
140b 120 P3855 ✓
2. Review of inj. contra. by Jan S. Fraser (Med. Journal)
120 P5112 (A lot of technical info. on side effects of depo)
3. Cultural warping of childbirth Doris Haire (MFC)
120 P1239,
4. Health - a gender issue in India
120 P2996
5. Hazard of being a woman - Saroj Jha (Sc. age)
120 P1757
6. Mothers the ultimate resource (conf. on 'safe motherhood').
120 P. 5871
7. Note on MFC & F's movement. Padma Prakash
120 P1297
8. A funny thing happened on the way to the office. Diana Scully
120 P 5498
9. ♀ protest dangerous drugs
10a. ~~120~~ P 4617 ✓
10. Teaching & practice of gynae. d.
120: 100g P1238
11. Policy considerations involved in research on drugs ICMR
120. 110 d ✓
12. AI practice in the US.
120 : 120 b P5384.
13. Feminist perspectives on ♀ & health: report of conf.
120 : 120 b. P2729.
14. Is there such a thing as perfect contra. Deepa Arora.
120 a P2733 (1986)
15. Towards a ♀'s perspective in FP. - V. Balsubramaniam -
120a P5464 (EPW) ✓
16. Contra & developing countries - role of barrier methods Judith Bruce
120 a P2781 (1983)
17. Role of coercion in F.P. prog. - Manisha Gupte.
120 a P2926

- 18) F.P. : ♀ as targets - Padma Prakash
120 a P2924
19. Fertility control - C. Sathyamale
120 a P1241
20. How to use the Arday Ally pessary
120 a . (52) P3329
21. Husband wife communication & contra. behaviour - study in A.P.
by Mr. Siva
Raju.
120 a (5484) P2971.
22. Contra development process & quality of care in repro. services
120 a - 2 . P. 5016.
23. Feminist perspective on RT . - Lorri Andrews.
120 b P6185
24. Hard labours ; N.R.T.s & ♀ Margaret Green
120 b P6159 .
25. The ethics of choice - Rayna Rapp
120 b . 1 P4820 .

Female Infertility



Source → R.C.W.S. Lib.

Name of the book → Contraceptive technology 1982-83.
11th Revised edition.

Author's Name - Robert A Hatcher

Gary B. Stewart

Felicia Stewart

Felicia Guest

Nancy Josephs

Janet Dale.

Male Infertility.

- ① Hypothalamus (produces gonadotrophin releasing hormone for anterior pituitary)
 - lesions, inflammation.
- ② Thyroid Gland. thyroxin SHBG
 - hypothyroidism causing low sperm count.
- ③ pituitary Gland. produces LH FSH
 - tumor • hypogonadotropic hypogonadism (Kallman's Syndrome) • Panhypopituitarism.
- ④ Liver. produces bile, regulates metabolism.
 - Cushing Disease. (causing low sperm count)
 - Cirrhosis.
- ⑤ Adrenal Glands production of androgens
 - Adrenal hyperplasia
 - Adrenal insufficiency.
- ⑥ Penis deposits sperm.
 - hypospadias phimosis infections such as gonorrhoea and filariasis.
- ⑦ seminal vesicles. produce Fructose, co-agulants)
 - absent.
- ⑧ Prostate gland produces acid phosphatase & fibrinolysin
 - infection.
- ⑨ Vas deferens conveys sperm
 - absent • ligated • occluded by infection.
- ⑩ Testes. - sperm & hormone production.
 - cryptorchidism germinal cell hypoplasia
 - anorchia • sclerosis of seminiferous tubules epididymitis or orchitis.

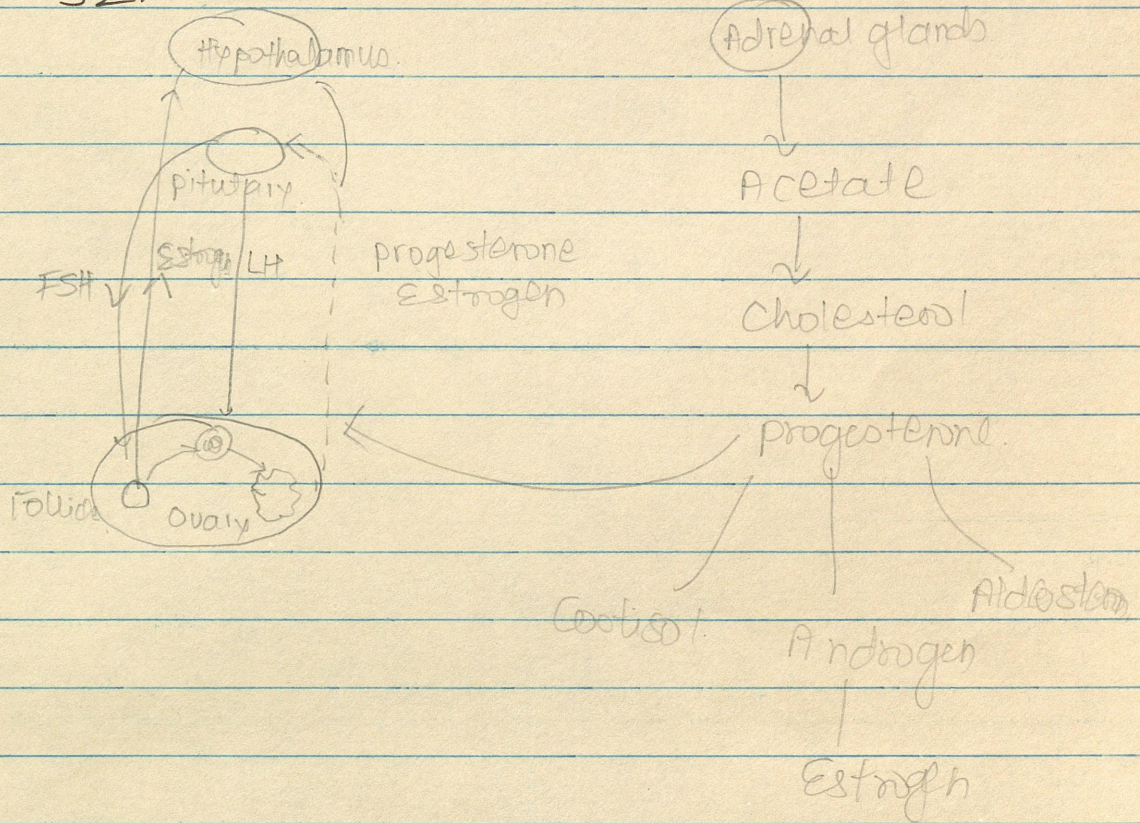
Source. R. C. W. S. Lib.

Name of the Book: - Menstruation and menopause.

The physiology and psychology, the myth and the Reality.

Author's Name: Paula Weideger.

P. 52.



and
Maternal/child health services in India are very poorly developed.

Only 40-50% of pregnant women at present receive antenatal care, less than 15 percent are delivered by trained birth attendants, only about 20 percent receive tetanus toxoid and a mere 30 ^{are} covered by the nutritional supplement.

(Iron & Folic acid) programme.

AS, Science Age April 1984. JHA Sanjeev.

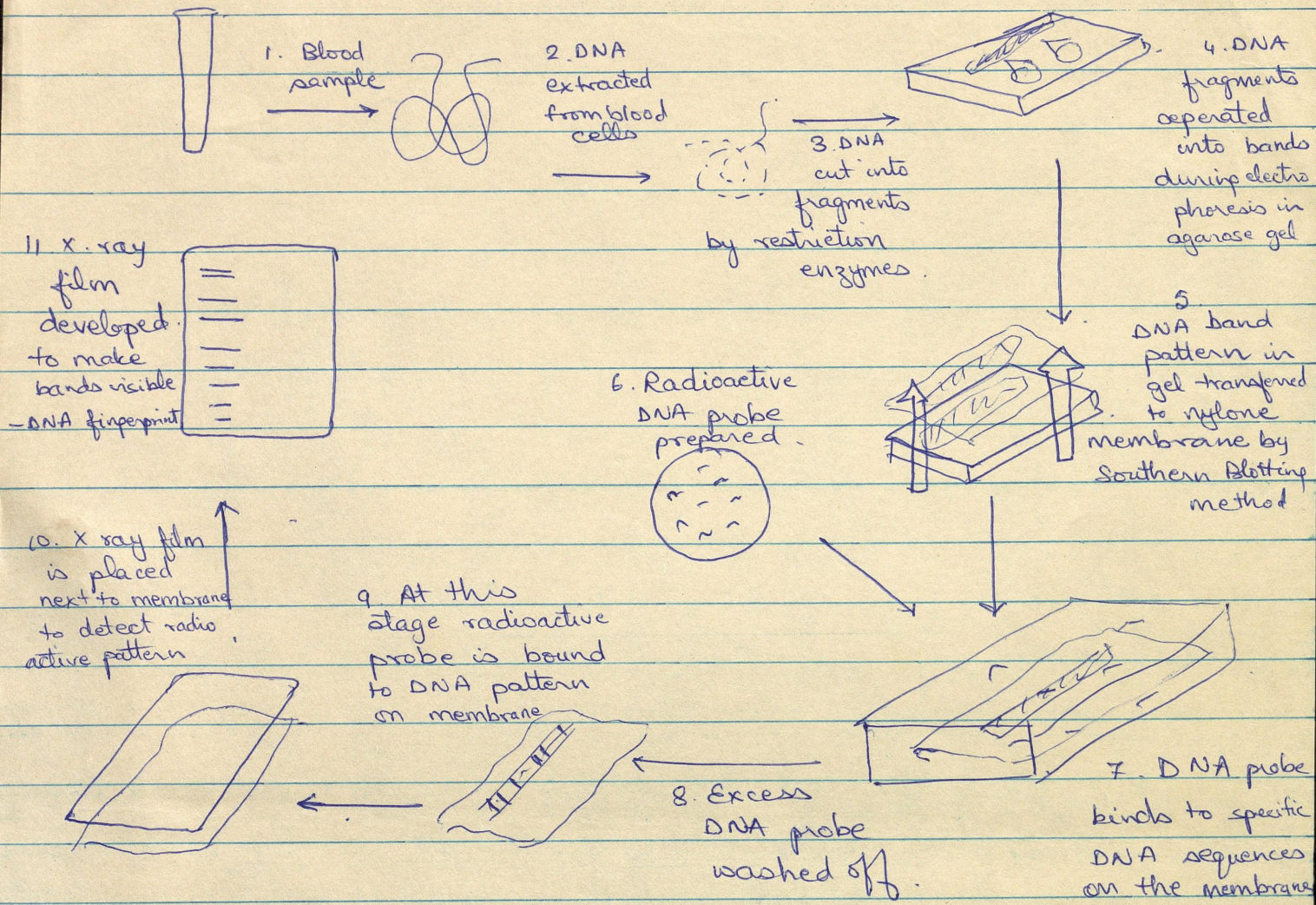
Artificial Insemination practice in the U.S. Summary of a 1987 survey.

An OTA Survey indicates that approximately 172,000 women underwent artificial insemination last year, spending \$164 million to obtain the service from upwards of 11,000 physicians nationwide.

Screening women who request Artificial Insemination

OTA found that one in five women requesting artificial insemination is turned down by her physician, most commonly on nonmedical grounds. Over half the physicians surveyed have rejected a woman because she is unmarried, and over half are likely to reject a woman whom they consider psychologically immature. For those who are accepted, physicians are almost all willing to match the women's specifications for the donor's race, eye color, and body type. A majority are also willing to match specifications for educational attainment, intelligence quotient and religion.

DNA fingerprinting process.

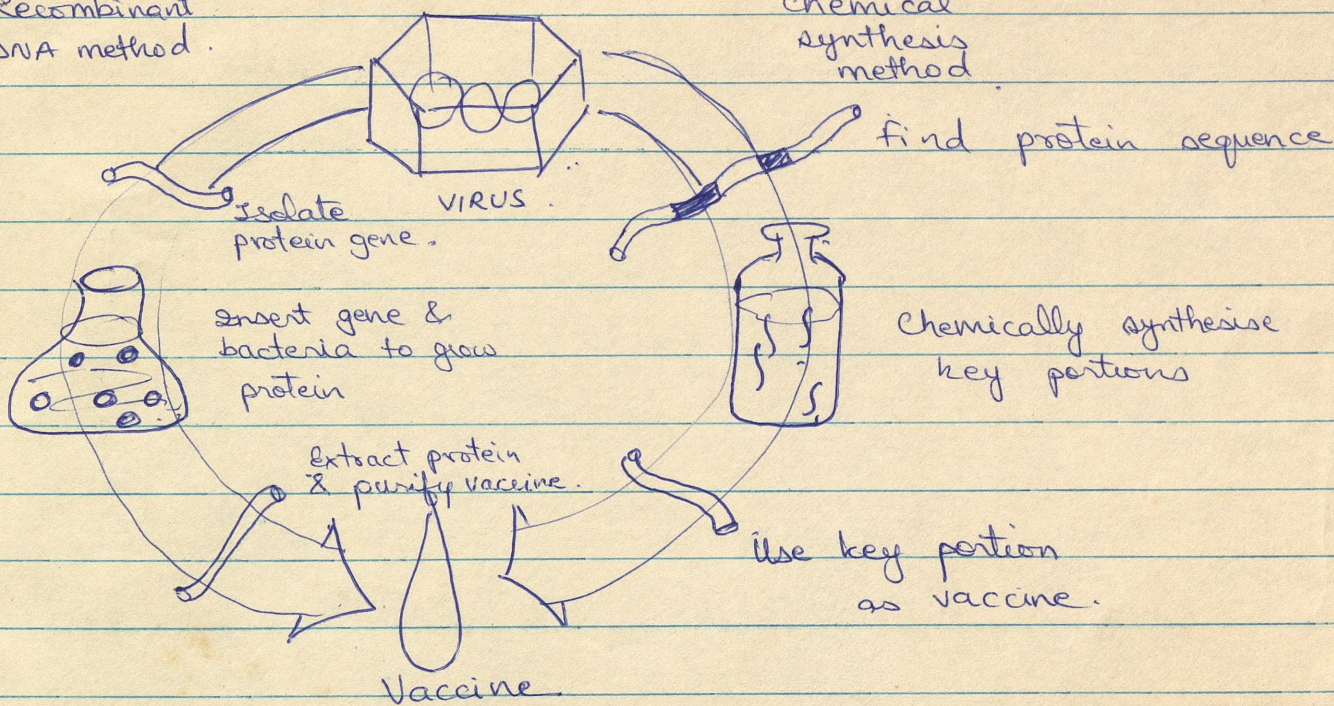


- From 'Now, the gene sleuths'
 Jean Yves Nau.
 'Frontline' Dec. 12-25, 1987.

condom has been used for contraception for at least 250 yrs and as protection against sexually transmitted diseases even longer than that.

Recombinant DNA method.

Chemical synthesis method



Two new ways of building vaccines : GE & chemical synthesis