FAMILY PLANNING MANUAL

APPROVED BY THE FAMILY PLANNING BOARD APPOINTED BY THE GOVERNMENT OF MADRAS

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A REQUEST.

From

SRI R. A. GOPALASWAMI, I.C.S.,
CHAIRMAN, PROGRAMME COMMITTEE,
FAMILY PLANNING BOARD.
Secretariat, Fort St. George,
Madras-9.

DEAR FRIEND,

1. On behalf of the Programme Committee of the Family Planning Board, Madras, may I request you (when you have completed your study of this Manual), to write to me a letter and let me know what you think of it. We shall treat your letter as strictly confidential. Our aim is to secure as many answers as possible to the questions specified below, and to be guided by the answers * in making further arrangements for the promotion of Family Planning.

2. The questions are as follows:—

I. Have you practised Family Planning? If so, which method did you adopt and with what result?

II. Which are the items of information, if any, you have learnt for the first time in this Manual, and which you consider to be important?

III. Are you convinced that it is the family duty as well as national duty of every married couple to practise Family Planning? If so, have you decided that you will practise it yourself hereafter? Will you co-operate with us in any organized effort which we shall undertake in order to promote Family Planning?

IV. Have you any advice or suggestions to offer for the consideration of the Family Planning Board? If so, tell us freely.

Yours sincerely,
R. A. GOPALASWAMI,

* An abstract of the replies received in response to the first question is given in the next page.

ABSTRACT OF REPLIES.

1. *Elementary Precaution Method.*—(i) *Husband Careful Method,*—Out of 198, 102 practised the method, 76 have no complaint, 14 continue it, though with complaint, 12 were dissatisfied and gave it up (38 per cent + 7 per cent + 6 per cent = 51 per cent).

(ii) *Safe-Period Method.*—Out of 198, 78 practised the method, 51 with safety, 14 are not sure, 13 failed and gave it up (26 per cent + 7 per cent + 7 per cent = 40 per cent).

2. *Sheath Method.*—Out of 198, 57 practised the method, 36 with full satisfaction, 2 not sure, and 13 gave up (18 per cent + 1 per cent + 7 per cent = 26 per cent).

3. *Spermicidal Method.*—Out of 198, 19 practised the method, 12 with satisfaction, 3 were not sure and 4 gave up (6 per cent + 2 per cent + 2 per cent = 10 per cent).

4. *Husband Sterilization Method.*—Out of 198, 18 have had it and are satisfied, 8 wish to have it (9 = 9 per cent).

5. *Diaphragm Method.*—Out of 198, 6 tried it with success and 4 tried and gave it up (3 per cent + 2 per cent = 5 per cent).

6. *Wife Sterilization Method.*—Out of 198, only 3 have reported the use of this method (2 per cent).

A. B. SHETTY, M.L.A.,
MINISTER FOR HEALTH.

FORT ST. GEORGE,
MADRAS-9,
SEPTEMBER 25, 1956.

FOREWORD.

The imperative need for Family Planning has now been recognized by the Government of India and a provision of nearly five crores of rupees has been made by them for Family Planning Programme in the Second Five-Year Plan. In furtherance of this policy, the Government of Madras have set up a Family Planning Board, for the propagation of the practice of proper methods of Family Planning in this State. There is no doubt that the first step should be to educate the people on the best and safest methods of securing limitation of their families. This publication issued by the Family Planning Board, Madras, is intended to make this basic knowledge available to the people.

2. The practice of family planning is a duty which every husband owes to his wife, to safeguard her health. It is the duty which both owe to their children, to promote their health and welfare. Whether you do or fail to do your duty is not merely a matter of concern to you and your children. It is a matter of vital concern to that larger family to which all belong—"The Indian Nation".

3. I hope this manual will help every married couple to make their contribution to the welfare and well being of the nation.

ABShetty

TABLE OF CONTENTS.

PAGE

FIRST PART.

Advice to every Married Couple 1

SECOND PART.

METHODS OF FAMILY PLANNING.

I The "Safe-Period" Method 3

II The "Husband-Careful" Method 8

III The "Elementary Precaution" Method 13

IV The "Spermicidal" Method 16

V The "Sheath" Method 19

VI The "Diaphragm" Method 21

VII The "Husband-Sterilization" Method 28

VIII The "Wife-Sterilization" Method 31

THIRD PART.

Family Planning and National Planning 32

FAMILY PLANNING MANUAL.

FIRST PART.

ADVICE TO EVERY MARRIED COUPLE.

1. After every confinement, try and make sure as well as you can, that there is an interval of at least three years before another pregnancy occurs. If the wife is weak or ailing, the interval should be longer —just as long as necessary for safeguarding her health.

2. When three or more children have been born to you, make up your mind that it is time to stop. Make quite sure that no further pregnancy occurs, unless there are altogether exceptional reasons to the contrary.

3. Do not imagine that it is necessary to give up conjugal union in order to avoid undesired pregnancy. It is not. If you practise family planning, you can have conjugal union and yet avoid undesired pregnancy. There are some *Ten Crores of Married Couples* in the world today who do this. You can be one of them, if only you make up your mind.

4. In the Second Part of this Manual, eight different methods of family planning are described and explained. They are—

The " Safe-Period " Method	I
The " Husband-Careful " Method ..	II
The " Elementary Precaution " Method.	III
The " Spermicidal " Method	IV
The " Sheath " Method	V
The " Diaphragm " Method	VI
The " Husband-Sterilization " Method.	VII
The " Wife-Sterilization " Method ..	VIII

Study all of them carefully. You can then judge for yourself which method will suit you best at the present stage of your married life, your family income and living conditions.

5. If you can afford the expense and command the privacy and other necessary home facilities, there is no doubt about the choice to be made. The husband should practise the " Sheath " Method No. V. Alternatively, the wife should practice the " Diaphragm " Method No. VI. There is no good reason why you should not stick to the chosen method throughout your married life.

6. If you cannot afford the expense and command the privacy and other necessary home facilities, you will find it necessary to practise different methods in different circumstances.

First.—The " Elementary Precaution " Method No. III is the best method to practise until you reach that stage of your married life when (either because of the state of health of the wife or the number of children already born) further pregnancy cannot be risked and the practice of a method which confers certain protection becomes an imperative necessity.

Secondly.—In many cases, experience may show that the " Elementary Precaution " Method No. III confers sufficient protection. If, in your case, it does not, then you may adopt the " Husband-Careful " Method No. II practised exclusively.

Thirdly.—In many cases again, and especially during middle age, this should work well. But, if, in your case, you find that it does not agree with either the husband or the wife, then give it up. Seek

the help of a doctor. Adopt either the " Husband-Sterilization " Method No. VII, or the " Wife-Sterilization " Method No. VIII, whichever you prefer. The method will not fail you. It will give you permanent protection.

Fourthly.—The " Spermicidal " Method No. IV and the " Safe-Period " Method No. I do, indeed, offer protection. But there is a larger risk of failure than in other methods. These two methods are best practised as " Supplementary ", in appropriate combination with other methods.

SECOND PART.

METHODS OF FAMILY PLANNING.

I. The " Safe-Period " Method.*

1. *The idea underlying the method.*—Pregnancy will not result from a conjugal union, unless the sperm deposited by the husband meets an egg released from the ovary of the wife and fertilises it. It has been established scientifically that the *wife produces and releases from her ovary one and only one egg during every menstrual cycle.* This is the basic fact, which has given rise to the idea underlying this method. If conjugal union takes place more than two days prior to egg-release, no pregnancy can result, because the sperm loses its vitality (or capacity to fertilise) within 48 hours. If conjugal union takes place more than two days after egg-release, no pregnancy can result because the egg loses its vitality (or capacity to be fertilised) within 48 hours. If, therefore, a method can be found whereby the

* The instruction given in this section regarding the safe period are intended for people who cannot be expected to make elaborate calculations. Those interested in such calculation may refer to Appendix I.

exact time of egg-release can be predicted in advance, it will be possible to localise 5 days within every menstrual cycle as the " Fertile Period " during which alone pregnancy is likely to follow conjugal union. The " Fertile Period " will consist of the day of egg-release, two days before and two days after. The interval of time after the disappearance of menstruation and before the commencement of the " Fertile Period " will be a " Safe Period ", during which conjugal union can take place without risk of pregnancy. Similarly the interval of time between the end of the " Fertile Period " and the onset of the next menstruation will be another " Safe Period ". (The two " Safe Periods " of every menstrual cycle may be distinguished from one another as the " After-menses Safe Period " and the " Before-menses Safe Period.") The idea underlying this method is that every married couple can find out the Safe Periods; limit conjugal union to those periods; and abstain from conjugal union during the " Fertile Period ".

The difficulty in giving effect to this idea is that it is impossible to predict in advance the exact time of egg-release. On the basis of statistical analysis of observed data, it has been deduced that egg-release takes place at some time or other " during three middle days of the menstrual cycle ".

If, therefore, the duration of the menstrual cycle is known, and it is also known to be exactly the same for all cycles, the " Fertile Period " can be identified as the " Seven middle days of the menstrual cycle ".

But then there is the difficulty that the menstrual cycles of different women are liable to be different from one another. Further, different menstrual

cycles of even the same woman (even when she is in normal health) are liable to vary by a few days. Occasionally, they may vary widely (as after confinement, illness, or on the approach of Menopause).

One way of meeting the difficulty is to keep the woman concerned under observation for a sufficiently long period, perform clinical tests designed to ascertain when the egg-release (or " ovulation ") actually occurred in successive menstrual cycles and thus fix the range for her individually.

For obvious reasons, such a method cannot be practised without professional assistance. This leaves only one course open for general use. This is to fix a sufficiently long " fertile period ", and correspondingly short " safe periods " on a purely ad hoc basis and then specify the range of duration of menstrual cycles for which these " safe periods " can be expected to be safe. In this manner, *general working rules* can be evolved which would be suitable for all those women whose menstrual cycles fell within the indicated range. This is the idea underlying the method described below.

2. *The method described.*—A married couple desiring to practise this method should know the names of the seven days of the week (ஞாயிறு) and should be able to note and remember what may be called the " Menstrual Weekdays " (or மாதவிடாய்). The day on which menstruation first appears is the First Menstrual Weekday. The next time after the First Menstrual Weekday, when the same day of the week recurs, is the Second Menstrual Weekday. Again, the next time after the Second Menstrual Weekday, when the same day of the week recurs, is the Third Menstrual Weekday.

The married couple should then learn and apply the following "General Working Rules":—

Rule I.—The "After-Menses Safe Period" begins immediately after the menses period and ends on the Second Menstrual Weekday. (*But this period is not safe for any woman whose menstrual cycle is liable to be* 25 *days or shorter.*)

Rule II.—The Second Menstrual Weekday is followed by thirteen days constituting the "Fertile Period". The period includes the Third Menstrual Weekday, six days before it, and six days after it.

Rule III.—The "Before-Menses Safe Period" begins on the fourth menstrual weekday and ends immediately before the next menses period. (*But this period is not safe for any woman whose menstrual cycle is liable to be* 35 *days or longer.*)

3. *Whether reliable or not.*—There are a priori grounds for believing that the method should be reliable for most wives, in normal health, whose menstrual cycles range between 26 and 34 days and are not unduly irregular. But, in the present state of knowledge, this cannot be regarded as certain *. For, there are no data based on the experience of sufficiently large groups of people. Until such data become available, it must be assumed that there is a residual risk of pregnancy occurring (for reasons not yet known) to some exceptional women, even within the indicated range of menstrual cycles.

4. *Extent to which the method is prevalent.*—It is known that there are individual married couples even in this country who have tried the method, found it successful, and relied on it exclusively. But

* In the light of reports of personal experience the safe period recommended in this Manual appears to be free from risk of failure for wives in normal health whose menstrual cycle ranges between 27 and 32 days.

there is no evidence of the existence of large groups of people in any country of the world who rely on it exclusively as the chosen method of Family Planning. In England, it has been ascertained by careful enquiry that " the amount of reported use of the safe-period was trivial ". Hence the need for caution in practising this method.

5. *Advantages and disadvantages.*—If a risk-free rule of determination of safe-periods can be found, there can be no doubt that this is the ideal method. It involves no expense or bother; and it permits complete satisfaction of the desire for conjugal union without physical interference of any kind. But (for the reasons mentioned already) it cannot be used by women whose menstrual cycle is irregular. This may happen, temporarily, even to normally constituted women as a result of confinement, illness or other disturbing causes. Even for normally constituted women (as noted above) it cannot (in the present state of knowledge) be regarded as free from risk. *The method should not be adopted when the occurrence of another pregnancy is likely to endanger the health of the wife; or, for other reasons, the avoidance of pregnancy is an imperative necessity.* This, however, is not likely to be the case generally for most married couples, until after they have given birth to three or more children. Until then, there is considerable scope for practising this method with advantage. Each married couple should be able to find out for themselves whether the " General Working Rules " are risk-free in their case. But, even here there is difficulty. Those who can afford to take the risk are precisely the people, who are also apt to chafe against enforced abstinence from conjugal union for 13 days at a stretch. There is thus a dilemma. Those who are

most likely to practise the needed self-restraint should not take the risk involved. Those who can afford to take the risk involved might not exercise the needed self-restraint.

6. *Final comment on the method.*—Having regard to the advantages and disadvantages discussed above, the *best advice to married couples would be to practise the* " Safe-Period " Method in combination with the " Husband-Careful " Method in the manner explained in Section III. The combined method is referred to as the " Elementary Precaution " Method.

II. The " Husband-Careful " Method.

7. *The method described.*—The " Husband-Careful " method is the name colloquially given in England to the practice which is known to the learned by the name of " Coitus Interruptus ". It is sometimes also referred to as " Withdrawal " method. But it would be more accurate to refer to it as the method of " Interrupted conjugal union ". The method consists in the husband withdrawing the male organ from the vagina just before the occurrence of ejaculation; so that the seminal fluid is deposited outside the genital canal. Such withdrawal may or may not be followed by re-entry according to circumstances. The method, if successful, obviates the possibility of the sperm deposited by the husband coming in contact with the egg produced and released by the wife. Thus the avoidance of pregnancy is secured in most cases.

8. *Whether reliable or not.*—This method is one among the three most reliable methods of (temporary) contraception—the other two being the " Sheath " method and the " Diaphragm " method.

As in the other methods, there are risks of failure. Occasionally the husband may fail to exercise sufficient control under excitement and ejaculation may precede withdrawal. Sometimes, a few men appear to have sperm cells in the flow of mucus which immediately precedes ejaculation. Where the wife has not experienced her orgasm before withdrawal, the husband may effect re-entry after withdrawal and complete her orgasm, if he can. If this is done without elimination of seminal fluid, there is a risk of sperm cells getting in. Such risks of failure are not, however, important. The high degree of reliability of this method is not merely to be inferred from its widespread use (to which reference is made below) but also by a remarkable fact brought to light by the fertility inquiry in England. That enquiry showed that the average number of children born to married couples who relied solely on the " Husband-Careful " method was exactly the same as the average number of children born to the married couples who used all other methods of Family Planning.

9. *Extent to which the method is prevalent.*— This method is in use in every country of the world. There are good reasons to believe that the number of married couples who rely on this method alone is larger than the number who rely on any other single method, e.g., the " Sheath " method or the " Diaphragm " method. It is also the oldest known method and practised for the longest time in history. Anthropologists have observed its widespread prevalence among primitive communities in different parts of the world. Social scientists have observed its prevalence in nearly all advanced countries of the world. It is known that this method was widely prevalent in France long before it took root in England. The

British Royal Commission on Population has furnished figures which show how Family Planning developed in the initial stages almost wholly through this method and how large a place it occupies in Family Planning practices even today. Thus, among married women who married before 1910, it is found that 15 per cent practised Family Planning and 80 per cent did not. Among the 15 per cent, no less than 13 per cent relied solely on the " Husband-Careful " method; while 2 per cent relied on all other methods. During the next thirty years the percentage of married women who practised Family Planning rose steadily, until it reached 66 per cent. Throughout this period, the use of appliance methods increased; but the " Husband-Careful " method continued to be practised by larger numbers than all other methods put together for a long time. The position was first reversed only during 1935-39. But even among the women who married during this period, there were as many as 29 per cent who relied solely on the " Husband-Careful " method against 37 per cent who used all other methods put together. From these facts it may be regarded as established that there are well over 30 lakhs of married couples in England, who rely solely on the " Husband-Careful " method of Family Planning. They include one in every three Planned Families of Social Class I; two out of every five Planned Families of Social Class II, and no less than two out of every three Planned Families of Social Class III.

10. *Advantages and disadvantages.*—The method is simple; available at any time and place; entails no preparation; and involves no handling or after-care of materials and appliances. A combination of these advantages with a very high degree of reliability no doubt explains its enormous popularity and

widespread prevalence. In spite of all these considerations, it is, however, true that nearly all advocates of Family Planning generally steer clear of open advocacy of this method and some advise against it strongly. This is because of the opinion expressed by certain medical authorities. The opinion of those authorities who oppose this method is thus expressed by Dr. Hannah M. Stone:—

" The act of withdrawal itself and the constant tension and anxiety on the part of both mates lest it be delayed too long, interferes seriously with the normal physiological processes of the sexual relation and may give rise to organic or emotional disturbances. Furthermore, if withdrawal occurs too soon it may prevent the woman from experiencing an adequate response and thus affect her sexual reaction." It is probable that this is the preponderant view among the medical authorities who have expressed an opinion publicly. On the other hand, there are some medical experts (e.g., Terman) who have expressed the view that this method is physically and mentally harmless to both partners.

The opinion of Dr. Hannah M. Stone was expressed in 1937. Much other adverse opinion seems to have been expressed long before the facts set out in the previous paragraph regarding the actual extent of prevalence of this method were authoritatively made known. The facts are conclusive. It is quite impossible to believe that people would practise this method in such large numbers over so long a period in so many different parts of the world, if it was invariably (or even frequently) calculated to cause them harm. It is necessary, therefore, to re-examine the old views critically and distinguish carefully between the exceptional

circumstances in which harmful results might conceivably follow and avoid mistaking them for the general conditions which do, in fact, permit millions of married couples to practise the method of their own free will and without any complaint of adverse effects. Such reorientation of thinking is especially necessary among advocates of family planning in India, since it is clear that the " Sheath " method and " Diaphragm " method are most unlikely to be practised by any very large proportion of the people of this country.

11. *Final comments on the method.*—Married couples are adults who may be expected to recognize readily what agrees with them and what does not. Few couples are likely to persist in any method for an unduly long time if it involves " constant tension and anxiety ". There is no risk of the people practising this method suffering irreparable harm without being able to recognize, in time, that the method does not agree with them. Apprehension on this score is misplaced. The genuine difficulty is more likely to be presented by the other consideration indicated by Dr. Stone, viz., that the wife may be denied satisfaction and left in the air, if the husband withdraws too soon and is unable to effect re-entry. In other words, the method may not be feasible for all married couples. Whether or not any particular married couple are physically so constituted that they would be able to practise this method successfully and achieve reciprocal satisfaction without " constant tension or anxiety " is clearly a matter which the couple should be advised and encouraged to find out for themselves by a process of trial and error and mutual adjustment. Judging from the findings of the British Royal Commission on Population, satisfactory mutual adjustment ought to be

possible in a large majority of cases. This should be the case, at any rate, when the married couples are past their first youth and are reaching or have reached middle age and have had three or more children. These are the people who, if they cannot afford the " Sheath " method or the " Diaphragm " method, stand in most need of the " Husband-Careful " method which offers the maximum protection without expense. It is strange but true that even among those who can afford the expense and command the facilities necessary for the " Sheath " method or the " Diaphragm " method, there are some who positively prefer the " Husband-Careful " method, because it is so much less bother. This is proved by the experience of a New York Birth Control Clinic where it was found that over a period of eighteen months from receiving advice at the clinic, more than half of the couples advised had abandoned the clinic contraceptives and, in many cases, had returned to " coitus interruptus ". Referring to this experience, the British Royal Commission on Population commented in its report, " It must not be assumed that in the present state of birth control technique, there may not be a considerable number of people who positively prefer this method ".

III. The " Elementary Precaution " Method.

12. *The idea underlying the method.*—Both the " Husband-Careful " method and the " Safe-Period " method offer a great advantage over every other method in that they can be practised by every one without any expense whatever. Of the two methods, the " Husband-Careful " method is as highly reliable as the best appliance methods. The practical difficulty in using that method is that, in certain cases, it would leave the wife in the air, aroused but not satisfied. This difficulty would be largely met, if

uninterrupted conjugal union also takes place at regular intervals. The "Safe-Period" method which permits such union, is open to the objection that it requires abstinence in the "Fertile Period" lasting 13 days at a stretch. This objection will be largely met if interrupted conjugal union takes place during the "Fertile Period". Hence the idea that the "Husband-Careful" method should be limited to the "Fertile Period" and uninterrupted conjugal union limited to the "Safe Period". This will involve, however, the taking of a risk which is not present when the "Husband-Careful" method is practised exclusively. This risk may be offset, without much expense or inconvenience by using tablets, as a supplementary. This is the idea underlying the (proposed) "Elementary precaution" method.

13. *The method described.*—A married couple desiring to practise this method should know the names of the seven days of the week (திறமை) and should be able to note and remember what may be called the "Menstrual Weekdays" (or தாரக்திறமை). The day on which menstruation first appears is the First Menstrual Weekday. The next time after the First Menstrual Weekday, when the same day of the week recurs, is the Second Menstrual Weekday. Again, the next time after the Second Menstrual Weekday, when the same day of the week recurs, is the Third Menstrual Weekday.

The married couple should then learn and apply the following "General Working Rules":—

Rule I.—The "After Menses Safe Period" begins immediately after the menses period and ends on the Second Menstrual Weekday. (*But this period is not safe for any woman whose menstrual cycle is liable to be* 25 *days or shorter.*)

Rule II.—The Second Menstrual Weekday is followed by thirteen days constituting the " Fertile Period ". The period includes the Third Menstrual Weekday, six days before it, and six days after it.

Rule III.—The " Before-Menses Safe Period " begins on the Fourth Menstrual Weekday and ends immediately before the next menses period. (*But this period is not safe for any woman whose menstrual cycle is liable to be 35 days or longer.*)

Rule IV.—Uninterrupted conjugal union should be limited to desired days in the " Safe Periods ". It should not be attempted on any day in any " Fertile Period ".

Rule V.—If conjugal union is desired on any day in any " Fertile Period ", the desire should be controlled, if possible. But if it is felt too strongly, it may be satisfied through interrupted conjugal union. The husband should be careful to interrupt the conjugal union before ejaculation and deposit the seminal fluid outside.

Rule VI.—If spermicidal tablets are available, it is desirable that they are used whenever uninterrupted conjugal union takes place. This is a supplementary precaution which is well worth taking.

14. *Whether reliable or not.*—This method cannot be relied on by wives whose menstrual cycle is excessively irregular. *It is also wise not to rely on it when the occurrence of another pregnancy is liable to endanger the health of the wife; or when the avoidance of pregnancy is, otherwise, an imperative necessity.* In all other cases, this method may be regarded as sufficiently reliable for all practical purposes. Reliability will be enhanced if tablets are used.

15. *Extent to which the method is prevalent.*—This is a combination of three different methods already described. This combination has been suggested on a priori grounds. There is no information about whether it has been actively practised anywhere.

16. *Advantages and disadvantages.*—This method possesses all the advantages of the " Husband-Careful " method and the " Safe Period " methods. That is to say, any one can practise it anywhere, at any time, without command over privacy and other home facilities and without the need to consult doctors. It can be practised with as little expense as can be afforded; and if need be, without any expense. The disadvantage is that it does entail a somewhat larger percentage of failure than the three best among known methods. The risk, however, must be small if tablets are used as supplementary.

17. *Final comments on the method.*—On the basis of all available knowledge, there is every reason to believe that this " Elementary Precaution " method may play a very important part in the spread of Family Planning in this country. There can be no hesitation about recommending it to all who can use " Tablets " as supplementary. To those, who cannot, the caution should be given frankly that the degree of risk involved in the " Safe Period " is as yet untested by adequate experience. At the same time, they should be told that the method is well worth trying even in the absence of tablets, *provided that the avoidance of another pregnancy is not an imperative necessity.*

IV. The " Spermicidal " Method.

(Tablet, Jelly and Cream.)

18. *The idea underlying the method.*—There are several substances which can destroy the sperm cells

or immobilise or paralyse them. The idea is to introduce such substances in the vagina before conjugal union and thus prevent the sperm from fertilising the egg.

19. *The method described.*—There are different kinds of spermicidal substances which can be divided into two broad types, viz., (i) tablets, (ii) jellies and creams.

(i) The tablets are the easiest to handle. They are easily placed inside the vaginal canal before conjugal union. They dissolve in the vaginal moisture and give rise to a foam which has a spermicidal effect. The tablets are available in the market as shown below:—

	Name.	*Manufacturer.*	*Prices vary.*
1	Speton (12 tablets)..	Temmler—Works Vercinte —Chemische.	From Rs. 1·87 to Rs. 2·25.
2	Gynomin	Coates and Cooper, Limited, made in England.	From Rs. 1·75 to Rs. 2·25.
3	Rendell's foam tablets.	....	Rs. 2·25.

(ii) Jellies and creams (which require specially designed "applicators" for their use) are available in the market as shown below:—

	Name.	*Manufacturer.*
1	Volpar Paste	B.D.H., London.
2	Koremex	Holland Randdoz Corporation, New York.
3	Orthogynol Jelly	Ortho Pharmaceutical, Limited, Highway-combe, Bucks, England.
4	Preceptin	Do.
5	Protecto	Cipla Chemical Industrial, No. 7, Pharmacy—Lab. Bombay-8.

They are available with most of the chemists and druggists and their prices vary from Rs. 4.56 to Rs. 6.19 with applicators and from Rs. 1.94 to Rs. 4.50 without applicators.

20. *Whether reliable or not.*—The method confers some protection; but it is probably apt to fail more often than other methods. The risk of failure

of the method varies in degree from one substance to another. Those to whom the avoidance of another pregnancy is an imperative necessity will do well not to depend upon this method exclusively.

21. *Extent to which the method is prevalent.*—The supply in the market indicates that people use it. The " Tablets " are distinctly popular in England where one married couple out of every five using appliance methods is said to have relied on tablets exclusively. The jelly is often used in combination with the " Diaphragm " method and sometimes also the " Sheath " method when it provides lubrication as well as additional safety.

22. *Advantages and disadvantages.*—These spermicidal substances appear to be generally harmless, though a few women are said to be allergic to one or more of the ingredients. Jellies and creams need careful storage and handling as well as adequate privacy, time and patience for application. Jellies are apt to be messy in the hot weather. It is unlikely, therefore, that they will be used to any very large extent except as " supplementary ", by those who practise the " Diaphragm " method. " Foam Tablets " probably present a somewhat larger risk of failure than jellies and creams; for there is the risk of failure to dissolve and inadequate foaming. Their greater popularity in England evidently reflects their superior convenience in use. This is presumptive evidence also of their harmlessness.

23. *Final comments on the method.*—There is not much scope for wide use of jellies and creams, as an independent method. They are at best regarded as supplementary in the use of the " Diaphragm " or " Sheath " methods.

There is a distinct possibility of large-scale use of tablets; and the development of large-scale manufacture in this country of cheap and harmless tablets is to be welcomed. They are best used as "Supplementary" in the practice of the "Elementary Precaution" method described in Section III.

V. The "Sheath" Method

24. *The method described.*—The "Sheath", also known as the "Condom", is a cover for the male organ. It is designed to be worn by the husband just before conjugal union. It collects the seminal fluid within itself and prevents it or the sperm from being deposited in the vagina of the wife. There are two kinds of sheath in general use; one is the "Rubber Sheath" and the other is the "Thick Sheath". The former is thin, elastic and has a ring at the base. It is cheaper but cannot be used so often as the "Thick Sheath" which is costlier. The "Thick Sheath" is unavailable in local drug houses. The "Rubber Sheath" is available in several makes as shown below:—

Name.	*Description.*	*Manufacturer.*
1 Durpac	Three in a box with airtight packing (Transparent Latex).	Durex, England.
2 Gold Coin ..	....	..
3 Primers ..	....	Watch & Co., Limited.
4 Durex Protectives.	Three in one loose packet	Durex, England.
5 Silver-Tex (Deluxe).	Three in a small box ..	Made in U.S.A.
6 Washable paragon.	In celluloid paper ..	Indian.

They are available with almost all the chemists and druggists and their cost varies from 75 naye paise to Re. 1 per box containing three.

25. *Whether reliable or not.*—The use, with reasonable care, of a sheath of good quality is one of the three most reliable methods of temporary contraception.

There are risk of failure but they are very small and can be guarded against. A defective sheath may have holes or may tear during use. The sheath should be tested before use by blowing into it and thus inflating it and looking for holes in it against a strong light. It may roll down and come off after use and thereby spill the contents into the vagina. This is easily avoided by holding on to the sheath before and while removing the male organ from the vagina. The likelihood of breakage and discomfort is avoided by lubricating the sheath with a contraceptive jelly. The jelly is placed inside the tip of the condom and also smeared well on its outside. This also provides an added margin of safety by its spermicidal effect.

26. *Extent to which the method is prevalent.*— The method is very widely prevalent in all countries where family planning is practised. The British Royal Commission on Population ascertained that the " Sheath " method ranked next only to the " Husband-Careful " method and was well ahead of any other method, so far as the number of users was concerned.

27. *Advantages and disadvantages.*—The great advantage of the method is its extreme simplicity. The assistance of a doctor is not required. It is easy to carry about during travel. Care is needed, however, to keep the sheath in good order. It should be tested before use for leaks. The sheath should be washed well, after use (with soap and water), dried and powdered before being put away. Oil or grease should not be put in the sheath, as it will be spoiled. The thin sheath can be used only three or four times, even if cleaned well and kept in good condition.

Expense, therefore, is a consideration to be borne in mind. A certain amount of privacy is also necessary and this may not be available for poor people.

28. *Final comment on the method.*—Every husband who can afford the expense and privacy required for this method should be advised to adopt it as preferable to all other methods.

VI. The "Diaphragm" Method.

29. *What is a "Diaphragm"?*—"Diaphragm" is an appliance designed for use by the wife, for much the same purpose as a "Sheath" is used by the husband. It is made of soft rubber with a flexible metal spring around the circumference. The original Mensinga diaphragm had a flat watch-spring rim, while the new models have a coiled spring around the circumference. Both types serve the purpose equally well. The different makes available in the market are mentioned below:—

Name. (1)	*Manufacturer.* (2)
1 Durex	Durex Products, 684, Broadway, N.Y. 12, U.S.A.
2 Koromex	Holland Randdoz Corporation, New York, U.S.A.
3 Kemi	Kemi Products Corporation, New York, U.S.A.
4 Orthodiaphragm	Ortho Pharmaceutical, Limited. Highwy Combe, Bucks, England.

They are available with almost all chemists and druggists and their prices vary from Rs. 3.75 to Rs. 7.75 each.

30. *The method described.*—The diaphragm is so designed that it can be made to lie diagonally across the vaginal canal. The upper part of the vagina and the opening into the uterus are thus closed off from the lower part of the vagina. The sperm deposited in the vagina along with the seminal fluid of the husband is thus prevented from entering the

womb. The sperm does not get access to the female egg in the tube and thus pregnancy is prevented from occurring. Almost always, a contraceptive jelly is used along with the "Diaphragm". This provides lubrication and has also got a "Spermicidal" effect, an additional safety-factor.

31. *Selection of the diaphragm of the right size.* —Diaphragms differ not only in type and make, but also in size. The range of sizes varies from 50 millimetre diameter to 105 millimetre diameter. It is essential that the wife who proposes to practise the "Diaphragm" method should consult a doctor. The doctor should make a careful pelvic examination and ascertain by actual trial of different sizes which is the correct size required for the particular individual. The doctor will also explain to her (*a*) what every woman should know about how she is made inside; (*b*) how to insert the diaphragm herself; (*c*) how and when to remove it; (*d*) how to take care of it; and (*e*) other necessary instructions. In view of their importance, all these matters are briefly described below. But printed instructions are not enough. Advice accompanied by demonstration given by a qualified doctor in each individual case is essential for avoiding failure in the use of this method.

32. *Advice to wife about how she is made inside.* —"The vagina—or birth passage—is open at the front and closed at the back. Away at the back, there is a small lump, like the tip of the nose. That lump is the mouth of the womb. It has an opening that goes up into the womb. That is where you get pregnant and that is what has to be covered up so that the sperms from your husband cannot get inside of it.

" The diaphragm is used to cover up the opening to the womb. This diaphragm has got to fit you and you have to learn, how to use it properly—otherwise, it won't do you any good. You have to use it with a jelly, which also kills the sperm and so you have double protection.

" The vagina is in a downward direction. Since it is closed at the back, the diaphragm you have placed in it cannot get lost or go beyond that point. The bladder is above the vagina and the rectum beneath it and they both have separate openings, so that, when the diaphragm is inside the vaginal canal, it does not prevent you from going to the bathroom.

" Just as all women cannot wear the same kind or size of shoes, all women cannot wear the same kind or size of diaphragm also, since they are all built differently. The doctor will decide the correct size for you."

" *How will you identify your cervix?*—Since the important part is that the mouth of the womb should be covered so that no male cells can enter, you need to know how to find out and recognize the mouth of your womb, so that you can appreciate whether you have covered it well with the diaphragm, after its application. Insert your right index finger into your vagina, backward along its full length; whence you will feel the cervix like a knob, as firm as the tip of your nose and as smooth as your chin. After inserting the diaphragm inside correct, you can feel this knob well covered by the diaphragm (through the rubber), and the rim of the diaphragm can be felt snugly fit in place behind the pubic bone (in front)."

33. *How to use diaphragm and jelly?—*

(1) Bladder and bowel should be emptied first.

(2) Assume a squatting position or stand with one foot on edge of the chair, to insert the diaphragm.

(3) Squeeze out one teaspoonful of orthogynol or any other contraceptive jelly into the dome of the diaphragm and spread it inside the cup and around the rim and also smear it on the outside of the diaphragm so that both sides are covered.

(4) Holding the diaphragm in left hand (with the hollow of the cut facing you), squeeze the rim between the middle finger and the thumb of the right hand, steadying it with the fore-finger.

(5) Keeping it squeezed with right hand, separate the vaginal lips with the other hand, insert the free end of the diaphragm and continue to push it backward along the back wall or floor of the vagina as far as it will go. The end that enters first passes behind the cervix, while the front end is pushed upward under the pubic bone. (Make sure, the diaphragm is not caught in front of the cervix.)

(6) Diaphragm should completely cover the opening of the uterus and form a rubber curtain in vagina and the cervix must be felt through the rubber. If the diaphragm is of correct size it fits snugly behind the pubic bone.

(7) Conjugal union may take place immediately after insertion or any time within 4 hours. After 4 hours, additional jelly should be applied either with nozzle or finger.

34. *How and when to remove the diaphragm?*—

(1) The diaphragm should preferably be left in place for 8 hours after conjugal union. It may then be removed without taking a douche.* Never leave it in for more than 24 hours.

(2) If diaphragm must be taken out before 8 hours, a warm, slightly soapy douche must be taken. Half of the douche should be taken before removing the diaphragm and the reminder afterwards.

(3) If a second union occurs during the night or morning, additional jelly or cream should be used with finger or a nozzle, and it should be made sure that the top rim is pushed back under the pubic bone.

(4) To remove the diaphragm, same position as for insertion is assumed. The index or middle finger is hooked under the front rim and diaphragm pulled down and out. Sometimes, bearing down slightly helps to get the diaphragm within easier reach.

35. *Care of the Diaphragm*—

(1) After removal, wash with soap and warm water, rinse and dry. Powder with talcum and keep it in a box.

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* A douche consists of flushing the vagina soon after intercourse either with plain water or with water to which a sperm-destroying substance has been added.

(2) Examine the diaphragm for any defects or weaknesses, just before use each time (by holding it before a strong light and stretching it slightly).

(3) Oil, cold cream and vaseline should not at all be used on the diaphragm, since they will spoil the rubber.

(4) The life of a diaphragm is quite long—being 6 months to 2 years, depending upon the care taken.

36. *Other necessary instructions*—

(1) Success of the method depends upon the woman's following the instructions carefully.

(2) She must make certain, by constant practice, that she knows how to use the diaphragm and she must use it each time.

(3) She must go back to the doctor within a week after getting a new diaphragm for the first time, to see if the diaphragm fits properly and if she has understood the use of it and if it is comfortable for her and her husband.

(4) Refitting is necessary after delivery, abdominal and pelvic operations.

(5) She must equip herself with a continuous supply of contraceptive jelly.

37. *Whether reliable or not.*—This method is the most reliable *among all methods available to wives.* There are risks of failure (as in any other method) but they can be avoided if the foregoing instructions are carried out.

38. *Extent to which the method is prevalent.*—It is known to be the method *which is most widely*

prescribed in birth-control clinics of foreign countries. This is not the same thing as saying that it is the most widely prevalent method, even among methods practised by wives. In England, it appears, the spermicidal tablet method is practised by a larger number of women than this method. As between the "Sheath" method and this method, preference appears to be based on whether the husband or the wife feels greater responsibility for successful avoidance of pregnancy.

39. *Advantages and disadvantages.*—The instructions given above indicate how few people in this country are likely to be able to observe them. The method is unsuitable for homes where privacy is lacking and running water facilities do not exist. It requires an amount of leisure and patience which are often unavailable. Perhaps, the most serious limiting factor is the need for individual fitting by a doctor. There are so few doctors who possess knowledge of the technique. In these respects, the method is at a disadvantage as compared with the "Sheath" method. It is, however, definitely superior in one respect. The diaphragm does not interfere with the actual process of conjugal union, since it can be inserted even two hours or so before union and removed 6 to 8 hours afterwards. If properly fitted and inserted, both partners often forget about its presence. The diaphragm is more costly than the sheath, but it can be used very much longer without replacement.

40. *Final comment on the method.*—Every wife who can afford the expense and command the privacy and needed facilities and also possesses the leisure

and patience necessary for the practice of this method, should be advised to adopt it as preferable to all other methods.

NOTE.—Simple and inexpensive home-made substitutes for the diaphragm have been suggested for general use by poor people. The alternative usually suggested is a pad (usually of rolled cotton wool) soaked in either castor oil, or in gingelly oil, or in salt solution (two tea-spoonful of common salt in two ounces of water). If the pad is made up in a manner which is convenient for removal, and if the method is practised in a hygienic manner it should be capable of providing about as much protection as the "Spermicidal" method. But there are not enough data based on experience to justify confidence that the poor people, for whom the method is specially intended, will practise it in a hygienic manner. The objection to the diaphragm, based on lack of privacy in the homes of poor people, applies to the inexpensive home-made substitutes, no less than to the diaphragm.

VII. The "Husband-Sterilization" Method.

41. *The idea underlying the method.*—The idea underlying all previous methods is to prevent the sperm from meeting the egg and thus avoid the occurrence of a pregnancy following the conjugal union. These are methods of "temporary contraception". The idea underlying the "Husband-Sterilization" method is permanently to block the passage by which the sperms come out of the testicle and join the seminal fluid, and thereby permanently avoid the presence of sperms in the seminal fluid. It is a method of "Permanent Contraception".

42. *The method described.*—The method consists in performing a surgical operation on the husband called "Vasectomy". A half an inch opening is made on each side of the scrotum just above the testicle and the sperm passage (which looks like a cord) is drawn out. Two silk threads are then tied; and about an inch of the intervening portion is cut out. The operation is simple and does not require chloroform or other general anæsthetic. A local anæsthetic is given, and the operation completed in about 15 to 20 minutes.

43. *Whether reliable or not.*—The operation takes effect after some four to six weeks. During this period the semen may not be entirely free of sperms. Thereafter, the operation effectively prevents the sperms from being present in the seminal fluid.

44. *Extent to which the method is prevalent.*—Resort to this method appears to be of very recent origin. The practice is thus confined to very small numbers. But there is evidence that the practice is growing rapidly in the Madras State.

45. *Advantages and disadvantages.*—The great advantage of this method is that it solves the problem once for all. The inconvenience and expense of an operation is undergone only once. Thereafter, the married couple have conjugal union without any precaution, expense, or irksome restraint. There is the greatest possible assurance that pregnancy would not occur again. The permanent character of the result—the fact that it is not possible to undo the operation—also constitutes the limitation on its use. The method cannot be advised before middle age. It can be resorted to only at that stage of married life when both the husband and the wife (having had enough children) feel assured that there is no risk of their ever desiring another child. The doctor should make quite certain of this fact and secure written declarations from both the husband and wife to this effect before he undertakes the operation.

46. *Results of experience.*—In all the States in the United States of America, and particularly in the States of California and North Carolina, Vasectomy is performed chiefly for eugenic reasons. However, in recent years, those fathers of decent-sized

families who want permanent conception control are resorting to Vasectomy. This is done both in State hospitals and by private surgeons. Careful records have been kept and research has been undertaken on the after-effects of this operation. The considerable evidence that is available on this question demonstrates convincingly that there are not deleterious effects as a result of this operation on the male. On the contrary, due to the absence of fear and other psychological reasons, the health of those men who have undergone Vasectomy has, in many cases, actually improved. Once this simple operation is performed by a competent surgeon, there is no reason to expect, according to the available American data, any undesirable effects in health, sex urge and satisfaction.

A few months ago, the Director of Medical Services of the Madras State arranged for an enquiry to be made by a Civil Assistant Surgeon. This officer contacted 81 persons in the City of Madurai and 10 others in Madras City who had undergone the operation. It has been reported that almost all of them are of the view that the operation has been beneficial and that they would recommend it to their friends.

47. *Final comment on the method.*—This is a very important and highly promising method. It is the only alternative open to married couples who have already had many children and who cannot afford the " Sheath " or " Diaphragm " and do not find the " Husband-careful " method to be agreeable. The method is of great value in cases where an accidental pregnancy is liable to cause incapacitating illness or death to the wife.

VIII. The "Wife-Sterilization" Method.

48. *The idea underlying the method.*—This is very similar to the idea underlying the "Husband-Sterilization" method—just as in one case the sperm is permanently prevented from passing into the seminal fluid, so the egg is permanently prevented from passing to the uterus.

49. *The method described and discussed.*—The method consists in a surgical operation performed on the wife. It is best done within 24 hours after delivery before any organism could get into the uterine cavity. The chances of organisms reaching the uterine cavity are greater 24 hours after delivery. The operation is done through a small incision 2 inches in length made below the navel. The operation can be done in 10 minutes and is of a simple nature. The operation can be done under local or low spinal anæsthesia. In this operation about an inch of the Fallopian tube, where the female egg is fertilized and passed into the uterine cavity, is removed about its middle by a special technique.

It involves only a week's stay in the hospital or Nursing Home. After removal of the stitches on the seventh day, she can return home. It leaves only a fine, thin, short scar below the umbilicus which is hardly visible. Since the operation is quite simple and does not add to the time a mother must spend in the hospital after confinement, this method is becoming very popular amongst the lower income groups. She will have no discomforts after this operation. She will get her monthly periods regularly. She could attend to her normal household duties and also can have her normal married life. This does not in any way interfere with her normal conjugal life.

With the improved method of operation done at present, it is possible to undo the operation so that the woman may have the chance of becoming pregnant, if she wants more children as a result of unforeseen circumstances. Before the operation is done, the doctor should get the written consent of the couple.

Sterilization of the wife can also be done any time like any other operation either abdominally or through the genital passage. The same procedure is carried out here also. It does not in any way increase the risk of operation except that the operation has to be done through a longer incision 4 to 5 inches long. The patient may have to remain in bed for a longer time and there is also the possibility of the wife becoming pregnant in the interval after delivery. This risk can be avoided by the first method, done immediately after delivery. The same procedure can also be done through the genital passage especially in cases where she has got also some kind of prolapse of the uterus. The advantage here is that this does not leave a visible scar. Moreover a woman is willing to have any operation done through the genital passage rather than through the abdomen.

On the whole, it is preferable to have it done soon after delivery as it has got many advantages.

50. *Final comment on the method.*—This method is just as important and promising as the " Husband-Sterilization " method.

THIRD PART
FAMILY PLANNING AND NATIONAL PLANNING.

1. Whenever a husband and wife have conjugal union, there is the chance that the wife will become pregnant and give birth to a child. This is, however,

only a chance, never a certainty on any one occasion. Some married couples never get a child. On an average, every year, four out of every five married couples can expect to live a normal conjugal life and yet have no children. By the same token, however, it may be said that in every random group of, say, one hundred married couples in India, it is practically certain that some twenty children will be born, though no one can say to which couple those children would be born.

2. It is not within the power of a married couple to ensure that a pregnancy occurs in any particular year in which they want one. But it is within their power to take certain precautions and thereby avoid a pregnancy when they do not want it. This is a very important fact which every married couple ought to know.

3. A married couple is said to practise " Family Planning ", if they possess this knowledge and put it to use. Such a couple usually make a plan for themselves and decide how many children they would like to have and take steps to secure that that number is not exceeded. Further, they also decide, from year to year, whether that would be a convenient year in which a pregnancy might be permitted to occur. They normally take precautions (whenever they have conjugal union) to avoid the occurrence of a pregnancy; and they refrain from taking such precautions only at those times when they have planned to permit a pregnancy to occur.

This does not mean that unplanned pregnancies do not ever occur to them. The point is, they do plan; and the plan succeeds far more often than it fails.

4. Family Planning may be, therefore, defined as *planned regulation by a married couple of the*

pregnancies which are liable to result from their conjugal union, through the adoption of precautions calculated to avoid unplanned pregnancies.

5. The foregoing definition is carefully framed so as to elucidate not only what Family Planning is, but also *what it is not.*

" Family Planning " does not, for instance, mean " abstinence " from conjugal union. It has been sometimes stated, as an ethical principle, that conjugal union should not take place except on those occasions when the husband and wife actively desire that the union should result in pregnancy. The married couples who practise Family Planning do not seek to give effect to this principle. They regard it as natural and proper that the husband and wife who live together should desire conjugal union, even when they do not desire pregnancy. Family Planning consists in providing a means of satisfaction of such desire; and at the same time, avoiding the occurrence of an unplanned pregnancy.

6. The precautions adopted for this purpose are sometimes referred to as " Birth Control ". This is, however, not an accurate description. All methods of avoiding pregnancy (or methods of " contraception " as they are called) are no doubt also methods of avoiding births. But there are some married couples who permit pregnancy to occur and then terminate it prematurely by inducing abortion. What they do is a form of " birth-control ", but it is not Family Planning. It is indeed one of the deplorable consequences of failure to practise Family Planning. The practice of induced abortion is harmful to the health of the wife, besides being a punishable offence under the law.

7. Every married couple who practise Family Planning, and the children born to them may be referred to as a "*Planned Family*". Every other married couple and the children born to them may be referred to as a "*Traditional Family*". "Planned Families" are to be found in every country of the world, regardless of distinctions of race, religion or language. But the number is generally quite small in this country, as well as in the under-developed countries in Asia, Africa and South America. "Planned Families" form the preponderant majority and "Traditional Families" only a minority in England, France and other countries of Western Europe, as well as in the countries of North America and Oceania. A community which consists wholly or predominantly of "Planned Families" can be distinguished from a community which consists wholly or predominantly of "Traditional Families", if correct vital statistics are available for both.

It is roughly estimated that there are some 10 crores of "Planned Families" in the world to-day representing between one-sixth and one-fifth of the entire human race. The number and the proportion are increasing from year to year.

8. A few years ago, a British Royal Commission on Population carried out a very detailed and authoritative enquiry. In order to provide data needed by the Commission, a "Family Census" was specially carried out and this was supplemented by a "Fertility Inquiry" undertaken on a random sample basis by the Royal College of Obstetricians and Gynæcologists. The Royal Commission (which was assisted by many experts of international repute) studied the data and submitted a report. This report and other papers relating to the Family Census and Fertility

Inquiry have been published. These papers are important, because they show clearly the extent to which different methods are actually prevalent among different social classes of the people of England. The information contained in this manual about Family Planning in England is derived from these publications.

9. The British Royal Commission on Population found it to be conclusively proved that married couples in England had effected a substantial reduction in the total number of children born to them as a result of the practice of Family Planning. Thus, out of every 100 women who were born round about the year 1860 (about whom information was collected in 1911), 9 were childless; 5 had given birth to only one child; 6 had given birth to 2 children; 8 had given birth to 3 children; and no less than 72 women had given birth to 4 children or more. There were as many as 33 women who had given birth to 8 children or more. A similar count of 100 women married during 1925 (about whom information was collected in 1946) showed that 17 were childless; 25 had given birth to one child; another 25 had given birth to 2 children; 14 had given birth to 3 children. The number of women who had given birth to 4 children or more had dropped from 72 to 19. The number of women who had given birth to 8 children or more had dropped from 33 to less than 3.

10. In England to-day, the total number of children born every year, among 1,000 people, is only 15. Out of this number, 6 are first-born children; 5 are second-born children; 2 are third-born children. Only two children are fourth-born or of a higher birth order. The position in this country is very different. The total number of children born every

year among 1,000 people is 40 (against only 15 in England). Out of this number, the number of children who are fourth-born or of a higher birth order is 17 (against only 2 in England).

11. In this country, a married couple of a " Traditional Family " (who live to complete their reproductive age), beget—on an average—between 6 and 7 children. In England also the average used to be 6 in the last century. But it has steadily declined and is now just a little in excess of 2.

12. The main objective, then, of the married couples who practise Family Planning is to secure that the total number of children born to them does not exceed a limit which they set for themselves. And they attain their objective with complete success. Why do they set such a limit? There is no doubt about the answer. The enquiries made by the British Royal Commission on Population about the reasons given by married couples for practising Family Planning disclosed that the most common reason was *" that more children could not be afforded "*.

13. It is well-known that the British people enjoy much greater material prosperity than the people of this country. They have fuller employment, larger family incomes, more social services (provided at public cost) and a much higher standard of living. And yet the " Planned Families " of that country (comprising two-thirds of the nation) feel that they are unable to afford more than two or three children and take steps to limit their families accordingly. Why do they feel in that manner? Why is it that, even though the same reason applies with very much greater force in this country, married couples continue to live the " Traditional Family " life here? It

is primarily because the English people treat their responsibility as parents much more seriously than most of us do.

14. If a " Traditional Family " has got twice or thrice as many children as a " Planned Family " it is obvious that the former can afford to spend only between one-half and one-third as much as the latter on every child. *Every child born in a " Traditional Family " suffers from a serious handicap as compared with a child born in a " Planned Family ", even though both families may have the same family income.* The result is that (other things being equal) the child in the " Traditional Family " gets less nourishing food, feebler health, insufficient care and attention to its needs, fewer educational opportunities and altogether poorer start in life than the child born in a " Planned Family ".

15. In fact, the difference makes itself felt in the numbers of children who die prematurely. Though the death-rate in this country has been on the decline during the last three decades, it is still very high. It has been reckoned that the total number of deaths which occurred in the course of one year among every 1,000 people was 27 during the decade 1941-50. At least 6, and probably 7 among these 27 deaths took place among infants within one year of their birth. Four or five more deaths occurred among children of ages 1 to 4. The total number of infant deaths exceeded the total number of deaths among elderly persons of all ages from 55 onwards. The total number of deaths occurring among children under age 5 exceeded the total number of deaths which occurred during the next 50 years of age (5 to 54).

The picture is very different in England. The death-rate in England is 12 against 27 in India. The

infant death-rate is negligible in England. A child born in this country has a very poor expectation of life (a little over 32 years). The expectation of life at birth of an English child is 62 years. About 80 years ago when " Planned Families " were as few in England as in India to-day, the expectation of life at birth of an English child was 20 years shorter than to-day.

16. *A married couple who beget a child undertake a serious responsibility. They owe a duty to the child to make sure that they are in a position to protect it against premature death, feed it properly and promote its health and welfare and give it the best start in life which it may be in their power to provide.*

Family Planning is necessary in order to enable every married couple to discharge this duty to their children.

17. That " more children could not be afforded " was not the only reason behind Family Planning. Other reasons given by married couples who practise Family Planning are the need " to space pregnancies " and also " health reasons ". It is essential that there should be an interval of not less than three years between the end of one pregnancy and the beginning of another. (The interval may have to be longer in cases of specially weak or ailing wives.) Spacing of pregnancies is necessary, primarily, in order to safeguard the health and strength of the mother. A rapid succession of two or three pregnancies, without adequate time for regaining strength after each, is almost certain in most cases to impair the health of the mother permanently and possibly imperil her life in some cases. It is also certain to deprive children of the care and attention of the mother at the time when it is most needed. In this

matter, the husband is in a position of special responsibility. *He has a particular duty to safeguard the health and strength of his wife. Family Planning is necessary in order to enable every husband to discharge this duty to his wife.*

18. These considerations, affecting the health and welfare of wives and children, are valid for all time and for all countries. But they have acquired a special importance in recent years in this country. This is so because the traditional balance between births and deaths has been upset during the last generation. Famines and epidemics are no longer permitted to take the heavy toll of lives, which they used to do in the past. Malaria is being eradicated. Sanitation is being steadily improved and medical services are becoming available to an increasing extent. The incidence of mortality generally, premature mortality in particular, is being reduced slowly but surely from decade to decade. At the same time, however, there is no corresponding reduction in the incidence of maternity, more especially of what has been called "improvident maternity" (births of the fourth and higher orders).

19. The birth-rate remains high, while the death-rate is falling. The margin by which births exceed deaths is growing wider and wider. Hence the abnormal growth of population about which so much is being heard to-day. This is an unusual growth which has no parallel in this country at any time in its history before the last generation. The nation-wide food shortage lasted many years during and after the last war and necessitated controls and rationing for a long time. It had never happened before. It was not (as many thought at the time) an accidental result of the war. The war only disclosed

dramatically the change that had been occurring over two decades earlier—the failure of food production to keep pace with the abnormal growth of population. Again, everyone observes that there is a persistent tendency for the prices of essential commodities to increase, causing the cost of living to rise and the standard of living to fall. This is attributable jointly to the persistent growth of population and attendant food shortage. Again, the growth of unemployment which is causing increasing concern in recent years is yet another symptom of the economic disorders created by abnormal growth of population. So long as the number of births over a period of years was not much in excess of the number of deaths, it was easy enough for the new generation to occupy and cultivate the fields, carry on the businesses and get the jobs vacated by the old generation. But when the balance was upset and the new generation became so much more numerous than the old, unemployment and landlessness naturally tended to grow.

20. It was in order, primarily, to cure these evils that the First National Five-Year Plan was framed and carried out and the Second National Five-Year Plan has been taken in hand. The immediate aim of these plans is to develop the production of food and other essential commodities and services so as to keep pace with the growing demand of the steadily increasing population. But this will be a never-ending process and prove to be not a cure but only a palliative, unless the growth of population is checked. Colossal expense and effort which would, otherwise, improve standards of living are needed in order merely to prevent further deterioration of present low standards. A permanent cure for those disorders can be obtained only when the balance between births and deaths is again restored. But no one desires the

death-rate to go up again. On the other hand, everything should be done to reduce substantially the incidence of mortality, especially of mortality among infants and young children. The traditional balance of a high birth-rate (swollen by improvident maternity) matching a high death-rate (swollen by premature mortality) should *not* be restored. A *planned* balance must be achieved, with a low birth-rate (without avoidable improvident maternity) matching a low death-rate (without avoidable premature mortality).

21. It is in order to bring about such a planned balance and establish the durable basis for a better standard of living for the next generation that the Government of India have declared it to be their policy to promote the spread of Family Planning among the people. That is why the Planning Commission has declared, in its report on the Second National Five-Year Plan, that "*the problem of regulating India's population is of the utmost importance to national welfare and national planning*". A sum of Rs. 5 crores has been set apart by the Government of India in order to establish 300 urban clinics and 2,000 rural clinics and take all other necessary measures for the spread of Family Planning.

It is thus clear that the practice of Family Planning is no longer a matter of purely private interest to married couples. The welfare of the nation as a whole will be promoted or retarded by what every married couple does or fails to do about Family Planning.

22. To sum up, the practice of family planning is necessary because—

First.—It is the means of spacing pregnancies and safeguarding the health of mothers,

thereby enabling every husband to discharge his duty to his wife.

Secondly.—It is the means of limiting the size of the family; thereby, enabling every married couple to discharge their duty to their children.

Thirdly.—It is the means of stabilizing the size of the nation, thereby, promoting national welfare and assuring the success of national planning and thus enabling every married couple to discharge their duty to the nation.

23. In India to-day, approximately 150 lakhs of children are born every year. Among them, approximately 60 lakhs of children are the offspring of parents who have already given birth to 3 or more children. At the same time, approximately 100 lakhs of people, of all ages, die every year. Among them nearly 40 lakhs of deaths are accounted for by infants and young children under the age of 5. If "improvident maternity" is eradicated or substantially reduced and if every married couple who have given birth to three or more children refrain from having any more (except in exceptional circumstances), then the annual births will be reduced from 150 lakhs to only a little more than 90 lakhs. The deaths of infants and very young children will be proportionately reduced from 40 lakhs to less than 24 lakhs, say about 20 lakhs. Births and deaths can thus be both reduced and brought into approximate balance and the size of the nation will get stabilized.

24. It is the duty of every Indian married couple to help the nation to achieve such a planned balance

between births and deaths. They can do so, if they ensure as their individual contribution to the national effort—

First.—That the interval between the end of one pregnancy and the beginning of the next does not fall short of three years.

Secondly.—That when they have given birth to three or more children, they refrain from having any more (except in exceptional circumstances).

APPENDIX I.

SAFETY CALENDAR FOR 1958.

JANUARY					
Sun	..	5	12	19	26
Mon	..	6	13	20	27
Tue	..	7	14	21	28
Wed	1	8	15	22	29
Thur	2	9	16	23	30
Fri	3	10	17	24	31
Sat	4	11	18	25	..

FEBRUARY					
Sun	..	2	9	16	23
Mon	..	3	10	17	24
Tue	..	4	11	18	25
Wed	..	5	12	19	26
Thur	..	6	13	20	27
Fri	..	7	14	21	28
Sat	1	8	15	22	..

MARCH					
Sun	30	2	9	16	23
Mon	31	3	10	17	24
Tue	..	4	11	18	25
Wed	..	5	12	19	26
Thur	..	6	13	20	27
Fri	..	7	14	21	28
Sat	1	8	15	22	29

APRIL					
Sun	..	6	13	20	27
Mon	..	7	14	21	28
Tue	1	8	15	22	29
Wed	2	9	16	23	30
Thur	3	10	17	24	..
Fri	4	11	18	25	..
Sat	5	12	19	26	..

MAY					
Sun	..	4	11	18	25
Mon	..	5	12	19	26
Tue	..	6	13	20	27
Wed	..	7	14	21	28
Thur	1	8	15	22	29
Fri	2	9	16	23	30
Sat	3	10	17	24	31

JUNE					
Sun	1	8	15	22	29
Mon	2	9	16	23	30
Tue	3	10	17	24	..
Wed	4	11	18	25	..
Thur	5	12	19	26	..
Fri	6	13	20	27	..
Sat	7	14	21	28	..

JULY					
Sun	..	6	13	20	27
Mon	..	7	14	21	28
Tue	1	8	15	22	29
Wed	2	9	16	23	30
Thur	3	10	17	24	31
Fri	4	11	18	25	..
Sat	5	12	19	26	..

AUGUST					
Sun	31	3	10	17	24
Mon	..	4	11	18	25
Tue	..	5	12	19	26
Wed	..	6	13	20	27
Thur	..	7	14	21	28
Fri	1	8	15	22	29
Sat	2	9	16	23	30

SEPTEMBER					
Sun	..	7	14	21	28
Mon	1	8	15	22	29
Tue	2	9	16	23	30
Wed	3	10	17	24	..
Thur	4	11	18	25	..
Fri	5	12	19	26	..
Sat	6	13	20	27	..

OCTOBER					
Sun	..	5	12	19	26
Mon	..	6	13	20	27
Tue	..	7	14	21	28
Wed	1	8	15	22	29
Thur	2	9	16	23	30
Fri	3	10	17	24	31
Sat	4	11	18	25	..

NOVEMBER					
Sun	30	2	9	16	23
Mon	..	3	10	17	24
Tue	..	4	11	18	25
Wed	..	5	12	19	26
Thur	..	6	13	20	27
Fri	..	7	14	21	28
Sat	1	8	15	22	29

DECEMBER					
Sun	..	7	14	21	28
Mon	1	8	15	22	29
Tue	2	9	16	23	30
Wed	3	10	17	24	31
Thur	4	11	18	25	..
Fri	5	12	19	26	
Sat	6	13	20	27	

NOTE.—Instructions for the use of the calendar are given on pages 46–47.

FERTILE PERIOD KEY NUMBERS.

First Key Number.

Number of days in the shortest menstrual cycle. (1)	*The menstrual cycle day on which fertile period begins.* (2)
25	7th
26	8th
27	9th
28	10th
29 or more.	11th

NOTE.—*For mothers with menstrual cycle of 24 days or less there is no After-Menses Safe Period.*

Second Key Number.

Number of days in the longest menstrual cycle. (1)	*The menstrual cycle day on which fertile period ends.* (2)
30 or less.	19th
31	20th
32	21st
33	22nd
34	23rd

NOTE.—*For mothers with menstrual cycle of 35 days or more, there is no Before-Menses Safe Period.*

ILLLUSTRATION OF THE USE OF KEY NUMBERS.

JANUARY 1958

S.	M.	T.	W.	T.	F.	S.
			8 A.M. (1)	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

INSTRUCTION TO FATHERS REGARDING THE USE OF THE SAFETY CALENDAR FOR THE PURPOSE OF ASCERTAINING WHETHER ANY PARTICULAR DAY FALLS ON A SAFE PERIOD OR ON A FERTILE PERIOD.

1. *First step.*—Find out from your wife what was the number of days in the *shortest menstrual cycle* she remembers during the last three years. Find out similarly what was the number of days in the *longest menstrual cycle* she remembers during the same three years. In counting the number of days in any menstrual cycle, begin with the day on which menstruation first appeared as the first day and end on the day preceding the next menstruation as the last day. *Remember: The menstrual cycle includes the menstruation period.*

2. *Second step.*—You should now learn to fix in each menstrual cycle the day on which the Fertile Period begins and the day on which the Fertile Period ends. For this purpose you should ascertain and remember two "Key Numbers". Look at the Table of Fertile Period Key Numbers given on page 46. Locate the number representing the shortest menstrual cycle of your wife. The number shown opposite to it is your first key number. Then locate your wife's longest menstrual cycle. The number shown against it is your second key number. Your wife's fertile period begins on the day represented by the first key number, *counting from the date of appearance of menstruation as the first day.* The fertile period ends on the day represented by the second key number.

3. *Illustration.*—See the miniature calendar given on page 46. Sri X—the father is informed by his wife on Wednesday the 1st January about the appearance of menstruation. He immediately makes a note in the calendar, against that date and day, specifying the hour. He knows already that the shortest menstrual cycle of his wife is 27 days and so his first key number is 9. Her longest menstrual cycle is 32 days and so his second key number is 21. Remembering these two key numbers 9 and 21 he counts nine days from Wednesday, the 1st January, and locates Thursday, the 9th January as the beginning of the fertile period. Similarly he locates Tuesday, the 21st January as last day of the fertile period. *He has therefore crossed out all the days of the fertile period from Thursday, 9th January to Tuesday, 21st January.*

All days between the disappearance of menstruation and Wednesday, 8th January are safe days. Again, all days from Wednesday, 22nd January until the appearance of the next menstruation are safe days. *All the days which he has crossed out are days to be avoided.*