FROM "LEFT" TO "RIGHT":

A Perspective on the Role of the Volunteers in
Family Planning in the West and in South Asia

by

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B.A., Queen's University, 1935

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Date 2. 6. 71
ABSTRACT

This thesis is an examination of the role of the volunteers in the development of family planning programs in the West and South Asia, and of whether they have a continuing role to play. Through personal experience, interviews and correspondence with some of the leaders, through reports, other readings, and studies of motivation and the provision of family planning services, the writer concludes that the volunteers played an indispensable part. Governments would not have introduced family planning programs if voluntary organizations had not shown that they were needed and feasible. The volunteers laid the groundwork not only for official programs but for a variety of careers in family planning and related fields. They have a continuing role to play as friendly critics, in promotion, education, and innovative research, and to make sure that birth control, once considered to be far to the "Left", becomes firmly entrenched as a Human "Right".
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NOTES ON TERMINOLOGY

"When I use a word," Humpty Dumpty said, in rather a scornful tone, "it means just what I choose it to mean - neither more nor less."

As in other fields, communication in "family planning" is sometimes difficult. Depending on attitude and degree of involvement, terms mean different things to different people. For example,

"Birth control" can mean methods of preventing births, or may conjure up ideas of the emancipation of women, or racism.

"Family planning" can mean spacing or limiting pregnancies, the treatment of infertility, or some sort of budgeting of family income.

"Sterilization" may mean the simple, voluntary operation on a man or woman which gives permanent freedom from the fear of unwanted pregnancy without impairing sexual performance; or it may arouse images of experiments in Nazi concentration camps, castration and the state of being "no longer a man" or "no longer a woman".

"Abortion" may mean a medically safe, legal, back-up procedure for ignorance, rape, or contraceptive failure; or it may mean a forbidden solution, born of vice, carried out by a criminal, in which death is a possible consequence, and the prior rights of the foetus are incontrovertible.

"Population control" or "population planning" may mean a voluntary or compulsory family planning program with humanitarian intent, or genocide.

Historically, family planning terminology evolved in response to public attitudes. In the nineteenth century individual advocates of social reform through birth control
euphemistically called contraceptives "preventive checks". Later, when they formed a voluntary organization they called it a "Malthusian League" - even though Malthus opposed "preventive checks", and regarded continence outside marriage as the only acceptable means of controlling fertility.

In 1914 Margaret Sanger and a group of supporters in New York coined the term "Birth Control" to symbolize a "wanted child" and the emancipation of women from the "enslavement of motherhood". In the United Kingdom, in 1921, to offset criticism, Marie Stopes invented "Constructive Birth Control". A less feminist, but also defensive term, related to general concern over low birthrates in Europe and North America in the 1930s, led to the adoption in Britain in 1939 of "Family Planning" and, in the United States of America, in 1942, of "Planned Parenthood". Both terms were intended to identify the movement more closely with the idea of family well-being and freedom of choice; but neither has ever meant unlimited child-bearing, as implied in recent criticisms. To-day, "Family Planning" is also the popular term for voluntary government programs.

"Birth control", "Family Planning", and "Population Control" indicate also the shifts in orientation of the movement, over the years and as circumstances allowed - from individual to family, to national, and international well-being. A few people distinguish between "Family Planning" and "Population Control" as a private, vis-a-vis a public program, but no country has officially adopted the latter
designation. Compulsion is not contemplated - for the present, at least.

Depending on the policy of the organization or government, "Birth Control" can mean mechanical, chemical and biological methods of preventing conception, or it can also embrace sterilization and legally induced abortion.

Like the "family planners", I shall try to use the terms "birth control", "family planning", "planned parenthood" and "population control" in their permissive and interchangeable connotations; and that, as Humpty Dumpty said, is what I choose it to mean.

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<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>AID, or USAID</td>
<td>United States Agency for International Development</td>
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<td>FPA</td>
<td>Family Planning Association</td>
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<tr>
<td>PPAC</td>
<td>Family Planning Association of Ceylon</td>
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<tr>
<td>FPAI</td>
<td>Family Planning Association of India</td>
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<td>Family Planning Association of Nepal</td>
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<td>FPAP</td>
<td>Family Planning Association of Pakistan</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>IUCD or IUD</td>
<td>Intrauterine Contraceptive Device</td>
</tr>
<tr>
<td>LMS</td>
<td>Lanka Mahila Samiti (Women's Institute of Ceylon)</td>
</tr>
<tr>
<td>NMB</td>
<td>Nieuw Malthusiaanschen Bond</td>
</tr>
<tr>
<td>PP-WP</td>
<td>Planned Parenthood-World Population (U.S.A.)</td>
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<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<td>WHO</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNICEF</td>
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Space research and photographs of Earth have helped many people to realize that we live on a finite planet, with finite resources, and little choice but to learn to live in harmony with each other and with our environment. The information explosion of the past quarter century has also made it clear that many problems are common to all countries, and, generally, differ only in degree. One universal challenge is population growth and what to do about it.

Before 1800, populations were increasing in all countries, but the rate was slowed by death from disease, famine and war. In the nineteenth century, however, in the industrializing countries of Europe, higher standards of living, more political stability, and improving health services brought about a gradual decline in mortality. A population "explosion" would have occurred then, had it not been for emigration to other temperate climates, the growing practise of birth control, and economic expansion which was able to absorb most of the remaining growth. At no time did the rate of population increase exceed 1 to 1.5 percent per year, and in the past few decades, for example, growth rates have declined to around 0.5 in the United Kingdom, 0.8 in Sweden, 1.0 in the United States of America, and 1.1 percent in the Netherlands. (In this century, and for similar reasons, Japan has also
followed the same trend to an annual population growth rate of 1.1 percent.) Thus, the "demographic transition" from high birthrates and high deathrates to low birthrates and low deathrates in the rich countries came about gradually, over a period of approximately 150 years; and, because access to natural resources is still possible, population growth is not yet widely recognized as a threat (even though, in spite of the safety valves mentioned, European stock increased three times at home, and five to seven times abroad).¹

On the other hand, the transition in the poor countries of Africa, Asia and Latin America did not begin until after World War II. Health measures brought epidemic diseases in many of them under control, famine relief became more sophisticated, and, though wars continued to kill people, decimation from this cause was not significant in the over-all mortality decline. Because the majority were still engaged in farming, agricultural traditions prevailed, fertility remained high, and population growth rates in most Asian nations shot upward. In Latin America and Africa, though mortality is higher, population growth rates also rose; and now, on the three "developing" continents, they range from more than 2 to nearly 4 percent per year.² In addition to growth in total numbers, high survival rates have caused imbalance in the age structures of these countries. Percentages of persons under fifteen years now vary from thirty-five to more than fifty, increasing the demand for such basic services as food, housing, education, health,
and transportation, and draining off funds needed for other forms of job creation and international trade. Such high dependency ratios obstruct attempts to raise the standard of living, and eat up the benefits of each hard-won economic advance.³

On a world-wide basis, population is estimated to be more than 3.3 billion, increasing at 1.9 to 2 percent per year, with approximately 37 percent under 15 years of age. If current conditions persist, it is expected to double in about 35 years, and to reach 11 billion by 2050 A.D.⁴ The proportion of youth in the world age structure will increase still further. Even if, from now on, all couples try to restrict family size to two children (replacement level only), several generations will pass before a stationary population and a balanced age structure can be achieved.⁵ In the meantime, social, economic and political problems are sure to multiply.

In the face of this unpleasant reality, there is growing awareness that economic expansion alone cannot solve the problem, and that growth rates must be brought to zero per year, or even to a decline, as soon as possible.⁶ But there is no agreement on the urgency of the problem, or on how to go about achieving a stationary population. Canadians are only now beginning to consider the question. In the United States, opinions vary. Paul Erlich, a biologist, claims that zero population growth (ZPG) is essential at once, and that compulsion may have to be used. Garrett Hardin, a human
ecologist, also believes that ZPG is urgent, but is willing to see more effort put into improving the voluntary system before resorting to force. Frank Notestein, a demographer, agrees that the population problem is certainly urgent, but says it is more so in the developing countries than in the others. He regards compulsion in any country as unthinkable. He argues that if better incentives and voluntary services were provided the poor in all countries, ZPG would follow. The decline would be gradual enough, however, to be unlikely to cause panic reaction in favour of increase again. Jeannie Rosoff, of Planned Parenthood-World Population, views such crisis thinking and argument as a waste of time. It is known that in all countries some people have more children than they want, and that, in the United States, for example, twenty to forty percent of pregnancies are unwanted. It is also known that most people are receptive to the idea of fertility limitation. If unwanted pregnancies could be prevented, much unhappiness for parents and children alike would be avoided, and the population problem would be eased at the same time. Supporting Notestein, Mrs. Rosoff urges greater effort to satisfy known demands. Better voluntary programs, better methods, better education, and more opportunity for human fulfilment are attainable goals.

As a matter of fact, forced fertility control is impossible. No government to-day would risk revolution to try it and, in any case, the personnel to carry out such a policy are not available. The only solution in the foreseeable future
is the voluntary system, and the only way to make it really effective is a combination of social change, more active leadership from public figures, improved methods, and availability of birth control. In any plan to persuade people to adopt "family planning", motivation and services are crucial.

What influences people to limit their fertility? In 1965 Coale listed the decline of mortality, changes in the economic value of children in an urban society, prohibition of child labor, higher status of women, education, attitudes to religion, and the development of secular and rational thinking as the important factors. He also noted that if ninety percent of children attended primary school, and at least 50 percent of the population was urban-dwelling, declines would take place in any case. On the other hand, France reduced its fertility before any of these factors obtained in that country, but England did not follow suit until most of them existed. Notestein, Kirk and Segal accepted similar categories leading to social advancement, and added the breakdown of the extended (or joint) family system. But they, too, agreed that this is an oversimplification of the question. Berelson suggested that family welfare and educational opportunities for the children are key factors. In any event, the practice of contraception begins with the "middle classes" among whom motivation is high, and access to information and means is relatively easy. Lower income groups lag behind, either because they are not interested, are unaware that a choice is possible, or the means to make
it effective is not readily accessible. Therefore, it may be concluded that, even when birth control is widely practised, there is no universal pattern of incentives. Declines in fertility occur because individual decisions are made for personal reasons. If more sophisticated methods are not available, the attempt is made through such folk methods as coitus interruptus (withdrawal or "being careful"), induced abortion or even infanticide. The influence of the family planners is another question.

This study will examine the role of the family planners in three significant geographic areas - the industrialized countries in which the movement first developed; the international area, in which it grew, and South Asia, the first modernizing area in which either a voluntary or a government program was introduced. Two fundamental aspects - motivation (leadership, opposition, acceptance) and services (programs and results); and two rough time periods - one long (from 1800 until World War II), and the other short (from 1945 to the end of the 1960s) - will provide the framework for a shift in image from radical "Left" to "Human Right".

I have drawn from personal experience as a volunteer in family planning both in a developing country (Ceylon) and in Canada, on correspondence and interviews with some of the leaders of the voluntary movement, annual reports, conference proceedings, speeches, published and unpublished papers, and supplementary research.
I am indebted to Hon. James George, Canadian High Commissioner to India, and his wife, Carol, for introducing me, when they were stationed in Ceylon, to the volunteers: particularly, Mrs. E. C. (Sylvia) Fernando, Honorary Secretary of the Family Planning Association (FPA) of Ceylon and a Vice-President of the International Planned Parenthood Federation (IPPF); Dr. (Miss) Siva Chinnatamby, FRCS, FRCOG; and Professor and Mrs. C. C. DeSilva. For two years I served with them in two weekly clinics (one in a Colombo social service organization and the other in a suburban public hospital) and as a member of the Executive Committee of the Family Planning Association. Each has given me much information, both in conversation and correspondence. Prof. C.H.S. Jayewardene, co-author with the late Prof. O.E.R. Abhayaratne, of *Fertility Trends in Ceylon*, sent further information, and Mr. L.O. DeSilva some political comment. Miss Ray Blaze has sent information on the attitudes of other voluntary organizations in Ceylon. Mr. J.R. McPhail (Colombo) and Mr. Alan Langmuir (Vancouver), then of T. Ingledow and Associates, also sent relevant Ceylon government publications. Mrs. Wilfred Graham, Vancouver, kindly supplied background information on her sister, Dr. Mary Rutnam.

Smt. Avabai Wadia, President of the Family Planning Association of India, Bombay, sent me numerous published reports and periodicals, as did Smt. Dhanvanthi Rama Rau, also of Bombay, founder of the FPA of India (FPAI), and recently retired as President of the International Planned
Parenthood Federation. Dr. Alan B. Gilroy, Principal of the Ross Institute of Tropical Hygiene, India Branch, Jorhat, sent information and monthly reports of IUD insertions and sterilizations in the program being financed in Assam and West Bengal by the Indian Tea Association. Dr. Marian B. Hall, Richmond, B.C., for 23 years a medical missionary in Ajmer, Rajasthan, and, so far as I know, the only non-Indian to be a member of the national council of the FPAI, has allowed me access to her papers. The Christian Medical Association of India has sent me reports, and I have had helpful conversations with Dr. Robert McClure of Toronto, Dr. David Kennedy of Vernon, B.C., and Mrs. Wendy Marson of Ottawa, who worked in India with that organization. Dean C.F. Bentley, of the University of Alberta, passed on information on India, including speeches and articles by Dr. S. Chandrasekhar, when Minister of State for Family Planning, India.

Mr. A.M.A. Kabir, Dacca, Senior Vice-President, FPA of Pakistan, has also been very helpful. Dr. J.P. Sharma, President of the FPA of Nepal, Kathmandu, and Mrs. Shanti Rana, General Secretary, sent information; and Dr. (Mrs.) Attiya Inayatullah, Honorary Secretary, Indian Ocean Region, IPPF, Lahore, gave her help as well. Mr. George Cadbury, Chairman of the Governing Body, IPPF, and Mrs. Cadbury, of Oakville, Ontario, have given me two interviews, and Mrs. Francis Dennis, Information Officer, IPPF, London, deserves special thanks for her continuing assistance. Thanks are also due to Miss Beryl Suitters of the IPPF staff for historical information.
Miss Cassandra Kent, of the FPA (UK) also sent information.

The Swedish International Development Agency sent me reports of SIDA programs in South Asia. President Emeritus Frank Notestein, of the Population Council and Princeton University, took time for a conversation in Vancouver in November, 1969, and Dr. Nicholas Wright, Population Council Adviser in Ceylon, sent information and comments. Dr. John Friesen, also of the Population Council, now in Iran, sent information on Muslim attitudes to family planning. Dr. John Edlefsen, Population Adviser to the Colombo Plan Bureau, Colombo, also took time to talk to me in Victoria, B.C., in October, 1969.

Mr. Richard Gamble, son of the late Dr. Clarence Gamble, founder of the Pathfinder Fund, and pioneer in family planning work in South Asia, was also helpful; as were two former employees of the Fund, the late Mrs. Margaret F. Roots, of Victoria, B.C., and Mrs. Edna McKinnon, of Carmel, California.

Miss Dorothy Martin and Miss Dorothy Dutton, of the UBC library staff were very helpful. My supervisors in the Departments of History and Anthropology, Prof. Peter Harnetty and Michael Ames were patient, helpful and long suffering. To all these and any others inadvertently omitted, my heartfelt thanks. Without their co-operation, this study would not have been possible.
FOOTNOTES - Preface


21970 World Population Data Sheet.


41970 World Population Data Sheet. Also Vancouver Sun, 3 July 1970, citing AP dispatch from the United Nations.


PART ONE

INTRODUCTION

"Family Planning" Was Not New

Because of the need to compensate for population losses caused by disease, famine or war, pre-industrial societies in many parts of the world venerated fertility and thus encouraged high birthrates. But, when numbers threatened group survival, or individual interests were at stake, fertility control was practised, even to obtain "zero population growth". Direct means, such as induced abortion, infanticide, and the killing or desertion of the aged were, and still are, commonplace in some societies. Indirect means, such as delayed marriage or taboos related to health or religion, have also been used. In addition, there have been attempts to prevent conception itself—including such magical formulae as anointing the navel with salve, spitting three times into the mouth of a frog, or eating bees. A relatively effective method, withdrawal, has also been used, though practise has varied from country to country and from class to class.

From ancient times, through trial and error, several increasingly efficient means have been developed, but these
were known only to the well-to-do, and were mainly for use by women. For example, Egyptian papyri, dated about 1850 B.C. and later, describe female methods, such as pessaries made from crocodile or elephant dung, or douching with a combination of honey and sodium carbonate. Tampons of roots or grass, lint or sponge soaked with tannic acid, gum arabic (a component of modern contraceptive jellies) or other solutions were also used.\(^5\)

Some societies used potions said to induce sterility, but information on this topic is scant. However, one study reports forty-two medicines to be taken by women, three to be taken by both men and women, and one to be taken by men only.\(^6\) By the mid-sixteenth century a male method, a prototype of the modern condom (a linen variety to protect the wearer against syphilis) had been added.\(^7\) The skin condom, from membranous animal tissue, also made its appearance about this time. Descriptions of the device are numerous in seventeenth and eighteenth century European literature - in the writings of James Boswell and Casanova, for example - but it was used more often to prevent venereal disease than conception.\(^8\) Industrialization also played a part. When Charles Goodyear developed his method of vulcanizing rubber in 1839, the rubber condom, and new rubber appliances - cervical caps and diaphragms for women became possible. In the meantime, in the late seventeenth century (c 1678) the Dutchman, Anthony van Leeuwenhoek, had discovered the nature of spermatazoa, and inspired a succession of studies to find a means of
immobilizing them. This led to the introduction of further female methods - vaginal suppositories and the modern jellies, creams and foams. In 1929 the "rhythm" method was added, and given qualified approval by the Roman Catholic Church. After World War II, the population explosion and its social, economic and political implications added urgency to research; and Western family planners inspired the discovery of the modern oral contraceptive, and the revival and improvement of the intra-uterine contraceptive device (IUCD, IUD or "loop"). Both male and female sterilization have also become popular, and attitudes to induced abortion are growing more liberal. For all their effectiveness, all these methods have disadvantages, and research into others, such as injectibles, implants and abortifacients (suitable for mass use) continues. There is little doubt that the need is urgent, and that a more acceptable solution will be found. But, for the purposes of this study, the evolution of modern fertility control techniques and their worldwide use is only of interest for its relation to the history of the birth control "cause" which has developed over the past 170 years. This movement was an attempt to increase the use of birth control methods in order to hasten various social reforms such as improved working class wages and status of women. In each country it had similar characteristics, but as far as is known, it all began in those of European stock. Except for "Dr." Marie Stopes (an advocate of birth control in the United Kingdom from the 1920s until her death
in 1958), the early leaders of the movement in that country, the United States, and in Western Europe, were freethinkers. Nearly all came from "middle class" backgrounds. Many had egalitarian political views; some were pacifists; and all were convinced, for one reason or another, that sex should be brought out from under its "cloak of sin and shame". A solution to poverty, equal rights for women, maternal and child health, and world peace were cumulative goals, and reached their peak, after World War II, in support of family planning as a tool of national and international development, and finally, as a means of conserving resources and the environment. Techniques of promotion were adapted to the concerns of the time and place. Many of the birth control volunteers in the West were also active in campaigns for compulsory education, free speech, freedom of the press, universal adult franchise, land reform, the abolition of child labor, and other social measures which are taken for granted today, but were radical ideas when introduced in the nineteenth and early twentieth centuries. Birth control required the longest battle (not yet completely won), and it was fought first in the United Kingdom and the United States of America.

In the beginning, opponents were scattered, but the family planners' own peers were among them. Some freethinkers would not support the idea. Some radicals, some Trade Unionists, and some Chartists opposed it, and, when the feminist movement developed in the mid-nineteenth century, even these militants were divided on the question. As the century
advanced, and the advocates of birth control became organized, opposition also began to crystallize. Hardin suggests that the following quotation probably represents a fairly common, if not conscious, expression of male attitudes to women, and hence, to birth control in 1880.

God made himself to be born of a woman to sanctify the virtue of endurance; loving submission is an attribute of a woman; men are logical, but women, lacking this quality, have an intricacy of thought. There are those who think women can be taught logic; this is a mistake. They can never by any power of education arrive at the same mental status as that enjoyed by men .... Wifehood is the crowning glory of a woman. In it she is bound for all time. To her husband she owes the duty of unqualified obedience. There is no crime which a man can commit which justifies his wife in leaving him or applying for that monstrous thing, divorce. It is her duty to subject herself to him always, and no crime that he can commit can justify her lack of obedience. If he be a bad or wicked man, she may gently remonstrate with him, but refuse him never.... I am the father of many children and there are those who have ventured to pity me. "Keep your pity for yourself," I have replied, "they never cost me a single pang."15

In addition to the attitude of many individuals, several mutually dependent interest groups obstructed the movement.
Figure 1. Changing birth rates.

State policy makers, both bureaucratic and elected, had a vested interest in population growth because of the conviction that it was synonymous with international political muscle. As long as defence, the waging of war and the occupation of conquered territories depended on large numbers of men, it was natural that governments should favor pro-natalist policies. But birthrates in Europe and the United States began to decline: in France from about 1800, and, in such countries as Britain, Denmark, Norway, Sweden and the United States, from the 1870s. By the 1930s the decline was so persistent that demographers began to warn that populations might begin to shrink. Fryer reports a fringe element who added to the general panic by claiming that contraception would undermine the British Empire, allow the yellow and black races to dominate, cause the degeneration of women and deprive the world of geniuses – an argument resurrected from time to time by the opponents of birth control, and, lately, by those who oppose induced abortion. Even though total population was increasing, laws against contraception were passed in some countries, and pro-natalist measures such as family allowances and tax benefits were introduced. Due to government propaganda in Germany and Italy the birthrates in those countries responded for a short time, but the long term slippage in Europe and in many countries of European stock (including Canada) has continued.

Another interest group to oppose birth control for many years was the business community, and in this it received
government support. Commercial enterprise supported pro-
natalist policies on the basis that "More babies mean more
business". This cult had its roots in nineteenth century
attitudes to labor and wages on both sides of the Atlantic.
A growing population would keep labor costs low and increase
the demand for goods. Whoever profited from cheap labor was
prepared to resist to the last ditch any promotion of birth
control information. 19 The twentieth century industrial
expansion did not differ in its tenets, even though the
"biological Cassandras" were warning as early as the 1930s
and 40s that overpopulation was at hand. As per capita in-
come in the literate world increased, the latter were accused
of attacking the "religion of progress", and no one took time
to notice what was happening elsewhere. 20

Since World War II the attitude has persisted. Nathan
Keyfitz, a Canadian born demographer teaching at the University
of California, Berkeley, has identified urban developers,
landowners, manufacturers, churches, and the advertising
media as the contemporary promoters of the fertility cult. 21
Now, in addition to the biologists and a "reformed" breed of
demographers, a number of ecologists, economists, sociolo-
gists, and other professionals in fields related to population,
have added their voices to his protest about unbridled popu-
lation increase and consumption. Robert S. McNamara, President
of the World Bank, also has spoken out against it, first in
1969. 22 Confidence in increased consumption is diminishing
because of the influence of less materialistic philosophies,
questions about the merits of technology, and the facts of environmental damage.

Questioning is now widespread in occidental religious circles also, but this did not begin to gain strength until the 1960s. However, religious opposition to birth control had its origins in ancient times. Fertility cults were normal in primitive societies, and apparently the major religions had to struggle against the influences of fertility gods and goddesses. This produced a clash between the need for survival and inclinations toward license. The strongest opposition to birth control had its origins in this conflict and asceticism became meritorious. Richard M. Fagley, a demographer, and author of a study on behalf of the World Council of Churches, explained that the Old Testament injunction, "Be Fruitful and Multiply" conjured up a picture of an abundant society.²³ Preservation of the family name was another factor encouraging fertility, and, if a man died without progeny, it was his brother's duty to marry the widow and beget children for this purpose. Onan would not conform, and used withdrawal to evade his obligation to impregnate Tamar.²⁴ A controversy has since raged (among Christians) over whether the Lord slew Onan for the act of withdrawal itself, or for refusing to perform his Levirate duty.²⁵ Although the obligation to perpetuate the race remained, contraception must have been permissible later in Jewish history for the Talmud, written between the second and sixth century A.D., recommended coitus interruptus, a vaginal sponge, or a drink said to induce sterility.²⁶ About
230 A.D. there was an argument over man's duty to ensure perpetuation of the race, so the onus was placed on women to use the sponge, if desired. The Jewish Encyclopaedia indicates that urbanization induced the adoption of a two-child family norm, a pattern still observed by many Jews in Europe, the United States and Canada. In the "Princeton Study", Family Growth in Metropolitan America, it was shown that Jews in the United States today are better contraceptors than Protestants and Roman Catholics. Though contraception was permitted at first in Christianity, Greco-Roman license, in which the worship of Venus figured, was a factor in a change of attitude.

To prevent moral breakdown, at the end of the fourth century A.D., St. Augustine held that every conjugal act was for the purpose of procreation. This teaching was reinforced in the thirteenth century by St. Thomas Aquinas in his great work, Summa Theologica. Almost every aspect of Aristotelian philosophy was adopted except the principle of birth control. St. Thomas held that birth control was against nature and, in an age of famine, disease and war, it was a logical ruling. Since that time Christians have debated whether Aquinas was condemning the common practise of abortion and infanticide, or whether he was ruling out contraceptive practices. In any event, his views have survived and, until after World War I, on the ground that small families were selfish and reduced industrial production, they were upheld by Protestant as well as Roman Catholic Churches.

One of the first of the Protestant Churches to waver
was the Church of England in 1930 and, by the 1960s, overt approval was extended by most of the others as well. Although approving the rhythm method in 1930, Roman Catholic prelates maintained a more or less united opposition to "artificial" means until the 1960s. It was suggested that birth control would cause grave physical disorders, fibroid tumors, sterility, infidelity, separation and divorce. A married woman who practised contraception was no better than a prostitute. Today Roman Catholic churchmen are not unanimous, and, not only are many Catholics practising artificial birth control, but disapproval has not been strong enough to prevent the introduction of modern birth control programs in some Catholic nations. Birth control has been introduced also to try to combat the unusually high induced abortion rates and "unconscious infanticide", a result of parental neglect. In Chile, for example, the illegal abortion rate is estimated to be one to two live births, and in Uruguay and Honduras, one to three, and one to four live births, respectively. Marxists, who were once rigidly opposed to birth control, in both "West" and "East", have lately been ambivalent about it. Some adherents claim that "surplus labor" is characteristic of capitalism and imperialist exploitation, and that the ideal state should be able to absorb increasing population through economic growth in both agriculture and industry. To them, a big population is a political asset. Nevertheless, a recent assessment of Marxist opinion shows that, in the USSR, at least, Marx, Engels, and Lenin are now considered to have
favored birth control when necessary, even in the "socialist" state. Government policies are said to be based on the concept that women must have the choice regarding maternity, and that contraception is preferable to abortion. Their labor in other activities is also needed. Birth control is recommended to-day for developing countries as an aid to economic growth and to raise the standard of living. In fact contraception is available in such Marxist countries as Bulgaria, China, Cuba, Czechoslovakia, Hungary, the USSR, and Yugoslavia. Induced abortion is available in some.  

Another group opposing birth control has been the medical profession. Idolized as healers, doctors of the nineteenth and twentieth centuries in the West used Hippocrates, of the fourth century B.C., as the guide to ethical practice, and took pride in the tradition of service established by such physicians as Soranos of Ephesus (second century gynaecologist), and Avicenna, the tenth century (Islamic) doctor whose teachings were influential in Europe during the Middle Ages and after.

... I will use treatment to help the sick according to my ability and judgement, but never with a view to injury and wrongdoing. I will keep pure and holy both my life and my art. In whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrongdoing and harm....

These leaders of the profession in their times took it for granted that birth control would be practised, and discussed various methods in their writings. However, after Summa Theologica, there was discreet silence among Western trained
doctors on such matters. With very few exceptions (in the 19th and 20th centuries), the silence was maintained for seven hundred years.

Until the 1960s little or no instruction was given in lectures or demonstrations in medical schools or colleges anywhere in the world, and no information on the sociological aspects of fertility, human sexuality or population dynamics was imparted. Fryer notes that medical men gave the following excuses for their lack of interest in the subject: birth control endangers virility, is conducive to adultery, destroys the "glamour" of marriage, is a danger to health, leads to lunacy, has a sterilizing effect, or is tantamount to masturbation. Another problem was frankly admitted at a gynaecological conference in Budapest in September, 1969, when the doctors agreed that difficulty also arose over traditional rivalry between practitioners of curative medicine and those whose specialty was preventive medicine.

The reluctance of the medical profession to take a lead in the promotion of birth control was summed up by Dr. Alan Guttmacher, President of the United States voluntary organization, Planned Parenthood—World Population, as follows: Dedication to the preservation of life at all costs, to "doing no harm", to a desire for popularity, to medical politics, to a reluctance to play God, and lastly, because of all bodily systems, the reproductive tract is unique in that "it is the only one which fascinates State and Church."

Hospitals followed the doctors' lead in refusing to give contraceptive care - in New York, for example, until
1958. Dr. Guttmacher attributed the recent softening of attitudes to the fact that, still hesitant in the matter of family planning, the World Health Organization had agreed to define health as a human right, and a state of "complete physical, mental and social well-being" and not merely the absence of disease or infirmity. 40

In 1959 in the United States, the American Public Health Association passed a resolution in favour of family planning. The American College of Obstetricians and Gynaecologists followed suit in 1963, and the American Medical Association itself did so in 1964 but, even to-day, few doctors will speak out as individuals in its favor. The liberalized attitude of the medical associations to abortion and sterilization in the United Kingdom, the United States and Canada is of additional interest but few doctors as individuals will speak out in these matters.

Not surprisingly, education and the law have tended also to reflect the opinions of the opposition. From the 1850s in the United Kingdom these interacting and mutually supporting interest groups translated their opposition into laws forbidding blasphemy, obscenity, and abortion, while, from the 1860s in the United States the proponents of birth control were prosecuted and jailed for "pornography". In the last quarter of the nineteenth century, the United States Federal Postal Regulations were amended to forbid the dissemination of information about contraception, and many States followed suit with similar legislation. Laws against birth
control were also passed in Europe, at different times. "Malthusian" Leagues, and, later, Family Planning Associations to promote the idea as a tool of social reform were formed in countries of European stock, but it was not until the 1950s that they or professionals in the field had much impact. Then their governments began to accept in theory that family planning was a needed public service, but were slow to act at home, and obstructed help for developing countries until the late 1960s.

In spite of the opposition, and perhaps unrelated to the activities of the Family Planning Associations, declining birthrates showed that contraception was being practised widely by the middle and upper income groups in Western countries by individual choice. What will happen to "Western" birthrates in future is now thought to depend on education, economic conditions, childbearing intentions, and the size of the reproductive age group. But most western governments are still reluctant to develop population policies and take positive action to influence knowledge, attitudes and practice, and the volunteers are still attempting to persuade them to do so, but to build it on individual choice.
FOOTNOTES - Introduction


4John Peel & Malcolm Potts, Textbook of Contraceptive Practice, Cambridge, 1969, pb., pp. 49-51; Clyde V. Kiser, ed. "Panel Discussion on the Comparative Acceptability of Different Methods of Contraception", Research in Family Planning, Princeton, 1962, pp. 380-81; Medical men used to disapprove of this method, but there is no evidence that it is harmful, and it is now accepted as fairly reliable for those skilful enough to use it. It has always been popular in Europe and the United States, and also among educated classes in Asia.

5Himes, op.cit., pp. 3,4; IPPF, op.cit., p. 2.


11Ibid., p. 129. The latter was first introduced by Grafenburg in Germany and Haire in Britain in the 1920s, but was condemned by the medical profession at that time.

12Marie Stopes was not a medical doctor. She held a PhD. in Botany from a German university.


Peter Fryer, op.cit., p. 294; Vancouver Sun, 5 July 1969, p. 6.


Genesis 38.

Himes, op.cit., pp. 69-70. By 330 B.C., Palestine was overpopulated, and, at the time of the Jewish migration, large families were no longer an asset. Polygamy was abandoned, and a two child family became acceptable.
According to Marie Stopes, the Roman Catholic church deliberately confused contraception with "Onanism"; and some opponents also interpreted "Onanism" as masturbation. Marie Stopes, *Contraception*, London, 1923, p. 69, fn.

Pagley, op.cit., p. 121.

Himes, op.cit., pp. 77-78.


Pagley, op.cit., pp. 95-96.


CHAPTER I

The Social Reformers: The United Kingdom

It has always needed a devoted band of pioneers to introduce the idea, to brave uninformed opposition, and to establish the first services. Timidity is too often the most prominent quality of politicians and civil servants, and the courage of volunteers has had to show them that they had no need to fear. The demand is latently present in every country from the ordinary people....

The story of birth control as a tool of social reform began in the last decade of the eighteenth century when Marquis de Condorcet, a French philosopher, wrote of the ideal state in which all passion would eventually dwindle away; and William Godwin, an English materialist, believing poverty was caused by social inequities, urged man to make greater use of his capacity for self-determination and reason. Such views aroused considerable controversy. Among those who attacked them was an Anglican clergyman, Reverend Thomas Malthus, who later became professor of political economy at the East India Company's training college, Haileybury. His Essays on The Principle of Population as It Affects the Future Improvement of Mankind sought to demonstrate that the achievement of the ideal state would always be obstructed by the tendency of population to press upon the means of subsistence. Between
1798 and 1826 Malthus revised his original essay five times, but his ideas remained the same. They may be summarized as follows: Population increases in a geometric ratio, whereas subsistence increases only in arithmetic ratio. Were population not subject to certain checks, it would expand beyond the means of subsistence. In fact, given a total population of one billion, it would multiply by 256 in 200 years, whereas subsistence would only multiply by $9^3$. The long term check is want of food, but short term checks are moral restraint (a degree of asceticism through sexual restraint outside marriage, and late marriage), vice (prostitution and other forms of self-gratification), and misery (war, famine and disease). In spite of these checks, population growth continues, and the poor are the chief victims. Malthus claimed that, instead of helping to relieve poverty, the Poor Laws (instituted in the seventeenth century and since amended) were aggravating it. Because the low income population was encouraged to increase in number, "provisions" per capita were reduced. Some of those who were not yet on social assistance would be forced to apply. Prices of provisions were rising, but the real price of labor was declining. There was a lack of frugality, and there was increased spending for useless purposes. The French Revolution had indeed improved the condition of the poor in that country by giving them a greater share of land and the benefits of production, but this had been accompanied by a diminished proportion of births, greater industry, greater self-reliance and an inclination to save.
If it be taught that all who are born have a right to support on the land, whatever be their number, and that there is no occasion to exercise any prudence in the affair of marriage so as to check this number, the temptations, according to all the known principles of human nature, will inevitably be yielded to, and more and more will gradually become dependent on parish assistance. There cannot therefore be a greater inconsistency and contradiction than that those who maintain these doctrines respecting the poor should still complain of the number of paupers. Such doctrines and a crowd of paupers are unavoidably united; and it is utterly beyond the power of any revolution or change of government to separate them....

Malthus stated also that the only solution was to raise the buying power of the poor by controlling prices and reducing the labor supply, thus bringing about a rise in wages. If the rich really wanted to see the condition of the poor improve, they must accept an end to cheap labor. A stationary population was desirable, for it would bring about a balance between supply and demand. Then, if growth were needed, incentives could be introduced. (This must have been the nineteenth century version of Zero Population Growth!)

By reducing the labor supply, Malthus meant reducing the rate of natural increase, and stated that this could only be brought about by moral restraint. He did not favor birth control by any other means.

When this restraint produces vice, the evils which follow are but too conspicuous. A promiscuous intercourse to such a degree as to prevent
the birth of children seems to lower, in the most marked manner, the dignity of human nature. It cannot be without its effect on men, and nothing can be more obvious than its tendency to degrade the female character, and to destroy all its most amiable and distinguishing characteristics ...

Malthus is being re-read to-day with growing interest. In the light of progress in food production, technology, and studies of the factors affecting human fertility, a number of people believe he was wrong. On the other hand, perhaps his theory has been proven true for developing countries already, and, if total resources are limited, for the rest of the world as well. His suggestion that poverty could be solved by self-help and limitation of fertility may have been both realistic and useful. It is being tried to-day in some places. Right or wrong, Malthus did postulate a relationship between population and food, and inspired continuing studies of population change and the development of the science of demography.

The essays made enemies in more than one camp. The Utopians were upset by the argument that their ideal was unattainable. Business interests resented Malthus's advocacy of higher wages for labor, and used his comment that there would always be proprietors and laborers to justify inaction to improve the lot of the latter. The Utilitarians, who agreed with many of his ideas in principle, saw no hope of helping the working class to reduce fertility through asceticism. It was from the Utilitarian group that the forerunners of the family planning movement arose, and, when they
formed organizations in the late nineteenth and early twentieth centuries, many of them were so audacious as to call themselves, "Malthusian" or "Neo-Malthusian Leagues". Nothing associated population growth with human misery so readily, as did the name of Malthus, but, considering his views on contraception, nothing was a bigger sham.

The proponents of Utilitarianism, Jeremy Bentham, James Mill and Joseph Townshend, argued that, if the lot of the working classes could be improved through a reduction in their numbers, they should have contraception. The first of the active supporters of the idea, and a close friend of Mill, was Francis Place, a self-educated tailor who had known poverty but was becoming successful in business and politics. Urging the needs of the working classes, and of women with physical weaknesses, Place wrote *Illustrations and Proofs of the Principle of Population*, in which he condemned Malthus's "moral restraint" as impractical. Handbills were distributed in 1822 in working class districts in London and the industrial north. They were addressed "to the married of both sexes" in both "genteel life" and "among the working people", and suggested that, by limiting the number of children, the workers would enjoy rising wages and have more time for recreation and the moral and religious instruction of their offspring. Through withdrawal and the sponge, workers could make early marriages, and prostitution and debauchery would be reduced. Place's opponents called his handbills "diabolical" and said they would have the opposite effect. But no action
was taken to silence him, and he had the support of other Utilitarians as well.¹¹ John Stuart Mill summed up the case for birth control in 1823,

By checking population, no pain is inflicted, no alarm excited, no security infringed. It cannot therefore, on any principles, be termed immoral; and ... if it tends to elevate the working people from poverty and ignorance to affluence and instruction, I am compelled to regard it as highly moral and virtuous.¹²

As an exponent of birth control, Place was followed by Richard Carlile, a freethinking publisher who, besides continuing the campaign for contraception for the poor, also fought a long battle for the freedom of the press. Together with medical articles on other topics, he published Every Woman's Book, a pamphlet which advocated the sponge, the condom and withdrawal. So far as is known, however, neither Place nor Carlile had any effect on the working class birth-rate; and overt interest in birth control waned after passage of the Reform Bill and the new Poor Law of 1834 (which placed social welfare payments under the supervision of the national government). It is doubtful also if contraception was used at that time to any great extent by any income group in Britain, but in one very high place there was personal concern. In 1841 the young Queen Victoria wrote to her uncle, the King of the Belgians,

I think, dearest Uncle, you cannot really wish me to be the "Mama d'une nombreuse famille", for I think you will see with me the great inconvenience a large family would be to us all, and particularly to
the country, independent of the hardship and inconvenience to myself; men never think, at least seldom think what a hard task it is for us, women to go through this very often.\textsuperscript{13}

Nevertheless the Queen became resigned to the "hard task" nine times in less than seventeen years.

In France, however, where intellectual radicalism and sophistication were already well established, withdrawal and the sponge were much in vogue. The birthrate had fallen from 38.5 per 1000 in 1771-75 to 31.3 in 1816 (and was to decline to 25.4 by 1871-1880). What William Ranger called "disguised infanticide" was also very common - babies turned over to ancient crones or foundling hospitals, pacified with gin and dying of neglect, or perishing in the care of peasant women in the countryside. More than one third of babies died in this way.\textsuperscript{14} From 1846 emigration from Western Europe also reduced the population growth rate. Agitation for birth control increased, abortion became commonplace, the age of marriage rose, and, in pursuit of higher social and economic status, family size shrank.\textsuperscript{15}
Figure 2: Birth and death rates for Denmark, Norway, and Sweden combined (black lines and dates) are compared with Japanese rates (gray lines and dates) of 50 years later. Japan has been passing through a population change similar to that which occurred earlier in Scandinavia. Area between respective birth-rate curves (solid lines) and death-rate curves (broken lines) shows natural increase, or population growth that would have occurred without migration. In past few years both Japanese rates have dropped extremely rapidly.

* Illustrates the difference between a spontaneous and an induced decline in population growth rates.

In the United Kingdom, in 1854, after a time lapse of twenty years, the efforts of Place and Carlile were revived when Dr. George Drysdale wrote, anonymously, a book called *Physical, Sexual and Natural Religion*. It was published by Edward Truelove, a freethinking follower of Robert Owen, Scottish social reformer and pioneer in the co-operative movement. Later editions were called *Elements of Social Science*, and, in the Place tradition, favoured contraception and sex education as a means of raising wage rates. Drysdale went further, however, in holding that mankind suffered from the interrelated evils of poverty, prostitution and celibacy, and insisted that birth control was the cure for all three. Marriage should not be considered the prerequisite for intercourse and, if women would take the responsibility for avoiding pregnancy, by using the sponge, men could have full enjoyment of "the venereal act". Drysdale also included frank discussion of all methods of birth regulation - from prolonged lactation to induced abortion - very doubtful to very certain. He wrote articles on Neo-Malthusianism (birth control) for Charles Bradlaugh's *National Reformer*, and, in the early 1860s, founded, with Bradlaugh, a short-lived Malthusian League to promote contraception. Whether or not Drysdale's free love philosophy was the cause, the British government passed the Obscene Publications Act in 1857. It was not long before another uproar over family limitation occurred.

In 1868, Lord Amberley, son of Lord John, and father of Bertrand Russell, at a meeting on over-population and public
health, organized by the London Dialectical Society, expressed the hope that birth control methods would improve. The clergy and society promoted over-population, he said, and he was sure that, if women had a say, they would not favor large families. He was attacked from many quarters, including the medical press, and the furore lasted for more than a year, giving the issue increased publicity. But, from the days of Place, the campaign was more or less desultory until a greater public row was raised by Bradlaugh himself.

Dedicated to promoting free public discussion of any issue, and, specifically, such causes as compulsory education, land reform, the separation of church and state, republicanism, and the abolition of hereditary peerages — as a freethinker, Bradlaugh also attacked conventional religion, and, in particular, the swearing of oaths on the Bible. After a long struggle he was elected to the House of Commons where he won considerable respect, though little approbation, for his radical views. When a Bristol bookseller and publisher was prosecuted and jailed for selling an illustrated edition (believed to have included drawings of the reproductive organs) of *Fruits of Philosophy*, a book on birth control by Dr. Charles Knowlton of the United States, Bradlaugh decided that this was another instance in which free discussion of an important subject had been obstructed. The principle of free speech must be pursued. Forming the Freethought Publishing Company with Mrs. Annie Besant (another social reformer and a feminist) he published the same pamphlet — this time
with notes by Dr. Drysdale. Next, Bradlaugh notified the police that he intended to sell it, and where. He and Mrs. Besant were charged with obscenity. Though the book's circulation since 1832 had averaged only a thousand copies a year, in the three months between their arrest in 1877 and their trial, 125,000 copies were sold. The two were convicted of publishing "an obscene libel calculated to destroy or corrupt the morals of the people" but their defense was summed up as follows:

No better book can be published, for doctors will not write, and publishers will not sell, a work which may bring them within the walls of a gaol. It was for the sake of free discussion that we published the assailed pamphlet, and to make the way possible for others dealing with the same topic, that we risked the penalty which has fallen upon us.... Once more a cause has triumphed by the fall of its defenders ... and has gained a hearing from the dock that it would never have won from the platform ....

... This battle will end, as every other such battle has ended, in the triumph of a Free Press ....

On a technicality, Bradlaugh and Mrs. Besant won an appeal, and at once published a new pamphlet, written by Mrs. Besant, *The Law of Population: Its Consequences and Its Bearing Upon Human Conduct and Morals*. In it she discussed the population problem in India and in Ireland, and the humanitarian reasons for making birth control knowledge available to all. She described various methods - rhythm, withdrawal, douche, baudruche (condom) and the sponge, and warned against reliance
on lactation. She favored abortion only if absolutely necessary and concluded,

Thus has the effort to obtain social reform gone hand in hand with that for political and religious freedom; the victors in the latter have been the soldiers in the former. Discussion on the population question is not yet safe; legal penalty threatens those who advocate the restriction of birth instead of the destruction of life; .... We work for the redemption of the poor, for the salvation of the wretched; the cause of the people is the sacredest of all causes, and is the one which is the most certain to triumph, however sharp may be the struggle for the victory.\textsuperscript{19}

This publication enjoyed phenomenal sales (200,000 copies in six years) even as far away as New South Wales; but no further legal action was taken to suppress it in the United Kingdom.\textsuperscript{20} Mrs. Besant and Bradlaugh were frequently attacked, however, for contributing to "sexual orgies and social degradation" because it was assumed that freethinkers who would approve Drysdale's theories of free love must be wholly depraved. But, they had praised Drysdale for his courage, not for his philosophy. Really significant was the fact that the distribution of birth control knowledge was now more or less unimpeded in the United Kingdom.

In 1877 or 1878 the Malthusian League was revived, with Dr. C.H. Drysdale, younger brother of the author of Elements, as president, and Annie Besant as secretary. The younger Drysdale's wife, Dr. Alice Vickery, first woman doctor, and Edward Truelove were among the members.
Dr. H.A. Allbutt, a dermatologist, freethinker and republican, joined in 1880. Like the Utilitarians, with whom some were affiliated, these "Malthusians" saw themselves as crusaders against poverty. House-to-house canvasses of working class areas were conducted, and a monthly journal issued. The Malthusian became very popular and attracted new members.

But, due to the influence of Mme Helena Petrovna Blavatsky, leader of the Theosophist movement, Mrs. Besant left Freethought and the Malthusian League. Instead of contraception, she adopted the view that the sexual instinct must be controlled, and that its indulgence should be restricted to the perpetuation of the race. In 1928, however, she attended a dinner held in London in honour of the fiftieth anniversary of the famous Bradlaugh-Besant trial, and indicated that she had amended her convictions once more. Now, she said, she felt she had been right to follow Madame Blavatsky's views, and that self control was essential; but birth control must be promoted for material reasons.

By this time opposition was beginning to crystallize, but the efforts of the interest groups to put an end to this threat were only partially successful. As has been noted, in the 1870s the British birthrate commenced a more or less steady decline which has continued to this day. The first to control their fertility were business and professional families. Methods were improving and withdrawal popular. From the 1870s, the middle classes also married later. It is possible, too, that the small family
and "lady" wife had become a status symbol and means of social upgrading. D.V. Glass suggests that working class couples who wished to upgrade themselves did not really accept birth control until it was obvious that it had been adopted by the higher income groups; but, once the style was set, they followed suit.

The interest groups continued their overt opposition, however, and, when, in 1887, Dr. Allbutt published The Wife's Handbook— which included hygiene, pre-natal and baby care,—the medical profession forbade him the right to practise. Apparently the General Medical Council was not only confusing contraception with obscenity, but also with abortion. The movement itself continued to be accused of immorality and atheism, but it found new support from another controversial body, the Eugenics Society for Racial Quality, founded in 1883 by Sir Francis Galton. The Fabian Society, a Socialist organization led by George Bernard Shaw, Sidney and Beatrice Webb and others, also supported it. By this time, the term, "Neo-Malthusian" had been coined. However, the declining birthrate took on a new aspect.

Alarmed by what they considered a threat of under-population, the Anglican bishops, at the Lambeth Conference of 1908, condemned contraception and castigated doctors who provided information or fitted patients with the Dutch cap, otherwise known as the Mensinga diaphragm, (It was invented in the 1870s by Dr. William Mensinga of Flensburg, and, by 1908, was a very popular method). But their warnings went
unheeded. Ironically enough, the British Census of 1911 showed that clergymen, doctors and teachers had the smallest families – three occupational groups overtly opposed to birth control, but, apparently, the most effective practitioners.32

In Britain, illegally induced abortion was prevalent, and, not only dangerous appliances, but dangerous abortifacients were being promoted by pharmacists, herbalists, barbers, and market traders.33 Misunderstanding and misinformation about the real nature and purpose of birth control had become so widespread that Dr. C.V. Drysdale, President of the Malthusian League, (son of Dr. C.R. Drysdale, an earlier president and nephew of Dr. George Drysdale, author of Elements of Social Science) decided in 1913 to hold public meetings to clear up some of the confusion. He also circulated leaflets, particularly in working class districts, which included information on contraception and also about infertility. Not long afterwards Marie Stopes, a second woman advocate of sex education and contraception appeared on the scene.

Her orientation, though in part social and eugenic, was mainly humanitarian and personal. Birth control was for her a means of freeing women from the bondage of numerous and unwanted pregnancies; hence her outlook was also feminist and libertarian.34

Mrs. Stopes, a botanist who had earned a PhD. in a German University, and whose uncomsummated marriage had been annulled in 1916, decided to publish a book on sex and marriage so that others could be helped to understand their own
problems. Publication was financed by H.V. Roe, one of the founders of Avro Aircraft, whom she later married. Though it gave few details about the subject, *Married Love* caused an international sensation. Her readers demanded more precise information, so Dr. Stopes obliged with *Wise Parenthood*, in which she described various methods of intercourse and birth control, indicating her partiality for the cervical cap. The latter publication was very controversial, and even supporters of birth control felt that it was too frank and too readily available to school boys and girls.

Believing that she had divine inspiration, in 1920, Dr. Stopes attempted to persuade the Lambeth Conference of that year to approve contraception. Her private letter to each of the bishops was studiously ignored. But the opposition lost ground when Lord Dawson of Penn, physician to King George V, electrified a lay congress in Birmingham the next year by supporting birth control. His stand was backed by Dean Inge ("The Gloomy Dean") of St. Paul's Cathedral. As there was new concern for maternal and child health, and feminism was growing stronger, both the clergy and doctors began to relent.

In 1921 Dr. Stopes and her husband opened the "first birth control clinic in the British Empire" in Islington, where a nurse fitted women with cervical caps (known also as "check" or "occlusive" pessaries). As the clinic was in a mobile van, it could also be called the "first mobile clinic" in the world. Acceptance was handicapped by the atheism of
most of her predecessors, and by the advocacy of free love by some of her rivals (Havelock Ellis and H.G. Wells, for example), so Mrs. Stopes organized the **Society for Constructive Birth Control and Racial Progress**, appealing for members on the grounds of social betterment, eugenic improvement of the race and as a preventive of war. In her Presidential Address to the Society, she stated that opposition had arisen because people associated birth control with the radicalism and free-thinking of Charles Bradlaugh and Annie Besant, but that her supporters were really not radical at all. In fact, their chief aim was to help space pregnancies, in the interests of the individual mother, and of the race. Dutiful Christians could now discuss it, for the facts were innocent enough. In her book, *Contraception* Mrs. Stopes also accused the Roman Catholics of deliberately confusing "Onanism" with birth control.\(^{35}\)

A few months after her Islington clinic was opened, the Malthusian League started a clinic at Walworth, using the Dutch cap (diaphragm) – evidence of disagreement between the two over whether the cervical cap was superior to the Dutch cap, and, also, whether lay personnel should be allowed to fit these devices. There was also argument over which type of chemical contraceptive should be used.\(^{36}\) To encourage services which would be staffed by medical practitioners, in 1924 the Malthusian League organized the **Society for the Provision of Birth Control Clinics**. As they were able to overcome patient shyness more readily than men, women doctors
were in great demand, and training courses for both were set up by Dr. Norman Haire. As numerous unreliable methods of contraception were still being sold, and, as there was lack of scientific knowledge about the subject, the Society also supported in 1927 the organization of the Birth Control Investigation Committee, the membership of which added greatly to the prestige of the movement. It became a joint Anglo-American endeavor involving also the United States National Committee on Maternal Health; and, because of the Comstock Law (see page 47) the work was done in Britain. Outgrowths of the Birth Control Investigation Committee were the Population Investigation Committee in the United Kingdom and the Population Council in the United States.

In 1927 the Malthusian League decided to dissolve, paving the way for the formation, in 1930, of the National Birth Control Council. Sir Thomas Horder, physician-in-ordinary to H.R.H., the Prince of Wales, presided, and other members included F.R. Browne, Professor of Obstetric Medicine, London University; J. Maynard Keynes; Professor Harold Laski; Bertrand Russell; H.G. Wells; C.V. Drysdale and Marie Stopes. (Although she proposed the resolution which brought the organization into being, she resigned in 1933). In response to the needs of the unemployed, and the pressure of socialist writers and thinkers, in July, 1930, the Ministry of Health issued a memorandum authorizing birth control services for purely medical reasons (the only government concession to family planning until 1967 when the Family Planning Act was passed).
The members of the Council were disappointed when Local Health Authorities did not take up the challenge. The following year the name of the Council was changed to National Birth Control Association, and, in 1938, the Birth Control Investigation Committee, the Workers' Birth Control Group, the Society for the Provision of Birth Control Clinics, and the Birth Control Information Centre (see p. 82) amalgamated to form the Family Planning Association. This organization came into official existence in May, 1939, and was loaned premises by the Eugenics Society.

Opposition to all this activity centred mainly in the League of National Life, organized by Roman and Anglo-Catholics, with a few other religious elements. Numerous reasons for opposing contraception were advanced. Cysts and tumors would result, not to mention "Malthusian Uterus" - an ailment of dire proportions on the inside, it was said, which produced "an anxious, drawn expression" on the outside. Birthrates were low, in any case, and there were accusations that the family planners were encouraging race suicide.

At Marie Stopes's suggestion, the family planners decided it would be wise to incorporate into their program marriage guidance and pre-marital counselling, the diagnosis and treatment of infertility as well as counselling in eugenics. The goal of maternal and child welfare could embrace this service. In addition, "family planning" was adopted as a comprehensive term which would be less controversial and more descriptive than "birth control".
support for voluntary sterilization was also developing in the 1930s, but as was previously noted, experiments in Germany during World War II made the idea unpopular for some years afterward.

Even for ordinary birth control services, a problem arose for the Family Planning Association because so few doctors knew anything about contraception. It was necessary for them to refer patients to the voluntary clinics, and, in cases where patients visited the clinics without referral, the clinic doctors were forced to break a rule of medical ethics – that no-one would treat another doctor's patient except in an emergency, or when he requested such action. The problem was particularly difficult for women doctors who were in practice on sufferance in any case. Inasmuch as the local British Medical Association branch usually disapproved of family planning, all doctors who worked for the voluntary clinics placed themselves in jeopardy. If, as sometimes happened, lay committees set clinic policies without consultation with their doctors, further complications arose.

The British government would not concede the necessity to include family planning services as a routine in ordinary maternal and child health units, but did agree to assist Local Health Authorities, and the Family Planning Association grew rapidly, using the premises of the latter. The Local Health Authorities also provided some financial help. By 1967, when the government accepted more responsibility, the FPA was operating more than 900 clinics, over 90 percent
housed in Local Health Authority, Maternal and Child Health Centres, or hospital premises. Apart from medical officers and nurses, the clinics are still run mainly by volunteers who serve as receptionists, interviewers and supply clerks.

The Local Health Authorities are now allowed to set up family planning services themselves, but, because some of the members of the old interest groups in opposition are still influential in some cases, the government does not push them. The majority of L.H.A.s still prefer to leave it to the FPA, and provide financial support. In addition to making services available to married couples, the FPA now accepts single women and, besides conventional methods of contraception, accepts the usefulness of abortion as a back-up for accident or ignorance.

The Family Planning Association continues to train medical and paramedical personnel. Increased government services via area health authorities are being considered, but action is unlikely for several years.

In summary, leadership in the family planning movement in the United Kingdom came from the educated classes. Motives were numerous and varied, but all were directed to social reform of one sort or another. Opposition crystallized in the political, commercial, religious and medical arenas, but acceptance by the general public was growing as the needs of the society changed. The volunteers hastened this process through their public promotion, but, to the end of 1969, political support was still hesitant. The Family Planning Association was very helpful in the early financing of the International
Planned Parenthood Federation, but, before considering the origin and development of that organization, it is necessary to look at the parallel development of the movement, also as a means of social reform, in the United States of America.
FOOTNOTES - Chapter I


3. Ibid., "The Malthusian Controversy", p. 15. (Malthus's mathematics have since been questioned.)


5. Ibid., Chapter II, p. 25.


8. Ibid., Vol. III, Chapter IV, pp. 115-117.


10. John Peel & Malcolm Potts, Textbook of Contraceptive Practice, Cambridge, 1969, p. 2. Place was later active in the fight to repeal the Combination Laws, and for the Reform Bill of 1832.

11. Himes, op.cit., pp. 213-17; Fryer, op.cit., p. 82.


28. Peel and Potts, op.cit., pp. 74, 76.


31. Ibid., p. 211.
Among its members were Lord Brain, Sir Alexander Carr-Saunders, and Sir Julian Huxley. There was one holder of the Order of Merit, two Nobel Prize winners, two Presidents of the Royal Society, one President of the Royal College of Physicians, two Regius Professors of Medicine, two Oxford and Cambridge college heads, and four other Fellows of the Royal Society. Margaret Pyke, "Family Planning, An Assessment," *The Eugenics Review*, July, 1963, p. 6.


45 Margaret Pyke, op.cit., p. 8.


48 George Cadbury, Interview, Oakville, Ontario, 7.12.69.
CHAPTER II

The Social Reformers: The United States of America

In the United States the birth control movement was started by Robert Dale Owen, son of the Scottish reformer already mentioned. An admirer of Bentham and Place, the younger Owen had emigrated from Britain in 1825. He had acquired a copy of Every Woman's Book and was urged to have it published in the new country. In spite of his refusal a prospectus was issued. But he maintained his decision until someone circulated anonymous suggestions about his morality. Owen then felt obliged to make his position clear. In 1831 he published his own 72-page booklet, Moral Physiology: or a Brief and Plain Treatise on the Population Question. In it he gave social and eugenic arguments for family limitation and, describing the physiology of reproduction as he understood it, gave details regarding withdrawal, the condom and the sponge. The book, which was also printed and sold in the United Kingdom, earned the praise of ex-President James Madison and others. Owen did not make promotion of contraception a lifetime avocation however. From 1836 he entered politics, promoting education, emancipation, and spiritualism. He also helped to found the Smithsonian Institution in Washington, D.C. Nevertheless, his Moral Physiology was
the basis on which Dr. Charles Knowlton could build.

Knowlton, the first of the medical profession in the United States to promote birth control, in 1832 or 1833 published for his own patients, *Fruits of Philosophy*,

... showing how desirable it is, both in a political and a social point of view, for mankind to be able to limit, at will, the number of their offspring, without sacrificing the pleasure that attends the gratification of the reproductive instinct.

Knowlton noted that Malthus had suggested no solution but celibacy, and that the absence of birth control encouraged prostitution and intemperance. Early marriages were impossible. Human nature would not change, and, without birth control, the mind would become unsettled and judgment waiver. All men had a right to the knowledge. He discussed various methods, discarding withdrawal as unsatisfactory, and condoms because they were related to the prevention of venereal disease. His version of the rhythm method was incorrect, and recommendations of douching were later proven unreliable, but Knowlton did advocate the sponge.

He had been prosecuted and jailed already in the Massachusetts courts when a student (for illegal dissection, and for peddling a book on materialism) and was now punished for the booklet on birth control. Since his medical colleagues would give him no support, he decided not to pursue the topic. *Fruits of Philosophy* was reprinted in Britain, and enjoyed some popularity among working class radicals and freethinkers, and it was destined to become internationally
known as the focus of the Bradlaugh-Besant trial already referred to in Chapter VII. In the meantime, another flurry of excitement arose in the State of New York. ³

In 1847 John Noyes founded the controversial Oneida Community, which flourished near Syracuse for about thirty years. It was a religious "Perfectionist" and communal society which practised complex marriage and mating for eugenic reasons. As an unorthodox interpreter of the Bible and opponent of marriage as a sacrament, and as an advocate of coitus reservatus and the sexual rights of women, Noyes was fiercely criticized. His organization eventually broke up, and is remembered to-day mainly for its business activities — carried on from 1881 — as a steel trap and silverware manufacturing company — "Oneida" and "Community" being well-known trade names. ⁴

The circulation of pornography was increasing in New York State and, in 1868, after a campaign led by the YMCA, the General Assembly made distribution of such material an offense. Contraception was also forbidden as another form of obscenity. Other States followed suit, and, in 1873, the Federal Postal Law was amended to forbid the use of the mails for obscene material, including information about birth control or contraceptive supplies. This effectively blocked action in favor of contraception by all but the bravest of social reformers. ⁶

Chief enforcer was Anthony Comstock, a drygoods salesman who is said to have had a guilt complex about his youthful sexual aberrations. He also founded the New York Society for the Suppression of Vice in 1873. Believing himself inspired
by God and a love of children, Comstock held the unshakeable conviction that "infidelity (i.e. atheism) and obscenity shared the same bed...." Dealers in contraception were "abortionists", and for them he had no pity. Dancing, theatre, art and press sensationalism were equally reprehensible.

With the support of Theodore Roosevelt and the YMCA, Comstock was appointed a special inspector of the post office, and commenced his crusade. Through posing as one seeking information for his ailing wife, or through hired decoys or false mailing addresses, Comstock assembled evidence - abortificients, contraceptives and obscene publications - and was responsible for the arrest of more than 3,600 persons, the majority of whom were convicted and not only fined (up to $5,000), but jailed as well. In order to maintain support, Comstock frequently invited select audiences to view choice items of pornography before they were destroyed. So influential was he that few of the medical profession would stand against him. In fact, supporting the Comstock view, some of the medical journals even justified their position by explaining that, if the birthrate were to decline, medical incomes might also decline! Comstock also wrote Traps for the Young in which he described how he had located these items, and his experiences in bringing the offenders to trial. All social ills were due to "evil reading", he said.

The first United States citizen to run foul of the new law (soon to be known as the Comstock Law) was Dr. Edward Bliss Foote, whose pamphlet, Words in Pearl ("Pearl" - a
printer's typesize) sold more than 250,000 copies before it was suppressed in 1876. Dr. Foote advocated contraception for the chronically ill, or physically or mentally handicapped, for family welfare, and to reduce disease.\[12\]

In brief, I would, if possible, so fix things that none but the healthy people should procreate at all, and that wives should procreate only at will.\[13\]

A few other proponents of the social and eugenic benefits of birth control were also effectively silenced by the Comstock Law and its circumvention was a long, slow process, which lasted about forty years.

The first favorable opinion to appear in any medical journal in the world was printed in the Michigan Medical News in 1882. Here O.E. Herrick maintained that contraception was a woman's right, and also the only reasonable alternative to the widespread scourge of abortion. On the grounds of family welfare and marital harmony, and as an antidote to poverty and delinquency, he received some medical support. Those who agreed with him observed that birth control was essential to compensate for the men who would not refrain from intercourse even when their wives' health was at stake. Among the opposition were some who averred that it was a woman's "religious" duty to allow a man his "rights".\[14\] Around the turn of the century Dr. William J. Robinson, who edited several medical periodicals, wrote many articles featuring contraception. In 1905 he also published a leaflet on the subject for physicians. Based on the needs of the poor and of eugenics, Dr. Robinson
also persuaded Dr. Abraham Jacobi to include support for birth control in his Presidential Address to the American Medical Association in 1912. But the AMA was not ready to pass a resolution to this effect for more than fifty years.

About this time, however, the cause was taken up by Margaret Sanger - perhaps the most energetic and fearless of all the birth control pioneers. Though her decisions were sometimes unpredictable, and her personal relationships sometimes unhappy, her determination on this subject was such that she is recognized as the founder of the birth control movement in the United States, and also of the International Planned Parenthood Federation. No obstacles were too great, no criticism too harsh, and no jail too forbidding (she was jailed eight times) to shake her decision to make it acceptable as a health service. Using an ability to find staunch supporters among wealthy philanthropists, and considerable skill in gaining the maximum news mileage from every situation, she worked single-mindedly for birth control until she was over eighty. She died in 1966, at the age of eighty-seven, having lived to see the 50th Anniversary of the Planned Parenthood movement in the United States, and its acceptance as a government responsibility in many countries. Because the tactics of the Women's Liberation and other radical movements to-day are similar, and because other countries sometimes borrowed her ideas, special attention will be given to her story.

Margaret Higgins Sanger was the sixth of eleven
children, and raised in Corning, New York. The family was always in straitened circumstances because her father, a stonecutter, besides being a socialist was also a vocal freethinker. In consequence, little employment came his way. Her mother died in her forties from tuberculosis, exacerbated, Margaret maintained, by too much childbearing. As a Public Health Nurse, she had first hand experience with New York slum conditions, and with the ignorance of the women—about their own bodies, about reproduction and about venereal disease. Politically she became a supporter of the anarchist, Emma Goldman, and was a friend of Bill Haywood, a leader in the Industrial Workers of the World ("The Wobblies"). Emma was also an advocate of birth control, and Margaret, too, saw it as a weapon in the struggle to gain revolutionary muscle for the working classes against the "capitalist exploiters".15

After ten years of domesticity as the wife of William Sanger, an architect cum painter, she returned to nursing in 1912. Though they now had two sons and a daughter, and Sanger shared her radical political views, Margaret was chafing against household responsibilities and longing for a more active part in the class struggle she believed was coming. A new influence on her thinking was provided by the works of Havelock Ellis, a world famous sexual psychologist who believed that more honesty about human sexuality should be a part of personal relationships and that women should have the same sexual freedom and satisfaction as men. In addition, with depressing regularity she saw mothers of large families in
the slums die of self-induced abortion or $5.00 visits to neighborhood quacks. Doctors would not risk giving them information about contraception, and Mrs. Sanger began to see herself as the leader of a campaign for all these goals.

She identified the death of one Sadie Sachs from illegally induced abortion as the event which triggered her decision to campaign for birth control for all who wanted it. Though information on methods existed in several nearby library sources, and many Americans were already practising birth control, Mrs. Sanger claimed that she had to visit France to get it from the revolutionary labor movement there. It may be that American doctors would not help her, or that, as David Kennedy suggests, the family trip to France for a year in 1913 was arranged by her husband in a last ditch attempt to hold her affection and interest. But, whatever the reason, after a few months in Paris, Margaret and the children returned to New York ahead of him. From that time on they lived separate lives.16

Back in the United States, she devoted much time to editing Woman Rebel, an eight page periodical which was dedicated to radical politics and the advocacy of birth control. Because it did not describe contraception methods, it only challenged the law forbidding obscenity. After several issues, Mrs. Sanger was charged with violations, but no information was given as to how the law had been broken. After arranging with her husband for the care of the children, she adopted an assumed name and fled the country. A variety of
reasons have been given, none of which is very clear, but it appears that she felt she had to have time to marshal more support. (She had also written and published 100,000 copies of a pamphlet on methods, which did break the law, but Family Limitation was not yet distributed.)

Margaret sailed from Montreal for England and, while at sea, sent a message instructing her supporters to release the pamphlet. Circulation was obtained through trade unions and other sympathetic organizations, and it was enthusiastically received in working class districts.

On arrival in England she met the C.V. Drysdales, leaders of the Neo-Malthusian League. They applauded her efforts to challenge the Comstock Law, told her the history of birth control and the law in their country, arranged for her to do research on the subject at the British Museum, and introduced her to Havelock Ellis. Of considerable significance is the fact that the Malthusians and Ellis urged her to drop her exaggerated stances against capitalism, religion and marriage, and to concentrate on one issue only - the provision of birth control information and services. Another significant influence arose from a visit to The Hague, where Dr. Johannes Rutgers, who had pioneered contraception in his country, urged her to work for medical support, and to promote the use of the Mensinga diaphragm. She followed this advice, by and large, but was never able to overcome her old resentments entirely or to allow others to lead her movement.

Early in 1915, William Sanger was arrested by one of
Comstock's spies for giving him a copy of *Family Limitation*. Rather than pay a fine, Sanger elected to stick by the principle that the leaflet was not obscene, and chose to serve a thirty-day jail sentence instead. This left the children without adequate supervision, so Margaret had to hurry home. On arrival she found birth control under public discussion in the press, and a group of influential women ready to help her campaign.

The nuclear family, with its right to independence was an established characteristic of urban living; interest in eugenics was growing; and, in spite of warnings of population declines and race suicide, many of the middle and upper income groups were practising birth control. The emancipation of women, including a single standard, was much discussed. As Ellis had also convinced her that, besides being a protection for women, birth control was also a key to race betterment and adjustment of population to world resources, she took up the cause with renewed energy.

At the same time, she was informed that, if she would promise to obey the law in future, the charges against her over *Woman Rebel* would be greatly reduced. Mrs. Sanger refused, and braced herself for the trial. Her hopes of more publicity for her cause were disappointed, however, for the charges were suddenly dropped in February, 1916. Some said the authorities did not want to make a martyr of her. Whatever the reason, she was then forced to find a new means of challenging the law.

In 1916 she organized a birth control clinic in Browns-
ville, a Brooklyn slum. It was instantly popular; a legal charge under Section 1142 of the New York State Penal Code was speedily laid; and Mrs. Sanger and her sister, Ethel Byrne, were arrested. Ethel was tried first, convicted and given a 30-day sentence. She achieved world fame by going on a hunger strike – a familiar feminist technique. Force-feeding lent drama to the situation and Margaret, out on bail, issued daily bulletins on her condition. Finally Ethel's health was so endangered that Margaret guaranteed to the Governor that Ethel would take no further part in the movement while her case was being appealed, and Ethel was released. Margaret's own case followed. She was offered a light sentence if she would obey the law, but refused, stating that she could not obey a law for which she had no respect. Her 30-day sojourn in jail provided her with an opportunity to criticize conditions on the inside, and, before she was released, she refused to be fingerprinted on the ground that she was not a criminal.

It was decided to appeal her conviction, but the case was lost. In handing down his decision however, the judge re-defined Section 1145 so that, having provided for doctors to give contraceptive information "for the cure and prevention of disease" to men (treatment against venereal disease), he broadened "disease" to mean any sickness or disorder – which meant that birth control advice could be given to married women to protect their health. Birth control clinics could now be established legally so long as they were run by doctors.
This ruling did not allow birth control for any and all purposes, and there was argument over whether all restrictions should be abolished, or whether birth control should be made available only by a doctor. Quackery would be possible if all restrictions were removed, so Mrs. Sanger favored "doctors only". Support from the doctors themselves was the next challenge.

Dr. Robert Latou Dickinson, a leading gynaecologist and head of the National Committee on Maternal Welfare, wanted to see his colleagues involved in birth control to prevent damage to patients' health from visits to quacks. But other doctors feared that quacks might function just the same, and were reluctant to be involved in a field in which such a conflict could occur. Many of those who favored birth control disliked Mrs. Sanger's tactics and hesitated to be associated with her sensationalism. Others argued against birth control for non-medical - i.e. eugenic or socio-economic reasons. Most doctors were poorly informed in any case, and lack of a simple, effective birth control method also obstructed their co-operation.

To begin to answer their needs in a scientific way, Mrs. Sanger organized a Clinical Research Bureau in New York and hired a woman doctor to open it in January, 1923. Dr. Dickinson had run a hospital-based referral service, but medical ethics had prevented publicity, and the Sanger project, under no such restraints, was much more successful. Its findings were not eligible for publication in reputable medical journals, however, so it was obvious that there was
a need for mutual support.

Dr. Dickinson tried to arrange for a medical research council to take over the Bureau, but his colleagues hesitated because of Mrs. Sanger's connection with it, and Mrs. Sanger refused to give up her predominant position. In this she was supported by her non-medical board members - noted biologists, sociologists and the like, and the conflict was insoluble.

At least part of the responsibility for the tragedy of continuing medical ignorance of contraception had to be laid to Margaret Sanger. Had she relinquished control of the clinic to Dickinson in 1925, she would have facilitated research, opened up the best medical journals for the publications of test results, and made the clinic much more effective as a training centre for physicians interested in contraception .... Millions of women, finding no help with regard to contraception from orthodox medicine, turned to the quacks. And as in the nineteenth century, the absence of clear legal regulations exacerbated the situation.20

The impasse continued, although by 1930 there were fifty-five clinics in twenty-three cities. When Mrs. Sanger finally detached the Bureau from the American Birth Control League and left that organization herself the same year, also 1930, Dr. Dickinson joined the Board of the Bureau.

At the same time Margaret decided to organize a repeal of the Comstock Law and to replace it with a bill to allow doctors, hospitals or druggists free use of the mails. A monster lobbying campaign was set in motion in Washington, and, by 1931, she was testifying that birth control would lower infant and maternal mortality rates and improve family
welfare. She also noted its eugenic value and relevance to world population problems. There was considerable Catholic opposition on the ground that birth control would encourage immorality and weaken family relationships. A declining population would be another consequence, and agriculture, business and industry would suffer. An executive of the Metropolitan Life Insurance Company supported the Catholic claim. Mrs. Sanger replied that birth control would ease poverty and unemployment and reduce taxes. Without it, the lower income groups would continue to multiply, whereas middle and upper income levels would shrink, causing an imbalance in the age structure. In the end, in spite of her campaign, no amendment to the law was passed. It was being circumvented in any case by a wider interpretation of the law, so the matter was no longer urgent.

The only remaining obstacle for doctors was the rule which prevented importation of contraceptives. It was in 1936 that the Second Federal Circuit Court (New York, Connecticut and Vermont) decided that importation of contraceptives was permissible. Increased legal latitude and a broader definition of health as well as Mrs. Sanger's persistence, brought American Medical Association approval of birth control for other than pathological reasons in 1937.

In the meantime, during the twenty years since Brownsville, Margaret Sanger had promoted the feminist side of her case by writing two books, *Woman and the New Race*, and *The Pivot of Civilization*, in which she urged women to assert their right to voluntary motherhood, pleaded for population "quality -
not quantity", and for spacing or limiting pregnancies to prevent the arrival of unwanted children. Marxism, trade unions and the Roman Catholic Church were attacked for their opposition.22

During this period also, Mrs. Sanger formed a new group, the American Birth Control League in 1921, severing her connection with the conservative National Birth Control League. To honor the new organization, she scheduled a public meeting in New York's Town Hall to discuss Birth Control: Is It Moral? Two thousand people crowded into the hall to hear it, but when Margaret arrived with the guest speaker, the police were barring the door. It is said their presence was inspired by Archbishop (later Cardinal) Patrick J. Hayes. An eager press printed a continuing debate between Mrs. Sanger and His Grace, which was more noted for its heat than its reason. But Margaret managed to turn the publicity to the advantage of her cause—as she was also able to do on many other similar occasions.23 Funds to continue the campaign were always a problem, however.

After a quiet divorce from William Sanger in 1920, Margaret acquired an ardent admirer in J. Noah Slee, President of the Three-in-One Oil Company. He followed her wherever she went, seeking to marry her. After numerous refusals, she finally agreed to marry him, provided they could live independent lives and she would be allowed to pursue her birth control campaign under her own name and without interference. From Slee she got funds for the Birth Control League, and also for the Clinical Research Bureau. He also supported the National
Committee on Federal Legislation for Birth Control, and contributed to international conferences. When she fell out with the League (again, over Presidential prerogatives) Slee withdrew his League support as well, giving her considerable financial leverage to maintain her leadership.

When the National Committee dissolved there was a move to co-ordinate the work of the ABCL and the Clinical Research Bureau and, in late 1937, the Birth Control Council of America was the result. A year later it was suggested that the President should be a man, and the Council was replaced by the Birth Control Federation of America, headed by Dr. Richard N. Pierson. "A few years later, (1942) over Mrs. Sanger's loud protests, the name was changed to Planned Parenthood Federation of America, and others took over the reins. This coincided with Mr. Slee's serious illness and Mrs. Sanger's departure for Arizona to nurse him. She retained control of the Clinical Research Bureau, however, until 1960, and she had two more major contributions to make to the movement in the United States. From 1938 Mrs. Sanger and her supporters had pressed increasingly hard for birth control facilities in the US government health services. It was not until her friendship with Eleanor Roosevelt led the latter to intervene, and White House Conferences were called, that the logjam of hesitation was broken. In 1942 the US Public Health Service (USPHS) was able to begin to offer, both through its venereal disease control program and maternal and child health service, the
necessary information and supplies. Her second contribution was to arrange some of the initial financing for research into hormonal methods of birth control. She had always wanted a simple, reliable method, the use of which would not be related to the time of intercourse, and which would not require any particular privacy. In 1952 she secured a large donation for Dr. Gregory Pincus to start the research which culminated in "The Pill", a combination of progesterone as a suppressant of ovulation and estrogen (used by Dr. John Rock in the treatment of sub-fertility).

After World War II, the pressures for birth control on a large scale, both within the United States and in developing countries brought a considerable change in public attitudes in its favor. Restrictive laws began to be repealed and, by 1970, Planned Parenthood was operating 620 clinics in 350 cities in 40 states, and the District of Columbia, and had served more than 500,000 women. Its budget was $30 million, and 57 percent of its patients had incomes of less than $75.00 a week. After a slow start, public agencies were also serving an additional 200,000, but an estimated 5.3 million low income women in the United States would use the service if it were provided. As an illustration of the change in public attitudes, in the 1960s Presidents Kennedy, Johnson and Nixon, in varying degrees, supported family planning, and they were eventually joined by former Presidents Eisenhower and Truman as members of a sponsors' council of Planned Parenthood.

In summary, as in the United Kingdom, leadership in
the family planning movement in the United States came from the educated classes. Motives varied, but social reform was the ultimate goal. Opposition came from the same interest groups - political, commercial, religious and medical - but many members of the general public were already practising birth control. Death control and industrialization had created the climate, the volunteers speeded its wider acceptance but, in the United States, too, at the end of 1969, government support was not yet effective. Similar developments were occurring in continental Europe and East Asia.
FOOTNOTES - Chapter II


3 Himes, op.cit., p. 233.

4 Bible Communism: A Compilation from the Annual Reports of the Oneida Association and its Branches, Brooklyn, 1850, pp. 5-38. Coitus reservatus - a technique in which no ejaculation takes place, and detumescence takes place slowly, over a prolonged period.

5 Fryer, op.cit., p. 154.


7 Ibid., pp. vii, viii, 22; Also Fryer, op.cit., p. 213.

8 Anthony Comstock, op.cit., p. 137; Also Fryer, op.cit., p. 131.

9 Anthony Comstock, op.cit., p. xii.

10 Himes, op.cit., p. 286.

11 Comstock, op.cit., p. xxiii.

12 Fryer, op.cit., pp. 130-32.

13 Himes, op.cit., p. 279.

14 Ibid., pp. 286-87.


16 Ibid., pp. 4-35.

17 Ibid., p. 32.

19 Kennedy, op.cit., pp. 87-8.
20 Ibid., pp. 211-12.
21 Ibid., p. 233.
Renamed the Margaret Sanger Research Bureau, it is being amalgamated with Columbia University's International Institute for the Study of Human Reproduction, and will add to its education for marriage and clinic services, surgical sterilization and research in sterilization.
CHAPTER III

Some Developments in Europe and East Asia

On the European continent Malthusian Leagues were forming — in the Netherlands, 1881; in France, in 1885 (though it was not active until 1898); Bohemia, 1901; Spain, 1904; Belgium, 1906; Switzerland, 1908; Sweden, 1911; and Italy, 1913; but they were not very vigorous and, with two exceptions, little progress was made.

The most successful among them was the Dutch Nieuw Malthusiaanschen Bond (NMB), founded to promote the spacing of pregnancies for better maternal and infant health. One of the leaders, Dr. Aletta Jacobs, saw contraception as a weapon in the struggle for women's rights, and in 1890 opened the first birth control clinic in Europe in Amsterdam. In her search for the best method, she came to prefer the Mensinga diaphragm, and its use in the NMB became so widespread that it was dubbed the "Dutch cap". By 1892 four free clinics were operating. Another member of the NMB was Dr. Johannes Rutgers, of The Hague, who opened other clinics and trained midwives and working class women to fit the devices. His policy led to a split between the medical and non-medical workers in the movement, and Dr. Jacobs resigned in disillusionment. (By the time Mrs. Sanger visited
Dr. Rutgers he must have changed his mind, for it has been noted that he recommended against using non-medical personnel to fit diaphragms.

Around the turn of the century, right wing clerical parties in the Netherlands became influential enough to obstruct the organization, and it was not until the 1930s that it revived and the policy breach was healed. The prestige of the NMB was considerably enhanced when Queen Wilhelmina presented it with a medal of honour and a charter, and praised the organization as a public benefaction. It now operates fifty family planning centres in the Netherlands, and the Dutch government has recently given financial support to the International Planned Parenthood Federation.

Another Western European country in which the birth control movement is well advanced is Sweden. As in other related fields, Swedish policy is often incorrectly reported and misunderstood. Although the Malthusian League was formed in 1911, progress was non-existent until 1933 when Mrs. Elise Ottesen-Jensen organized the Swedish National Union for Sexual Information. Advocating sex information in the schools and universities, she was supported by labor and adult education groups. Training was arranged for teachers, youth leaders and doctors, and Mrs. Ottesen-Jensen herself gave many of the lectures.

Among opponents were members of the Lutheran Church. Another negative influence was a book by Alva and Gunnar Myrdal, *Population Crisis*, in which attention was drawn to
the decline of the Swedish birthrate. Pro-natalist policies, including glorification of the family and social responsibility, and tax and other incentives were offered by the government. Family Planning, which had been available through maternal and child health centres, was forbidden. The birthrate continued to decline, however, indicating private use of birth control. As the population also continued to increase, restrictions were lifted in 1938, family planning services were restored, and abortion, on socio-medical grounds was legalized. However, contraception continued to be advocated in preference to abortion.

Besides her other educational activities, Mrs. Ottesen-Jensen opened homes for unmarried mothers, and gave lectures on family planning and prevention of venereal disease to the Swedish army. (Her international activities are described on page 83.) In 1946 sex education in the schools became compulsory, and Mrs. Ottesen-Jensen assisted in the preparation of a teacher's guide. She was honored by the IPPF in 1965 because, at the age of 80, she, too, was still active in the movement. Today, the Swedish Family Planning Association operates three family planning centres, trains medical and paramedical personnel, is pressing for improved family planning services in rural areas, promotes sex education and is represented on two government commissions on sex education and abortion. The Swedish government supports the voluntary organization, directs sex education programs in the schools, tests imported
condoms and, at the urging of Mrs. Ottesen-Jensen, has adopted a policy of giving foreign aid in the family planning field. Through the Swedish International Development Agency (SIDA), two of the chief beneficiaries have been Ceylon and Pakistan. In 1968, family planning assistance amounted to twelve percent of the total Swedish foreign aid budget, and $500,000 of it was allocated to the IPPF.²

After World War II new activity took place in some other countries of Western Europe — Denmark, France and West Germany, for example — but, because of opposition or imagined opposition, in no country was there an all-out program either by a family planning association or government.

In the communist countries of Eastern Europe the German Democratic Republic, Poland and Yugoslavia have family planning organizations affiliated with the IPPF. There is general curiosity about family planning in the People's Republic of China (Mainland), where the population is estimated to have reached approximately 750 million. Although no official information is available, and it is not known whether any voluntary activity is present, certain trends are evident. Government policy advocates late marriage and small families. Birth control information and all methods are provided, particularly the IUD. Oral contraceptives are in use. Abortions and sterilizations are increasing. How extensive are the family planning services is not known, but it would seem that at least some Maternal and Child Health Centres, hospitals and medical schools are in action, and mobile medical teams
are being used on an increasing scale. 4

The postwar world has been fascinated by (but somewhat misinformed on the reasons for) the very rapid reduction of nearly 50 percent in the crude birthrate of Japan in the decade following 1949. The Japanese record does not necessarily prove that a similar speedy reduction in birthrates is possible in other Asian countries just because they, too, are Asian. The difference lies in the fact that, to all intents and purposes, Japan is a modern industrialized society like those in the West, and there, too, a demographic transition has occurred. Irene Taeuber traces its beginning back to 1868, when the Meiji Restoration began to open the country to Western ideas. As a feudal and agrarian society of 35 million, Japan had an archaic social and political structure, but it was united and disciplined. Mortality rates were high enough to keep population growth within the absorptive capacity of the economy. But, from the beginning of the modernizing period, mortality began to decline. As it was followed by a fertility decline, natural increase did not reach 2 percent per year until after World War II. But then, a baby boom occurred, similar to that in other industrialized nations. 5 Deathrates continued to decline, and population growth became a crucial problem. To counteract illegal abortion, and for eugenic and health reasons, sterilization, induced abortion, and contraception were legalized under the new Eugenic Protection Law of 1948. Although abortion was not provided by the public sector, so
many were performed that it was feared that, not only the health, but the lives of many women were threatened. So, in 1952, the government inaugurated a policy stressing that voluntary contraception was preferable and for both men and women. Through individual approaches and mass public education it was very successful. In Japan, population pressures on food, space, employment, and education, combined with a total transformation of the national economy to bring about a situation parallel to European industrialized societies. These conditions, coupled with government encouragement of the use of birth control, brought about a long term, and then a sharp drop in fertility. Two children at most, per family, became the vogue. In the meantime, concurrent with demographic change in the twentieth century a voluntary effort to promote birth control also developed.

The Family Planning Association of Japan began in New York in 1920, where Baroness Ishimoto, then wife of a leader in the Kaizo (Young Reconstruction League), took a business course under YWCA auspices. Instructed by her engineer husband to find a useful role for herself in serving the modernizing needs of her country, Shidzue decided that she would start a birth control movement — to relieve maternal and child health problems and to raise the status of Japanese women. She met Mrs. Sanger, and, through her help, the Kaizo set up a birth control committee, translated Family Limitation, and began a sustained campaign in Japan. Mrs. Sanger was soon invited to visit the country as one of four speakers on
Western thought - Albert Einstein, Bertrand Russell and H.G. Wells were the others. (The Kaizo suggested Mrs. Sanger should speak about the prevalent western concern about the "Yellow Peril" and its teeming millions as a threat to peace.) The Japanese government's reluctance to admit her was well publicized, and, although she was not allowed to give public addresses, she gave many to private organizations, and held numerous press interviews. Baroness Ishimoto went on with her to attend the Fifth International Malthusian and Birth Control Conference in London in 1922.

By 1935, the militarist faction had the upper hand in Japan and the birth control clinics were closed. The Baroness was arrested, and then kept under a long surveillance. Her husband changed his political sympathies and there was a divorce. Shidzue then married Kanjo Kato, a labor leader, and in 1946 both were elected as Social Democrats to the Japanese Parliament. As an advocate of an end to militarism and raising the status of women, Mrs. Kato was able to influence the writing of the new postwar constitution. The birth control clinics were reopened and run under the direction of a Dr. Majumi, with the co-operation of the Health Ministry. In 1951 the Japanese once more invited Mrs. Sanger to visit, but this time General Douglas MacArthur, commander of the occupation forces, refused her a visa. An outspoken American feminist in Japan may have been considered undesirable for a number of reasons - including her advocacy of contraception in preference to abortion - but Mrs. Sanger and the Tokyo press claimed that
minority Roman Catholic interests were behind the decision. She was able to pay her visit in 1954, however, sponsored by the Mainichi Press. She spoke to a committee of the Japanese Diet and gave many other talks and interviews, but the need and means for birth control were already established.

In 1952 the Cabinet Council announced that birth control services would be made available free for all through Maternity and Child Health Centres. Besides abortion, the chief methods were condoms and rhythm. (Oral contraceptives and IUDs are not yet included in the official program.) With the added support of industry and the volunteers, abortion rates began to decline and the use of conventional contraception to rise. In 1955 more than 1,100,000 abortions were done. In 1967 this figure had dropped to 740,000. Health Insurance schemes were financing birth control for the employed, and welfare agencies for the indigent.

This all-out attack on the population problem had improved health and welfare aspects and relieved the high youth dependency ratio which threatened economic recovery. The birthrate is now about 19 per thousand - still more than double the deathrate of 7, and the rate of population increase is 1.1 percent per year. The population is approximately 103.5 million; the doubling time is estimated to be 63 years; and 25 percent of the population is under the age of 15 - about the same ratio as in most European industrialized countries. But there is growing concern about the long term effect of drastically lowered fertility rates on the age structure of
the population, and fear that, as the rate of increase of the labor force has slowed, there will be a labor shortage, and increasing numbers of middle and older age Japanese.

The interim report of the Population Problems Inquiry Council, dated August 5, 1969, notes that, since 1957, fertility rates have been lower than required for a stationary population (2.0 instead of 2.13 children). The nuclear family, material values, and inadequate housing have contributed to the adoption of the small family norm; and the Council recommends that the country should take immediate action to rectify these influences through social reforms. But, as the effects of any increase in the fertility rate will not be felt for at least fifteen years, other interim measures are also essential: the movement of labor must be controlled, retirement age re-studied, productivity increased and labor-intensive activities discouraged. (The Council does not take up the question of whether continuing economic expansion is the only means of achieving improvements in the standard of living.)

In spite of this new preoccupation with its own population problems, Japan has announced foreign aid in family planning, for the IPPF and the United Nations Fund for Population Activities. Direct aid is also being given in Indonesia. Doctors, visual aids, educational materials and vehicles are being provided. In 1968 the Family Planning Federation of Japan set up the Japanese Organization for International Cooperation in Family Planning to raise money from private sectors and government and to mobilize Japanese expertise
In summary, the volunteers in family planning in the industrialized countries were educated social reformers, many were pacifist, and all were of middle class background. Over the years their objectives broadened from improving working class wages to include women's rights, maternal and child health, race betterment, family welfare, national and international well-being and, finally, conservation of resources and the environment.

Family planners in industrialized countries were not influential in reducing birthrates until other factors, particularly death control and economic conditions, had induced a downward trend. Their frequent conflicts with authority were well publicized, however, and increased public interest and knowledge of methods was the result.

Because their movement was controversial, and aroused opposition in political, commercial, clerical and medical circles, in particular, defensive tactics were introduced. It was claimed that birth control was the only sensible alternative to abortion. It was a means of spacing pregnancies for better health of both mother and child. Diagnosis and treatment of infertility, marriage counselling, genetic counselling, and family life education were added as time went on.

Because there was no background of information or training in this field, a workable system had to be developed through trial and error. But the experience of the volunteers was a valuable foundation on which government programs could
be built.

Much of the financial support for Family Planning Associations in modernizing countries has come through the International Planned Parenthood Federation.
FOOTNOTES - Chapter III


10. Family Planning in Five Continents, p. 27.

PART TWO

CHAPTER IV

International Cross-Fertilization and Expansion

Nor knowest thou what argument
Thy life to thy neighbor's creed has lent.
All are needed by each one;
Nothing is fair or good alone.

International activity in the family planning field began with the First International Neo-Malthusian Conference held in Paris in 1900 under the chairmanship of Dr. C.R. Drysdale, brother of the author of The Elements of Social Science. Succeeding meetings took place in other European cities - 1905 in Liege, 1910 in The Hague, and 1911 in Dresden. These sessions were sparsely attended underground affairs - usually taken up with tedious debates about the relation of Malthusian principles to Marxism. By 1922 however the topic had gained enough in respectability that such a reputable speaker as John Maynard Keynes graced the London program, and over one hundred physicians attended a session devoted to contraceptive techniques. 2

The Fifth International Neo-Malthusian and Birth Control Conference in London in 1922 was notable for the presence of Margaret Sanger, fresh from an Asian tour in which she had
been shocked by the condition of women and children, and had become convinced that population pressures lead to war. In confirmation of her belief, Keynes warned that population would become both an economic and a political problem. The Conference urged the League of Nations to warn its members. Press coverage was extensive.

Because she felt the message should have an equal impact in the United States, Mrs. Sanger persuaded the American Birth Control League to invite the next conference to meet in New York in 1925, and financed it from donations from subscribers to the Birth Control Review. More than 1,000 persons from a variety of professions (including medicine), from eighteen countries attended. Two practical innovations were included, the delegates heard evaluations of existing methods of birth control (prepared by Americans) and reports of Doctor Stone's work at the Margaret Sanger Research Bureau. As a result, the use of the diaphragm and jelly was confirmed as the most reliable method to date, and Dr. Dickinson arranged for the details to be published in The Medical Journal and Record - the first time such research information was included in a professional journal. This must have been the beginning of world-wide acceptance of the "d & j" method by family planners - a policy to be criticised later as a "middle class" solution unsuited to the poverty-stricken masses of South Asia. (See Chapter V).^3

Demographers were now assessing the rate of population growth and the estimated time required to add more billions.
In the hope of jolting the League of Nations into realizing how inexorable this increase would be, Mrs. Sanger organized a World Conference on Population in Geneva in 1927. Mr. Slee financed the gathering, and Mrs. Stanley McCormick, daughter-in-law of the founder of the International Harvester Company, commenced her interest in the movement at this time.

Assisted by an able committee which included Julian Huxley, Mrs. Sanger arranged for participation by many famous authorities. At the last minute, however, the chairman, Sir Bernard Mallett, was warned by the Secretary-General of the League, Sir Eric Drummond, that Europeans would boycott the meeting if they thought a woman had organized it. There was also religious opposition because her name was associated with birth control. Mrs. Edith How-Martyn, another feminist, was also working on the conference. Sir Bernard indicated that the names of all women associated with the program should be removed. The entire staff resigned, but Margaret persuaded them to return to their tasks. The meeting was held, and the facts on population became better known but the League remained unalterably opposed to recognition of the problem. Two worthwhile developments did, however, emerge with the formation of a continuing Medical Committee (which eventually became the medical committee of the IPPF) and the International Union for the Scientific Study of Population, a prestigious organization which subsequently sponsored two further World Population Conferences, one in 1954 in Rome, and another in 1965 at Belgrade.
That there should be no mistake about it, in 1930, the Seventh International Birth Control Conference was held in Zurich, and many new goals were defined. Birth control was declared the best way to reduce abortion. It should be part of the public health services and of preventive medicine and instruction should be included in the curricula of all medical schools and colleges. The conference also agreed that no doctor would prescribe any chemical contraceptive unless the formula was known to him. Sterilization was also approved, particularly for eugenic reasons.5

In the same year a Birth Control International Information Centre was organized in London, with Mrs. How-Martyn as Honorary Director and Mrs. Sanger as President. This centre made many contacts in Asia, and had many visitors, including Jawaharlal Nehru, then chairman of the Planning Committee of the Indian National Congress, and Smt. Dhanvanthi Rama Rau, a leader in the All India Women's Conference, and, later, founder of the Family Planning Association of India.

A Conference on Birth Control in Asia (India, China, Japan) was held in London in 1933 to identify obstacles to birth control and possible solutions and it was affirmed that birth control was a necessary condition of economic development.

As described in Chapter III, individual Indians had already started some birth control services in their country, and in 1934 Mrs. How-Martyn was invited to the All-India Women's Conference (AIWC). Mrs. Sanger was invited to their
session in Travancore in the winter of 1935-36, and Mrs. How-Martyn revisited India in 1936-37 and 1937-38. When the work of the Centre was combined with other birth control organizations in the United Kingdom in 1938, Mrs. Rene Datta, English wife of an Indian, served as organizer in India until 1945. 7

Up to World War II, then, family planners in the United Kingdom and the United States had developed the movement to a state of some, if not total, public acceptance - as a means of relieving poverty and promoting the welfare of the family. Though no national government programs were in existence in either country, the Family Planning Association had been organized in Britain, and the Planned Parenthood Federation was soon to emerge from unification in the United States. Comparable groups had developed in some European countries and Japan, and some services and discussion had been started by individuals in India. International conferences were now commonplace, and cross-fertilization among the pioneers and their organizations had developed on a direct basis and under the auspices of the International Information Centre. At this point another relatively strong influence entered the international picture - from Sweden.

After World War II Mrs. Ottesen-Jensen rallied former family planning workers in Europe, and laid the foundation for a new international voluntary organization. In 1946, a fresh series of conferences was inaugurated in Stockholm, with representatives from Britain, Denmark, Finland, Nether-
lands, Sweden and the United States. It was agreed that, as the term "birth control" had been dropped in the United States in favor of "Planned Parenthood" or "Family Planning" in the U.K. and other countries, it should also be dropped internationally. The newer terms more adequately conveyed the broader concept of "spacing" and the treatment of infertility would be encompassed. As the threat of over-population was not yet evident to many world leaders, and as the horrors of Hitler's sterilizations and genocide were still fresh in all minds, this was the only policy under which an international voluntary organization of this type could hope to encourage new national organizations to serve the health and welfare of the masses.

It was agreed to set up an interim committee to lay plans for a permanent organization, and to hold another conference in Cheltenham, England, in 1948. The Secretary of this committee was Mrs. Dorothy Brush (later Walmsley), a philanthropist friend of Margaret Sanger, whose personal and financial contributions were substantial. As the British were reluctant to play hosts because of war damage, the second conference was organized and financed by Mrs. Sanger via Mrs. McCormick's largesse and the British Family Planning Association co-operated. The topic chosen was Population and World Resources in Relation to the Family. Lord Horder presided and volunteers from twenty-three countries attended. Another Interim Committee on Planned Parenthood, with two representatives each from Britain, the Netherlands and Sweden,
and three from the United States, was set up, and a grant of $5,000 to assist in financing an office in London was given by the Brush Foundation for Race Betterment of Cleveland, Ohio. The Eugenics Society gave rent-free accommodation to the new group as well. From 1949 to 1951 the ICPP met annually in London, established contact with groups and supporters in some twenty countries, and made plans for regional committees. The need for a simple, cheap, effective birth control method was also agreed.\(^{11}\)

As interest in birth control was growing in India, and as the question of population growth in relation to economic needs was beginning to be recognized (John Maynard Keynes had predicted the problem in 1922 and it had been confirmed in 1951 by Kingsley Davis), an economic focus for family planning activities presented itself.\(^{12}\) It was decided to hold the Third International Conference in Bombay in 1952. With financial help from Mrs. Sanger's friends, the newly formed Family Planning Association of India (FPAI), headed by Smt. Rama Rau, undertook to organize it. The then Vice-President of India, Dr. Sarvepalli Radhakrishnan, inaugurated the sessions. Here it was agreed to form the International Planned Parenthood Federation, with headquarters in London. The Family Planning Associations of Hong Kong, India, the Netherlands, Singapore, Sweden, the United Kingdom, the United States and West Germany were the charter members. Mrs. Sanger and Smt. Rama Rau became joint Honorary Presidents. The former had fought for family planning for nearly forty years, had seen
the movement begin to flourish in the United States, and was
now inducing the birth of an international organization as
well. Smt. Rama Rau symbolized non-Western leadership, and
represented the first of the developing areas in which the
program could expand. Mrs. Ottesen-Jensen, who had fought
for family planning in Sweden and had taken the initiative
which led to the formation of the new organization, was
elected Chairman of the Governing Body. Mrs. Vera Houghton,
wife of a British Labour M.P., was secretary from 1953 to
1959.

A new Constitution for the Federation was to be
drafted, and it was decided to publish a monthly bulletin,
Around the World News of Population and Birth Control (the
title was eventually changed to International Planned
Parenthood News). The early issues were financed by the
Brush Foundation and edited by Mrs. Brush, from 1952 to
1957. In its first ten years, its circulation climbed from
5,000 to 13,500, and it is now published in English, French
and German. 13 The history of the Indian Family Planning
movement will be given in the next chapter, but it is of
interest to note that, shortly after the Bombay meeting,
Prime Minister Nehru recommended to the Indian parliament
that family planning be included in the First Five-Year Plan.
Rs. 6,500,000 (c U.S. $1,625,000) were eventually allotted
to the Ministry of Health for this purpose. 14

In 1953 the Fourth International Conference on Planned
Parenthood, held once again in Stockholm to commemorate the
twentieth anniversary of the Swedish National League for Sex Education, adopted a new constitution, to

... advance through education and scientific research the universal acceptance of family planning and responsible parenthood in the interests of family welfare, community well-being and international goodwill.

Membership would be offered irrespective of race, creed or color; and commercial interests would be excluded from association with the new organization. ¹⁵

When the Fifth International Conference on Planned Parenthood was held in Tokyo in 1955, Mrs. Sanger, now 76 and suffering from a coronary ailment, bursitis, sacro-iliac strain and lumbago, took the opportunity to lecture world heads of state for trying to use "stop gap" solutions to world problems when, in reality, population was "the basic issue". She regretted that the question had not been discussed at the recent Summit Conference in Geneva. ¹⁶

In addition to doctors, sociologists, demographers and other related professions, for the first time anatomists, biologists, biochemists, and other scientists were gathered to compare notes in the search for a biological means of contraception. As has been noted, this was a goal long advocated by Mrs. Sanger because of the world wide need for a simple, cheap and reliable method, the use of which would be unrelated to the time of intercourse. ¹⁷ It had been partly through her interest that Dr. Pincus had received a grant to begin the study of progesterone as a means of suppressing ovulation.
In the meantime, it was agreed that abortion should not be considered a primary solution to population problems.

The Sixth International Conference was held in New Delhi in 1959, and was memorable for a number of reasons: It was partly financed by a grant of Rs. 50,000 from the government of India, and inaugurated by Prime Minister Nehru. 800 delegates and observers from twenty-nine nations—including fifteen Asian countries—were present, and an observer from the USSR was on hand. Margaret Sanger, at 80, made her last visit to the IPPF. The theme of the conference was, Family Planning: Motivations and Methods, and the motivation of governments, too, was not neglected.

As has been noted, some Indians were already aware that population growth was hindering economic development. Keynes and Davis had pointed the way, and Ansley J. Coale and Edgar M. Hoover had recently published their study of India's prospects. (See also Chapter V.) The Asian family planners took up the chorus, pressing their governments to do something effective in the United Nations through WHO, FAO, ECOSOC, and the Human Rights Commission to support population control programs. Countries planning to attend the forthcoming ECAFE (Economic Commission for Asia and the Far East) conference, were urged to give the question serious attention when it was taken up. A study group on population problems under the chairmanship of Dr. William Vogt, National Director of The Planned Parenthood Federation of America, stated that his country was an example of "over-
development" and warned that it, too, had a population problem - an idea warmed over by Paul Ehrlich in 1968 in *The Population Bomb*. The group recommended that, in addition to a medical committee, another on economic and social problems be appointed, but, by the Seventh Conference, in 1967, only a committee on basic science had been added.

On family planning policy, the Sixth Conference now formally approved the principle of spacing pregnancies for better health, and urged members to provide, wherever possible, diagnosis and treatment of infertility. Though it had been acceptable in 1930, a resolution formally supporting sterilization was rejected - not because the idea of sterilization was abhorrent to all members, but because it was to some, and, since 1955 and the resolution in Tokyo on abortion, it had become IPPF policy to avoid taking a stand for or against any specific birth control method. (Chapter V, p. 129.)

Research in all aspects of human fertility was urged, however. Since 1956, Dr. Pincus had had the Pill under acceptability trials in the United States and Puerto Rico, and he was interested in further trials in Asia. It is reported that Indian authorities would not agree, reputedly because of the cost of supervision, the feeling that illiterate women would not be able to manage it, and fears of side-effects. Ceylon, however, was more receptive. (Chapter VI, p. 190.)

George Cadbury, who had spent the preceding ten years as head of the United Nations Technical Assistance Administration, had recently joined the IPPF as Honorary Field
Director and Special Representative. In pursuit of his new responsibilities, Mr. Cadbury and his wife, Barbara, visited eleven Asian countries advocating family planning as part of maternal and child health services, and also urging United Nations action. Mrs. Cadbury's report included this statement:

We expected that we should be concentrating on ways of educating Asian people to use family planning services; we expected that religion, superstition, myth and ancient custom would make it difficult for the ordinary people of Asia to accept birth control. On the whole we were wrong. The problem is to provide the service, not to educate people to use it. It is not Oriental religions and cultures which are a bar to its widespread use, but Occidental Roman Catholicism, and the wariness of politicians of the Roman Catholic voter in the Occidental democracies. 21

To assist the volunteers in these countries the IPPF needed greatly increased funds. These were raised by the combined efforts of the Cadburys and Mr. Cass Canfield (a leader of Planned Parenthood in the United States), and from $70,000 in 1960 the IPPF budget rose to $935,000 in 1965. 22 Liaison was established with the Population Council in New York; Consultative Status with the United Nations was achieved; the IPPF became a member of the International Conference of Social Work; and, in 1963, the International Council of Women passed a resolution recommending world-wide education in family planning. Mrs. Margaret Pyke, wife of a noted British school master, was appointed General Secretary after Mrs. Houghton.

It is of interest that in March, 1962 in Tokyo, ECAFE
set up a team of demographers to advise and assist Asian governments in developing family planning action programs.

The Seventh International Conference on Planned Parenthood, held in Singapore in 1963, was attended by four hundred delegates from thirty-eight countries. Scientific, medical and demographic papers were read on the theme, Changing Patterns in Fertility: Social and Cultural Factors. Sessions were held on current research and a workshop was conducted on promotion and publicity. Resolutions urging a balance between population, productivity and resources were passed. Aims were re-stated: to promote responsible parenthood for family welfare, community well-being and international goodwill. Education, training and conferences would be continued. Members should consider offering sex education and marriage counselling. Previous resolutions requiring impartiality regarding race, creed and color, were broadened to include "politics".

In response to criticisms about motives, Mrs. Ottesen-Jensen, retiring president, noted that, while they were not the first, women had joined the movement because it was devoted to family welfare. Men had joined for the same reasons, and recently also because of the economic and scientific significance of family planning. Smt. Rama Rau was elected president of the IPPF, and Cass Canfield and George Cadbury, Chairman and Vice-Chairman, respectively, of the Governing Body. A former British civil servant with wide experience in the Caribbean area, Sir Colville Deverell, was appointed Secretary-
General, succeeding Mrs. Pyke.

In addition to its world conferences, the IPPF had been developing regional conferences and seminars. Eighteen of these had been held from 1955 to 1963. All of its meetings were now attracting highly qualified personnel from many parts of the world and IPPF publications, films and special studies had achieved equal prestige. It was the only international body stimulating both voluntary family planning organizations and government action, and there were now thirty-five member countries in five continents. Help was being given to more than sixty non-member nations. The IPPF would continue to function in family planning promotion at least until the World Health Organization was ready to do so. 24

1964 was notable for a new focus – this time on Africa and Latin America. In the former, the organization of Family Planning Associations by the IPPF was welcomed, not so much for population control (though this would soon be a need) as for maternal and child health. In the latter continent, governments were still hesitant, but universities were freer to act and accepted help. The justification was the need to reduce the appallingly high abortion rates evident from hospital admissions and maternal death statistics.

Coupled with these activities, a dramatic development in birth control methods, was the confirmation by the Population Council in New York of exhaustive tests and acceptability trials of the polythene IUD, on which work had been done by Japanese as well as American doctors. As a result of
insertions in Taiwan and Korea, the Council recommended that
the IUD be adopted for general use throughout the world, and
many believed that here, at last, was the method best suited
to mass use.25 (See Chapter V for further comment.)

Liaison was set up with the United States Agency for
International Development (AID), the government of the United
Kingdom, and Oxfam. Consultative status was established with
UNESCO, the United Nations Children's Fund, the World Health
Organization, the Food and Agriculture Organization, and the
International Labor Organization. The IPPF Medical Committee
was setting standards of clinical procedure and training, as
well as the medical aspects of contraception. It was conduct­
ing evaluation and other research, and had access to labo­
ratory facilities in England, India, Poland, the Netherlands
and the United States.

The Eighth International Conference, held in April
1967 in Santiago, Chile, was inaugurated by President Frei,
and attended by more than 1,500 delegates from eighty-seven
countries. These included not only voluntary organizations,
but government agencies, religious orders, and university
staff members. A special session for youth attracted more
than 1,000 people. On the theme, Planned Parenthood: A Duty
and a Human Right papers were given on population growth in
relation to economic and social development in Latin America,
world food problems, education, housing, and maternal and
child health. The widespread problem of illegal abortion,
especially in Latin America, the need for both medical
promotion and increased family planning services was discussed. Basic science and medical sessions were also held, and, once again, the proceedings subsequently published. This conference was financed by government grants from Denmark, The Netherlands, Norway, Sweden, the United States (AID), the Brush Foundation, and the Ford and Rockefeller Foundations. In the opening session, Lord Caradon, then United Kingdom Permanent Representative to the United Nations, urged that the U.N. take concerted action in the coming Human Rights Year (1968) and announced that his government would make an annual grant of $140,000 to the IPPF for five years.26

A special drive for funds to support expanded activities by the IPPF was undertaken in the United States by Planned Parenthood, and headed by General William S. Draper, Jr. Known as the Victor-Bostrom Fund, it achieved its initial target of $3 million by the fall of 1968. A further target of $3 million to assist the IPPF through 1971 was oversubscribed, and was increased to $6 million. From its previously modest total of just under $1 million in 1965, the 1970 budget of the IPPF totalled $13 million, and, for 1971, $20 million.

A far cry from the handful of enthusiasts from six countries who met in Sweden in 1946, Family Planning Associations in sixty-four countries had affiliated with the IPPF by the end of 1969, as had several individual governments. Six regional offices (Singapore, Rawalpindi, Tokyo, Nairobi, London, New York) had been established; and another, in Beirut, was opened in March, 1970 to serve the Middle East and North
Africa. The IPPF was assisting in more than 70 other countries, and its government support was swelled by a grant from Japan. IPPF status in UNESCO had been raised to "Category B., information and consultative", and Mr. (later Sir) David Owen, former co-administrator of the United Nations Development Plan, was appointed Secretary-General of the IPPF, succeeding Sir Colville Deverell. In November, 1969, Mr. George Cadbury succeeded Mr. Canfield as Chairman of the Governing Body, and Dr. Agnete Braestrup of Denmark, succeeded Smt. Rama Rau as President. Direct government assistance to the IPPF was now an established procedure - a recognition of the usefulness of a non-government, non-political, international agency in the frequently delicate promotion of a needed program. The work of the Federation, always keyed to health and welfare on a worldwide basis, was still

... based on the belief that knowledge of planned parenthood is a fundamental human right and that a balance between the population of the world and its natural resources and productivity is a necessary condition of human happiness, prosperity and peace.²⁸

In summary, the volunteers from the United Kingdom, the United States and some European countries held a series of international gatherings from 1900 to 1939 which laid a foundation for international organization to promote the spread of the family planning movement. Though these gatherings issued warnings of the danger to peace of population pressures, no one listened. Meetings were renewed
in 1948, and the International Planned Parenthood Federation, with headquarters in London, England, was organized in Bombay in 1952.

The member associations have always insisted that birth control be voluntary, and that it should be offered with no distinction as to race, color, creed or politics. Though some methods, such as the diaphragm and jelly, and sterilization, were recommended before 1939, it was decided after 1955 that the IPPF would not single out any particular one in preference to any other.

In 1964 the main focus of the international organization turned from Asia to Africa and Latin America, where it could continue to fill its traditional role of helping voluntary organizations to start, and to be the catalysts of government action. In this, the IPPF was greatly assisted by increased income from both voluntary donations and direct grants by governments. By 1969 there were 64 member countries.

The Utilitarian and humanitarian philosophy in which the Family Planning movement had had its origins, appealed to the Western-educated leadership in South Asia when they were planning, not only for independence, but also for social and economic progress for their people.
1 Ralph Waldo Emerson, "Each and All", Stanza I, Bartlett's Familiar Quotations, Boston, 1955, p. 503.


6 Vera Houghton, op.cit., p. 3.

7 "The Story of Margaret Sanger and The IPPF", op.cit., p. 8.

8 Ibid.


17 Program, Seventh Conference, op. cit., p. 9.


19 In 1962 ECAFE (Economic Commission for Asia and the Far East) adopted a program of research into population problems and began to give advice to governments on economic and social planning.

20 George Cadbury, Interview, Oakville, Ontario, 7.12.69.


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Scientific Seminars

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Figure 3. Four Projections of India's Population Growth

A = Replacement level fertility reached by 1985
B = Replacement level fertility reached by 1995
C = Replacement level fertility reached by 2005
D = Fertility constant at 1965 level

Source: International Demographic Statistics Centre, U.S. Bureau of the Census
PART THREE

Social Reformers and Government in South Asia

CHAPTER V

India

... I believe that to wait until the moral sense of man becomes a great deal more powerful than it is now, and till then to allow countless generations of children to suffer privations and ultimately death for no fault of their own is a great social injustice which should not be tolerated.¹

As in the Western context, concern over population growth in South Asia began with Malthus. Although he did not visit the country, he noted in the 1803 version of his Essay that India was a classic example of his theory. Such positive checks on population growth as asceticism and taboos against widow remarriage, were offset by the compulsion for male heirs and early and universal marriage. Consequently, the "lower classes" were so numerous that they were reduced to frugality, and, therefore, very vulnerable to any deterioration in the food supply.² Abbé Dubois, a contemporary of Malthus, who did visit the country, described the Indian scene south of the Kistna River, and noted particularly the
inferior status of women:

The opinion is firmly established throughout the whole of India, that women were only created for the propagation of the species, and to satisfy men's desires. All women are obliged to marry .... Only courtesans are allowed an education. 3

Paralleling the nineteenth century interest in population growth and its social and economic consequences in European countries, there was growing discussion of the topic by British administrators and Indians reformers in the Indian sub-continent.

In 1888, the Viceroy, Lord Dufferin, commented with some asperity that the recently-organized Indian National Congress would be better advised to worry over the effects of over-population than over their exclusion from participation in government.

No one can pass even a few months in India without being aware that we are sitting under the shadow of an enormous danger — overpopulation of the country, or at all events of large districts and territories, whose inhabitants are yearly, nay monthly and weekly, multiplying beyond the numbers the soil is capable of sustaining — yet during the four years I have been here this most important subject has not attracted the attention of a single Native newspaper, still less of any Native public body. 4

By 1929 the British position in India had become uncertain, and, although after 1921 the population growth rate had begun to spiral upward, no administration wanted to interfere.
Nothing would end British rule more quickly than any attempt to introduce just those reforms which would do the most to improve the well-being of the masses. A well-proportioned decrease in the birthrate would unquestionably result in an increase in income per head ... Where is the Indian Malthus who will inveigh against the devastating torrent of Indian children?

Major-General Sir John Megaw, former Public Health Commissioner with the Government of India, and subsequently President of the Medical Board at the India Office in London, knew what was needed.

The truth is that the inhibitions connected with the study of the population problem have been chiefly on our side: we have been accustomed to plan our own lives in such a way as to secure a comfortable existence, but we have assumed, quite wrongly, that education in life planning is inadmissible in India.

Some Indians of the educated classes had been developing a growing interest in social improvement and one of the obvious avenues was health and welfare. A natural extension was interest in contraception, and, by the time of Megaw's comment in 1934, some were prepared to promote family planning as a form of national service.

One of the influences which laid the groundwork for this interest was the founding - in 1828 - of the Brahmo Samaj, a Hindu reform movement, started in Bengal by Ram Mohun Roy, a friend of Jeremy Bentham and an advocate, among other things, of universal adult suffrage. At the end of the nineteenth century, the teachings of the sage Ramakrishna and his
disciple, Swami Vivekananda added impetus to the idea of service. By the end of the century, the Moderates of the Indian National Congress were urging their countrymen to borrow from the West whatever measures would benefit their people. "Social service" became popular among the educated middle and upper classes. Gandhi used service to the state as a rallying cry for the Independence Movement, advocating equal rights for women on the basis of ancient Hindu tradition. It was natural, therefore, for "social workers" (as the volunteers were called) to participate in voluntary organizations dedicated to social improvement, and that their western education would induce them to adopt models of western origin such as the Boy Scouts, Girl Guides, Red Cross and the All-India Women's Conference.

In 1916 Sri Pyare Wittal, writing *The Population Problem in India*, urged Indians to plan their families in accordance with their social, economic and health needs. What was more natural than to press for birth control services as a means of social reform? Who were the first to do so?

Like the "European" family planners, the leaders of the movement in India before World War II were men, but they were joined later by women. Advocates of family planning appeared first in Calcutta, Bombay, and Madras, the three cities where contacts with the West had been most prolonged. In 1911 Babu Nilambura Mukerji, as President of the Calcutta Municipal Council, strongly advocated contraception. Professor Raghunath Dhondo Karve, a teacher in the Christian
missionary-supported Willson College, opened the first birth control clinic in India in 1915 in Bombay. Though British officialdom was indifferent, so much local criticism was aroused by the clinic and by Professor Karve's speeches and writings on the subject, that he was asked to resign from the college. This he did, but, with his wife, he spent the remaining twenty-eight years of his life working for the family planning movement. Another development was the organization in 1929 in Madras of a Neo-Malthusian League, headed by two distinguished citizens - a justice of the High Court, who had ten children, and a member of the Governor's Executive Council, who was childless. The League published a regular bulletin on birth control and sold rubber sponges and jellies. In June 1930, the princely state of Mysore opened the first state-supported clinic in the world in Bangalore, and the British province of Madras shortly after followed suit.

In 1932, in spite of opposition from some of its members, the All-India Women's Conference, a co-ordinating body of women's voluntary organizations, passed an unprecedented resolution supporting birth control clinics for both men and women. This was the first time the subject was discussed openly at their meetings, and there was much enthusiasm. But the President, Smt. Lakshmi N. Menon, observed that although it was a humanitarian program, the British government would not want to introduce it "for fear of offending the religious sentiments of the people."
Also in 1932, The Senate of Madras University passed a resolution favoring inclusion in the curriculum of instruction in family planning. Two years later a new family planning organization was started in Bombay. It began to publish a journal, *Marriage Hygiene*, edited by Dr. A.P. Pillai, and, for the first time in the world, included marriage counselling in its program. In 1935 Smt Cowasji Jehangir founded the Society for the Study and Promotion of Family Hygiene, also in Bombay, and a free clinic for women was opened in a local cotton mill.\(^\text{13}\)

In 1935 the Indian National Congress set up a National Planning Committee, headed by Jawaharlal Nehru. This body supported birth control on socio-economic grounds, both for the sake of the individual and for society. It would improve the health of the mother and infant, increase family happiness, and help to combat induced abortion. The planning committee was the first also to discuss the question of population growth in the context of economic planning and natural resources, but there was disagreement both as to priorities and methods. Both self-restraint and contraceptives were approved, as was eugenic sterilization — a popular cause in some Western countries at the time.\(^\text{14}\) In his Presidential Address to the Congress at its forty-ninth session in 1936, Nehru urged the middle classes to renew their efforts for the cause of Indian independence, and to work more closely with the "people at large" — an exhortation to greater involvement in solving national problems.\(^\text{15}\)
In the meantime, Mrs. How-Martyn had visited India in 1935 on behalf of the Birth Control Information Centre; as a result, the All-India Women's Conference invited Margaret Sanger to speak at their meeting in Travancore at the end of 1935. Though a resolution supporting birth control was opposed by Eurasian Roman Catholic members, and the chairman, the Maharani of Travancore was hard pressed to keep the meeting on an even keel, the vote was passed by a 3 to 1 margin. In recalling those days, Smt. Dhanvanthi Rama Rau, who later founded the Family Planning Association of India, noted that the educated people in India concerned with population problems wondered why Americans considered Miss (sic) Sanger immoral when she talked about the limitation of family size. Paramount in Mrs. Sanger's appeal was the need to reduce infant mortality and the importance of spacing pregnancies for better health of both mothers and children.

Mrs. Sanger travelled 10,000 miles, visited eighteen cities and towns, gave sixty-four lectures, saw scores of government officials, and met many leaders of Indian opinion. Mrs. How-Martyn, on her 1935 visit and a subsequent one in 1937-38, travelled 6,500 miles and addressed forty-one meetings, including the All-India Medical Conference; the Institute of Population Research, Lucknow; the Marriage Welfare and Child Guidance Association of Calcutta; and the Bombay Women's Work Guild. Taken together, these two women spoke to 32 medical associations.

It is not known whether the vote was unanimous, but
the All-India Medical Conference resolved that instruction in contraception should be included in all medical curricula. The resolution had little impact, but a Birth Control Information Centre, already opened in Calicut, was strengthened, and in addition to the clinic at Bangalore clinics were operating in Delhi, Nagpur, Akola, Satara, Indore, Calcutta, Poona and Mysore City. The Bombay Mofussil Maternity, Child Welfare, and Health Council adopted a birth control policy and arranged for its medical staff to take training.

The first organized step toward the scientific study of population in India was taken in 1936 when Dr. Radhakamal Mukerjee convened the first of a succession of Indian population conferences at the University of Lucknow. Papers on demography, nutrition, health, economics, family hygiene, and eugenics were presented and discussed. In the same year Dr. A.P. Pillai set up training courses in Bombay, and toured South India to promote the provision of birth control services—but doctors there showed little interest.

Birth Control World Wide opened clinics in what are now Uttar Pradesh and Madhya Pradesh; and Col. B.L. Raina, later Director of Family Planning in the Central Government, and eventually Director of the Central Family Planning Institute in New Delhi, started a clinic at Ujjain, also in Madhya Pradesh. In 1938 the Second All-India Population and First Family Hygiene Conference was held in Bombay, and the National Planning Committee of the Indian National Congress once again warned of the need for fertility constraint. In 1940
Sri. P.N. Sapru "successfully moved" a resolution in the Council of States for the establishment of birth control clinics - a much broader plan. That year also, the Family Planning Association of London sent Mrs. Rena Dutta, Scottish wife of the Indian head of a missionary college in Lahore, on an extensive tour of the sub-continent, where she met with varying success in organizing services.26

Thus, the initiative in setting up family planning clinics in the 1930s came from a few organizations, but their activities were interrupted by the war. No data on their achievements are available, but it seems that only a few middle class, educated, urban dwellers who were motivated towards family planning made use of the facilities provided; the general population remained untouched.27

Between 1921 and 1941, 67.3 million people were added to the Indian population and in 1943 the government took official cognizance of the problem and appointed a Health Survey and Development Committee, headed by Sir Joseph Bhore. For the first time, birth control was discussed as a question of public policy. Although the Committee was divided on whether to introduce family planning to the poor on economic grounds, it did agree that it should be provided on health grounds and through official medical sources. Contraceptives should be free to women who needed them and the state should control their manufacture and sale. An information program should be started.28 The findings of the Bhore Committee were substantiated by the Bengal Famine Enquiry Commission
in 1946, which recommended active government participation in a family planning program. But, when the provincial governments were consulted, the idea was not favored because of the fear of religious opposition. The number of beneficiaries would have been low, in any case, because the proportion of doctors to population was 1:6,300 and 75 percent were located in urban areas. The ratio of Health Visitors to population was 1:400,000, and health services were few.

Even in States like Madras where the suggestions of the Bhore Committee were supported, the number of people who were given advice must have been very limited.29

Nonetheless, the preliminary groundwork was laid.

The Bhore Committee recommendations were shelved until after Independence in 1947, when the effects of wartime shortages and inflation were exacerbated by the arrival of eight million refugees from Pakistan as a result of Partition.30

It was seen that a "population problem", with social, economic, political and international aspects, was one of the challenges which the Indian people would have to face. In this they were not alone....

It was at such a time that, as a result of the persistent demand by a group of men and women interested in the health and welfare of women and children, two free family planning clinics were started under the Bombay Municipal Health Services. Two years later, some of these workers found that these clinics were not being put to full use because many needy mothers in the city were not even aware of their existence. In July, 1949, therefore, a handful of women social workers formed a Committee to bring this facility to the notice of families living in Bombay city.31
Publicity brought interested men and women to meetings in different parts of Bombay. This Family Planning Committee, headed by Smt. Rama Rau, applied for and was granted a license to import and sell contraceptives at cost to the Municipal and other bona fide clinics. This would fill the gap between the Bhore Committee recommendations and their implementation. By March, 1950, the Family Planning Committee had become a full-fledged Family Planning Association, incorporating several of the interested groups.32

Objectives included education of the general public on the necessity of family planning; and centres for advice on spacing pregnancies, for treatment of infertility and for marriage counselling. Contraceptive appliances would be provided for married couples as cheaply as possible, so that low and middle income groups might benefit. Other objectives were research and "to foster and develop contacts with organizations engaged in a similar type of work in India and abroad."33 To achieve these aims representations were made to the newly-appointed Indian Government Planning Commission "to include family planning as one of the measures for economic development". An integrated scheme for propaganda, clinics, training, field studies, research, guidelines for all voluntary agencies and standards for all clinics was suggested.34

The leaders of the Family Planning Association (FPAI) have been accused of being "middle class women, battling simultaneously against the shackles of puritanism and the
tyranny of men." In the first place, they were not all women. Men were actively involved in the organization from 1953 when a Col. R.N. Khosla of the Family Planning Association of the Punjab, and Professor Sripati Chandrasekhar (who became Minister of State for Family Planning from 1967 to 1970) were members of the Association's delegation to the IPPF conference in Stockholm. Professor Chandrasekhar was also the first editor of *Planned Parenthood*, a four page bulletin still published monthly by the Association. Other men have been members of the All-India council and in 1969, two of the three Vice-Presidents were men. Male doctors headed the clinic services from the beginning. Male participation has been prominent in each of the biennial All-India Conferences on Family Planning, and the several international conferences sponsored by the Association; and they represented a cross section of university faculty, military and government institutions. The President of India, the Vice-President, the late Prime Minister Nehru, and Ministers of relevant departments of the central and state governments have inaugurated meetings and given keynote addresses. The volunteers have been represented on high level government councils and committees and have been urged by government to undertake specific tasks. Battling women would hardly likely have been accorded such courtesies. In the second place, in a society where sexual freedom was rare, and male domination still solidly entrenched, it is not likely that, whatever their aims, FPAI leaders expected to change these conditions over night.
Feminism in the Western sense was not their inspiration. There was a specific and urgent need in the fields of maternal and child health. At least two thirds of the deaths of women in the reproductive age group were from causes connected with pregnancy and childbirth. The maternal death rate was 25 per 1,000 population and infant mortality was as high as 200 per 1,000.

Indian Family planning leaders welcomed outside contacts. Their attitudes were expressed very well in 1959, in the PAI report of work over a ten-year period.

The countries of Western Europe have an experience of several decades in the management and control of human fertility, and lately, Japan has made significant strides in this direction. The movement in India, although directed by Indians on lines suited to their own country and culture, has had the great advantage in that its leaders are able to study and analyse factors which have influenced Western and Far Eastern population trends. Also, the exchange of information by way of correspondence and personal meetings and conferences between Indian and Overseas workers through the IPPF and its member organizations, the Population Council, Inc., the UN Population Commission and other expert bodies, have helped considerably in placing the Indian movement on a sound basis.

But, as far as attracting prospective users of birth control was concerned, there were built-in obstacles - just as in Western countries. Some were the same, others differed. The difference was not so much organized opposition as a combination of nationalism, inadequate social and medical
services, cultural tradition, poor communications and political caution.

Before Independence, to many educated nationalists, the cause of Indian poverty was not population growth, but British exploitation of the sub-continent. In spite of high birth-rates, Japan had made progress after her victory over the Russians in 1905. Her industrial expansion had been impressive and India could follow the same course, they said. Even if her population growth was too rapid, artificial birth control was barbaric. Self-regulation should be the only means, and would help to inspire people to return to Aryan traditions of self-reliance and reason.

Both the progress of industry and the more conscious limitation of families will follow in strict measure the realization of progressiveness and purposeful action in our conduct.

Similar objections were heard after Independence, and supported also by Marxist argument that over-population could be cured by bringing capitalism to an end. As for cultural obstacles in diverse India, a few generalizations are possible.

Indian cultural tradition was still male-centred. Sons were vital - to share the work in the fields and to support parents in their old age. They ensured family continuity and filled an important role in paternal funeral rites by propitiating the dangerous spirits which might impede the path to reincarnation. At least two sons were desired, in hopes that one would live to maturity. Therefore, the number and birth
order of sons influenced the degree of marital fertility. Shyness, and ignorance of the physiology of reproduction also played a part — for example, in the cases where the "safe period" was known, it was frequently believed that the fifteen days of mid-cycle were the safe days. The fact that contraception was possible at all was unknown to the majority and led to the commonly asserted phrase, "It's God's will" — meaning that nothing could be done to avert a pregnancy if it was going to occur.

On the other hand, tradition also provided some fertility regulation. In some parts of India, intercourse is forbidden on more than one hundred festival days a year. Some people believe that coitus by the parents is inauspicious for a baby who is being breast fed (an almost universal practice), and that the period of self-restraint should be shortened only by its death or premature weaning. When this taboo is observed, it tends to lengthen the period between pregnancies. Practitioners of indigenous medicine also believe that semen, when retained, produces energy (ojas) which is diffused over the body via the heart. This idea has been used to support the case for vasectomy.

Related to the idea of energy through restraint, among middle and upper income groups, at least, there is the Hindu tradition of asceticism during the first, third and fourth stages of life (the asramas). Gandhi was a very influential proponent of this rule, believing that self-control was a very important ingredient for social and economic
progress, and, as a leader of the Independence movement (and, having fathered three living children) he decided in 1899 to live a continent life. In 1906 he took a formal vow of celibacy (Brahmacharya). Thus, when Margaret Sanger paid him a visit in 1935, he agreed that women should have control over their own bodies and that family size should be limited, but was adamant that continence was the only acceptable method of birth control. Women must say "No" to their husbands; and, after three or four children, couples should live apart. Otherwise they would never learn the virtue of self-restraint. Gandhi was also convinced that, if each person labored only for sufficient to satisfy his individual need, all would have enough, and there would be an end to the cry of over-population. On the other hand, an equally noted Indian, Dr. Sarvepalli Radhakrishnan, former president of India, and a scholar of repute, always maintained that birth control is necessary, and there is no specific opposition in Hinduism to contraception.

If religion was not a serious obstacle, other conditions impeded family planning. Welfare programs and medical services were scant. In addition, lack of training for doctors and others in birth control services also obstructed the program. Western trained physicians had acquired Western attitudes to contraception, and with the few individual exceptions noted, the result was medical inertia. Resolutions might be passed at medical meetings in support of family planning and in response to such leaders as Margaret Sanger and Mrs. How-Martyn,
but that was the end of it. Although by 1966 some Asian countries were reported to be giving five times as many hours of instruction in family planning in their medical courses as were the United States, the United Kingdom, and Canada, in 1967 Dr. Chandrasekhar was still exhorting Indian medical schools and colleges to greater effort. 48

But, as a result of these obstacles, and because there was no way of estimating the political consequences, the Union government was slow to put into effect a fully supported family planning program, and State governments were even slower. Not only were political pitfalls feared, but the states were reluctant to spend money on a program for which necessity had not been proven. Furthermore, the first Minister of Health in the Central government, an Indian princess named Raj Kumari Amrit Kaur (a Protestant, but a devotee of the Mahatma), stood in the way of any method but rhythm for ten years. 49

Nevertheless, as a tentative health and welfare measure, the Union government was prepared to subsidize the FPAI in increasing amounts to carry out an action program of birth control services, and to have its representatives sit on planning bodies. These funds were never enough to do an effective job, however. Vast amounts were required for training, for research, for propaganda, and the extension of services, and, though the FPAI knew it, they were never given carte blanche. On the other hand, officials in the field of population policy did not hesitate to take advantage of opportunities available through the FPAI to travel, to
participate in conferences and to learn what they could. Unfortunately, because of reluctance for the first ten years, population pressures have greatly increased, and now that the government is seriously promoting birth control, politically led communalism - both racial and religious - has posed a new threat to the program.

The Jan Sangh, a right wing Hindu extremist party, has attacked the family planning program as a threat to Hindu numerical supremacy, and Dr. Chandrasekhar, as Minister, was forced to counter with the information that

... Muslims, Christians (both Protestant and Catholic) and other minority religious communities are all coming to government clinics, and the communal ratio of the Indian population shows no signs of changing. All evidence shows that these Hindu extremist fears are groundless and that educated and motivated husbands and wives resort to family planning while the very poor, the ignorant and the unmotivated do not - among all religious groups.

He observed that Muslims, in theory, had the privilege of four wives, but that, in practice, 95 percent had only one, and further reform must originate with the Muslims, themselves, particularly the Muslim women. Indian and Foreign News noted that the Papal Encyclical of July, 1968, against artificial means of contraception, had provoked a crisis of conscience for the Roman Catholics of India (there are only 10.5 million Christians altogether) and speculated whether they would initiate a campaign against government policy and thus create further communal tensions, but no action of this sort is apparent, the prelates on the spot being realists.
But what of the individuals who used birth control?

As far as they were concerned, for the intellectually motivated, there was continence. The more prosaic middle and upper classes practised *coitus interruptus* or used the diaphragm or other artificial methods. *Coitus interruptus* was practised by some village people as well, but induced abortion or "unconscious" or deliberate infanticide (of girls, in particular) was their main alternative to unlimited fertility. In proportion to the population of India, those who used contraception were very few, and motivation to accept the services offered by the FPAI and, later, by government, depended largely on the influence of the obstacles already discussed. The role performed by the FPAI was in providing a forum for discussion and exchange of information among influential Indians, and in testing public reaction to both promotion and provision of services. It also marshalled evidence to persuade the government that action should and could be taken with safety, and developed the prototypes for promotion and the delivery of services.

Co-operation between the government and the FPAI was close from 1950 on, when the voluntary organization was invited to send representatives to the advisory panels on health and welfare of the Planning Commission. Smt. Rama Rau joined the former and Smt. Wadia the latter. Family planning was included in the First Five Year Plan, and Rs. 6,500,00 allocated for the program. In the meantime, the FPAI inaugurated the first in a series of increasingly prestigious periodic
All-India conferences on family planning which have had an important educational function, and in which the interaction between the FPAI and the professionals is of interest. It was held in Bombay in December of 1951. Dr. Chandrasekhar, then Director of the Indian Institute of Population Studies, University of Baroda, and a Board member of the FPAI, gave the inaugural address. The presence of 110 delegates, including many doctors, indicated wider interest in the idea of family planning than had been anticipated. Instead of the "birth control" concept of former years, the theme was, "Conscious and Responsible Parenthood". Resolutions advocating a national institute of population research, demographic, sociological, health, and other studies were adopted. Education for medical and para-medical personnel was urged, and it was agreed that treatment of infertility and marriage guidance should be given. As had been recommended by the Bhore Committee, a wide choice of contraceptives should be manufactured in India, and distributed free to all. Better public education, training, data collection, and evaluation were essential.\footnote{54}

In 1952 the organization of the Third International Conference on Planned Parenthood in Bombay and the formation of the IPPF, drew more attention to the movement. Eighty delegates from thirteen foreign countries, and four hundred from India (including the Union Ministry of Health, some State governments and the Indian Army) attended. As has been noted, in 1953 the FPAI commenced publication of the four-page monthly news bulletin, *Planned Parenthood*. In 1954 Dr. Pillai started
the Journal of Family Welfare, a source of information and reports both of which are still published by the Association, and subsidized by government grants. Posters, films and other visual aids were also undertaken.

In the meantime, the Union Ministry of Health had made a tentative start on a government program by approving sterilization and advice on contraception for medical reasons, but only if doctors had time! Furthermore, contraceptives were not to be given to the poor as "they might not use them". Studies were to be allowed, but no action was to be taken. The Minister of Health, Raj Kumari Amrit Kaur, agreed to an experimental research project on the "safe period" in which, after considerable negotiation, the World Health Organization was persuaded to assist. Under WHO auspices, Dr. Abraham Stone, of the Margaret Sanger Clinical Research Bureau in New York, was loaned to conduct experiments in Calcutta, Madras, Mysore and the Delhi area. These trials began in May 1952, lasted for nearly three years, and suffered many vicissitudes. The women were given charts on which to record details of their menstrual cycles, but they proved unable to do so. It was concluded that they were too poorly educated, so an alternative was devised. They were given strings of coloured beads - orange for the days of menstruation, green for safe days, and red for fertile days. Special adjustments had to be made for the women whose cycles varied in length, and, because the color was indistinguishable at night, the shape of the beads had to be changed. Some women disliked the beads
because they caused gossip in the neighborhood; others (applying the commonly accepted taboos about menstruation) would not touch the beads on the days of their periods; still others forgot to move a bead a day, or assumed that the mere moving of the bead provided protection against pregnancy. In the end, only a few were able to use the method, and the project was judged a failure. Because Roman Catholic influence was strong in WHO, no further experiments were permitted by that agency for another ten years.56

The Second All-India Conference on Family Planning was held at Lucknow University in January, 1955. Smt. Rama Rau reviewed progress in the government program to date. Little of the money allocated in the First Five-Year Plan had been spent. Training had been neglected, especially in the medical colleges. No plan had been devised to spread knowledge of family planning among the people, or to manufacture contraceptives in India. No research had been done on simple methods. A centralized institution for research was needed and an inter-disciplinary approach was required. Marriage counselling and help for the infertile was also a must. Spacing or limiting pregnancies for health or economic reasons was the best approach. Because they were "non-political", voluntary social workers could play a vital role with government, and with organizations in other countries.57 Dr. Radhakamal Mukerjee, Vice-Chancellor of Lucknow University, urged a stable population, a three-child family ideal, and, to encourage the practice of family planning, a program for social security.
Birth control would not cause immorality, but a mass campaign was necessary to create new values. Indiscriminate increase would only increase the dependency ratio and place an unnecessary drain on resources.\textsuperscript{58}

Dr. K.C.K.E. Raja, of the Ministry of Health, where Gandhism still prevailed, warned that with reduction in mortality, the population would increase in any case, and that the rest of the world should share its resources with India. Spacing was not a useful theme, as there was already an average of four years between pregnancies. Women instinctively resisted artificial birth control, and those who used it would create psychological problems for themselves. Semen had a beneficial effect on them, stimulating their generative powers. Cancer could result. If the middle and upper classes were encouraged in fertility control, the overall intelligence level of the population would be reduced. Abortion and sterilization were also unthinkable. Rhythm was the most suitable method, and would be successful if the husbands were educated to its use. Other speakers favored contraception, however, and the usual resolutions urging research and medical training were passed. Dr. Chandrasekhar's arguments in favor of birth control were published the same year. It was an alternative to abortion. Because people wanted to limit their fertility, it should be an integral part of the development program. Conservation of human resources through improved health was essential. Village women were emerging from their apathy, and their attitudes to childbirth should be guided along these
lines. Sex education for women and for all students in schools and colleges was essential, and birth control should be free. "Whether it is moral or immoral is not a matter of objective fact but one of subjective attitude", he said; and the Gandhian view, which favored freeing women through abstinence, ignored the fact that women might enjoy intercourse.

The Third All-India Conference on Family Planning was held in Calcutta in January, 1957. Guests from Egypt, Indonesia, Pakistan, China (Peking), Singapore, the United Kingdom, the United States, the Pathfinder Fund (Mrs. Margaret Roots), and N.K. Sarkar, a demographer from Ceylon, attended. Nineteen papers were read, followed by a seminar on marriage counselling and sex education, conducted by an American, Dr. David Mace. Dr. J.C. Gosh of the Planning Commission praised the FPAI for its crusade, and urged it to persuade the Social Welfare Board (a co-ordinating agency for women's voluntary organizations) to support the cause. Smt. Rama Rau's presidential address noted that government support of family planning was increasing, but there were still many shortcomings in the official program. Less than half the money appropriated had been spent, there was no central institute for clinical work, training, trials, fertility and infertility studies, and nothing at the state level. No special courses were being given in schools of medicine, nursing, or social work. Some research had been done in genetics, economics, and demography, but progress was uneven. Volunteers were still needed to pioneer where the government was unable to do so, and the FPAI could assist in
standardizing policy and procedures. Family Planning was not a plan to limit fertility, but one to space pregnancies for health and happiness.

Lt. Col. B.L. Raina, Secretary of the Central Family Planning Board, and Director of Family Planning, assured the audience that better organization was on the way and that more help would be given the states, local bodies and voluntary organizations. Dr. K.C.K.E. Raja, now co-ordinating officer of the Demographic Training and Research Centre (to be opened later that year under Indian and UN sponsorship), spoke once more. This time he was more enthusiastic about the program. He was still opposed to abortion, but approved sterilization by mutual consent of parents with completed families. There was an acute shortage of doctors, so teams and camps for birth control were a good idea. Mass education was also needed. Genetic study of intelligence and heritable defects should be carried out (there was ample material in the caste system and endogamous marriages). Dr. C. Chandrasekharan, Professor of Statistics, All-India Institute of Hygiene and Public Health, Calcutta, doubted that raising the age of marriage would succeed. Instead, rural people should be motivated to change their attitudes, and economic development should be prompted to help them do so. 61

It should be noted here that studies of the economic aspects of population growth had already been done by Indians and outsiders. In 1946 D. Ghosh had published Pressure of Population and Economic Efficiency in India, in which he urged
a population control program. J. M. Keynes had suggested it in the 1920s, and Kingsley Davis had recommended it in 1951 and 1954. At the Calcutta conference itself, Dr. M.C. Balfour of the Rockefeller Foundation, gave a summary of a 1956 preliminary draft of a book by Ansley J. Coale and Edgar M. Hoover, showing the negative effect of population growth on economic progress. In its published form its message was,

High fertility is a necessity for human survival when mortality risks are great. When mortality risks are reduced, high fertility becomes a burden - by increasing the dependency ratio, by diverting capital from uses that would raise per capita output, and in the long run by overwhelming any finite resources. If better health and longer life are valued, high fertility must be considered an extravagance. A population with high incomes and ample resources may be able to afford it for a period, perhaps for many decades. But a low-income area with high fertility that chooses the luxury of sustained births inevitably chooses to forego a much more rapid expansion of per capita incomes. Reduced fertility permits higher per capita incomes in the short run and in the intermediate future; in the distant future it can avert the otherwise inevitable return of poverty and high death rates.

In the same year Robert C. Cook gave India only a generation to find a solution, and urged incentives to speed the process and avoid catastrophe.

The Calcutta conference urged once more that medical training in methods of birth control be given, and pressed the government to introduce the program in the plantation areas and in industrial enterprises. About the only progress made had been in slogans: birth control in the First Five-Year Plan
had been for "family welfare". In the Second (1956-61) it became a "key factor in development", but action was still hesitant and tentative. The frustration of the FPAI was summed up by Warren S. Thompson, a pioneer observer since the 1920s:

The Planned Parenthood movement in India is well organized and quite vigorous, but its leaders would be the first to recognize that it does not reach many people and that it is having only a negligible effect on the birthrate at present. Handicapped by inadequate funds and by lack of trained workers, it cannot carry on any large campaign.... Most of the clinics now in operation are in the large cities, and some of these are not yet being used to capacity, probably because of inadequate propaganda. To say the least, this situation is profoundly discouraging to those people who are the most deeply convinced of India's need for family planning and who are giving generously both of their time and money.65

The FPAI's own summary of ten years of propaganda contained the urgent recommendation that services be extended through a "country-wide network of clinics supported by a massive and sustained educational programme which must be implemented with patience and faith," but a dynamic start was still five years away.66

The Sixth International Conference on Planned Parenthood was held by the IPPF in New Delhi in February, 1959. The theme was, "Motivation and Methods". It has already been described in part in Chapter IV, but items about India should be noted here. Sir Julian Huxley, a famous biologist, the former Director General of UNESCO, summed up India's
motivational problems as conformity, illiteracy, undernutrition, pressure on space, urbanization, special problems because of migration and unemployment, deforestation, and erosion, water shortage, spoliation of recreation areas, and lack of conservation policy. Like Robert Cook, he, too, recommended incentives to reduce fertility - a reduction in family allowances after two children, and a modified tax system penalizing those with large families. A paper by Dudley Kirk, then Demographic Director of the Population Council, urged more motivation for men and the promotion of more male methods of contraception. In any case, a wider choice of methods, especially those which did not require a doctor's assistance, should be used. There should be less "clinic" orientation, more publicity, and more research in knowledge, attitudes and practice. People were interested however, motivation in urban areas was higher, but, in both cases, services must be well organized and all must be warned that methods could fail. 67

Professor S. Chandraskhar, by this time Director of the Indian Institute for Population Studies in Madras, reported on the Kaufman Foundation Clinic at Mangadu (Madras State). This project had been financed for four years from 1955, by Mr. A.S. Kaufman, President, Parents' Information Bureau, Ltd., Kitchener, Ontario, to find out whether the average mother wanted to space those she had with a minimum interval of two years, what were the barriers to acceptance, and what methods would be well received. It was found that most would
like to limit family size, but that the need for sons took precedence. There was the need to emphasize spacing, child care and general health. The women were not aware that the government had approved the experiment; so better information services were needed. In two-and-one-half years there were 1,200 acceptors but 192 failures because the method chosen was not used. The reasons for failure were reported as: lactation, aversion to handling the genitals, or the method was too messy. Dr. Chandrasekhar's American wife had done most of the work and it was concluded that an outsider could promote family planning. Most of the patients wanted it for economic and health reasons, but motivation was not strong enough to induce long term use. As diaphragm and jelly was unsuited to a rural setting, simpler methods had been tried. Tampons and oil or salt solution were unpopular. The sponge and foam powder were acceptable. An ideal method was needed—an injection, a pill or the like—and vasectomy should be pushed because it made an end of fear and encouraged better child care. The government of Madras was undertaking such a campaign.

A study group on sterilization, presided over by Dr. C.P. Blacker, and with Dr. G.M. Phadke as rapporteur, appears to have produced some conflict. In the meeting there was no opposition in principle to the method, and a resolution urging support was passed unanimously. It was a safe, acceptable and effective method, and reversible by Dr. V.N. Shirodkar's technique; and more information should be given to the medical
profession and the public. The necessary facilities "should be made available free of charge to persons who seek them voluntarily." Though it was legal, doctors seemed to feel the need for protection, and governments should make sure this was provided.

The motion was proposed by Sri R.A. Gopalaswami of Madras, and seconded by a "Dr. A.M. Mehta" who appears to have been neither a delegate nor a speaker, and, judging from his name, was from the Bombay area. When it was considered by the Governing Body of the IPPF the following resolution was passed:

The Governing Body noting the recommendation... and realizing fully the value of sterilization in many situations, hereby resolves that, in the present state of knowledge, it would be premature for the IPPF to take a position in this matter at this time.

It was decided to leave the question to the member countries to deal with as they saw fit.

Dr. C. Chandrasekharan, another Indian demographer now Interregional Adviser on Population at the United Nations, like Thompson, noted that people were interested in family planning but rural motivation was weak. Motivation in urban areas was higher, but, in both cases, services must be well organized, and all must be warned that methods could fail.

In a private brief to the Central Government in October, 1959, the FPAI expressed its impatience with the lack of progress. It pointed out that the Central Family Planning Board (of which Smt. Rama Rau was a member) had not met for a year.
State efforts were inadequate, and co-ordination and inspection were required. More money was needed by the voluntary organizations. Cheap contraceptives, manufactured in India, were essential; and a better plan should be made to enlist support of the medical profession, labor departments and trade unions. The FPAI urged more research in India (in preference to waiting until the West did it); and, once more, the need of instruction in medical colleges, nursing schools, and schools of social work, was stressed. The government program was good, so far as it went, but there was danger that it would slow down routine health services, that it would be subject to the usual bureaucratic convolutions, and that the sense of urgency would be lost. Economic incentives were recommended and a special ministry was required to carry out the whole concept. 71

No doubt as a result of this challenge, Smt. Rama Rau was appointed chairman of the Central Family Planning Board's committee on the Third Five-Year Plan, to survey progress and formulate proposals. She and Mrs. Wadia sat also on the Advisory Health Panel of the Planning Commission while discussions of family planning were in progress. But still the program lagged.

At a conference on research in family planning, held the same year in New York, Professor J. Mayone Stycos, a sociologist, now of Cornell University, who was also concerned about the delay in effective action in developing countries, blamed the "Traditional Planned Parenthood Approach" for the problems. He repeated the criticism three years later in a
slightly different form, and many of his points were well taken. But the bad as well as the good have since been enshrined in two books which are frequently read by students of population problems; and the impression has been created, by inference, that the volunteers were behind the times, ill-informed and inflexible. Because it has a bearing on current and future relations between professionals and volunteers, the air should be cleared.

Stycos said that, because it was derived from American and British experience, the traditional planned parenthood approach should not be used in developing countries. But, as noted earlier, other countries also influenced the "traditional" approach and, from these contacts, India introduced her own action program. So long as the basic IPPF tenets were observed, the member organization could make it fit local circumstances and needs. As there was no other background of experience than that of the volunteers in the industrialized countries, it was natural that some attitudes would be transferred. But the result was not all bad.

Specifically, Stycos said that the "traditional" approach had three biases - all unsuited to Asian cultures. It was too medically oriented, too middle class, and too feminist. In the first instance, it was dominated by doctors, the most conservative of professions, so the health of the mother and child took precedence over other considerations, and services were clinic-bound. Even though it was not necessarily suited to all Asian users, the diaphragm-and-jelly was advocated before
other methods. Though sterilization and abortion might be socially therapeutic, these procedures were forbidden, and, regardless of their value in population control, the IPPF had refused to support either at its 1959 conference. The idea of spacing pregnancies as a means of birth control was incomprehensible to parents in a developing country who spaced them by 3 to 4 years anyway, and the treatment of infertility had been built into the program to give it acceptability with the establishment.

Second, he said the program was middle class and, hence, moralistic in its approach. It refused to serve the unmarried, and was based on unfounded elite theories of the fertility of the "lower classes". It was frequently said, for example, that rural electrification would slow their reproductive activities.

Third, it was feminist. Services were run by women, for women, to free them from male exploitation, and probably even to help them dominate. On the grounds that males were irresponsible, male methods such as condoms and withdrawal were not taught. Stycos approved contraception for maternal and child health, but suggested that an effective appeal could also be made to men on economic grounds. If home visiting or promotion through village leaders were built up, motivation would be more sustained. Simple methods should be distributed through commercial channels and withdrawal taught. More men should be employed in promotion with men. Finally, government should take over all policy control, and replace medical
influence with that of social scientists, community development and communications specialists. The amateurs should be replaced by professionals.\textsuperscript{72}

Dr. William Vogt of Planned Parenthood, George Cadbury of the IPPF, and Prof. D.V. Glass, of the Institute for Population Studies in England, explained the reason behind some of the "traditional" policies, and certain points should be made here.\textsuperscript{73} Medical support was needed for acceptance of a controversial service, and also for the delivery of "medical" methods. It was also necessary in order to have family planning included in ordinary health services, one of the most obvious routes to multiparous women. Clinics were useful as demonstration projects and for training. But the need for home visiting was also recognized, and, limited though their effort was, the FPAI, had pioneered the idea. They had also pioneered the use of the mass media, and, in addition, had started family planning services in industry. Because their funds were limited, and personnel few, their work did not extend far into the rural areas. The diaphragm was favored by the volunteers in South Asia, too, because it was the most reliable method. While low income women might not have the privacy of bathrooms, some found a way to use it, especially as intercourse often takes place without preliminaries, and, for example, when they take lunch to their husbands when the crops are high.\textsuperscript{74} In addition to the diaphragm – sponge and jelly, and foam tablets were also distributed. The condom was associated in the medical mind with prostitution and the
need for protection against venereal disease, so it was not popular at first with the family planners either. Withdrawal was opposed because it was then believed to be emotionally unsatisfactory, and also because it sometimes failed. Female sterilization had been performed in India as early as 1954, and vasectomy was also offered by the FPAI. The latter was not popular for some years, however, because men thought it was castration. Doctors were also cautious because of imagined legal liability. Professor Chandrasekhar, as a member of the FPAI, had been advocating sterilization since 1955. Infertility services were indeed defensive in both the West and in South Asia, and for good reason; but, in the latter, they had an added attraction. Infertility was such a social tragedy for women that the diagnosis of both husband and wife and treatment for whichever was responsible, could sometimes relieve women of the serious stigma of being "inauspicious". The "traditional" approach to induced abortion had several bases: it was illegal, and, before the advent of antibiotics, induced abortion, even in the best circumstances, was still relatively dangerous. It would also require massive investment in facilities and training; and, after all, Margaret Sanger and her contemporaries had used the dangers of abortion as justification for contraception as an alternative.

The movement was indeed middle class, but most reforms originate with the middle class. Their attitudes to birth control for the unmarried varied from country to country, but, from the point of view of public relations, it was the best to
emphasize that it was for the married. In India and Pakistan the formal statement uses the term "married couples". In Ceylon, it is "couples", and in Nepal, the married state could be inferred, as the service is for maternal and child welfare, and it, too, is a traditional society. In practice in South Asia, exceptions were made, no doubt. As for invidious opinions of "lower class" fertility, it would be surprising if some family planners had not had them; but, from personal experience, I believe they were few. In any case, in India the FPAI set out to serve "middle" income groups as well as the "low".

In Asian countries "class" was irrelevant and caste distinctions too complex for easy definition. Those who suggested to me that electrification would reduce fertility, were not active in the family planning movement.

As for feminist bias - a few feminists were active in Western countries and Japan, but it has been shown in this paper that nowhere was the movement run exclusively by women, for women. The need for maternal and child health in Asia has already been noted. (See p. 113.) Because birth control services were usually open in the daytime only, it was natural that most of the workers and clientele would be women. From 1952 the FPAI had offered male sterilization, and, from 1954, condoms were prescribed. More men were certainly needed in the task of getting male support, and also in delivering the services, but men were running the government program, and most doctors were men. Their shifts in policy and emphasis
over the years show that inflexibility was not a characteristic of the volunteers.

There were weaknesses in the system, to be sure, but no background of experience had existed; there was little or no dynamic political support, and socio-economic and logistical problems had not been solved. It was still a controversial and vulnerable program, and needed a few safeguards. There was no doubt that medical influence was strong, and should have been leavened by other professions, including social scientists, community development workers and communications specialists. But in 1960 these were relatively new professions. Demographers and economists were already active, trained social workers were beginning to enter the field, and the volunteer family planners were prepared to welcome anthropologists and sociologists as well. For example, their sponsorship of conferences was a direct means of encouraging interdisciplinary communication.

By the time the FPAI organized the All-India Family Planning Conference in Hyderabad early in 1961, the Indian government was beginning to realize that the economic consequences of population growth were serious, that Independence by itself had not provided the solution, and that birth control was an urgent necessity. But their approach was very "traditional" just the same. The Planning Commission had said that family planning was the "key programme for the Third and Fourth Five-Year Plans". D.P. Karmarkar, Union Minister for Health, explained that family planning in the
first two plan-periods had been "preparatory" phases for the Third Plan. Limited services were now being offered, but they should be taken to the masses, especially those in rural areas. More rural leaders should be involved, and the help of the voluntary organizations was still needed. The Family Planning Commissioner, Lt. Col. B.L. Raina described in glowing terms a fourfold plan for the reorganization and expansion of government services, training, education and research. Orientation camps for local leaders, and exhibitions were now proving successful, and Honorary Family Planning Education Leaders to promote local voluntary groups were also effective. Considerable progress had been made to date, both by government and by the volunteers, and targets for the future were established. It was agreed that more effort should be made to enlist male support (Dudley Kirk had suggested it at the Sixth IPPF conference in 1959). A resolution to the WHO Assembly (soon to meet in Delhi) pointed out that saving lives was admirable, but people also needed information to plan their families, and thereby improve their lot. 

By the end of 1963, some 28 Knowledge, Attitude and Practice (KAP) studies had been done by professionals in India, and the government published the results. In general, people were receptive to the idea of family planning, but methods and provision of services were weak, and motivation depended on individual circumstances. Three or four children was the desired family size. There was little or no communication between husbands and wives on the subject of birth
control and methods suited to village life were needed. Parents-in-law, and the demands of religion were said to have little influence in decision-making, but in view of tradition, of the need for old age security, and for sons to participate in religious rites, this last point is questionable.

When the Fifth All-India Conference on Family Planning was held in Patna in January, 1964, 300 representatives of both government and voluntary agencies heard Sri Asoka Mehta, Deputy Chairman of the Planning Commission, repeat what they already knew - that attitude surveys had indicated receptivity. There were 9,000 clinics and service centres, of which 7,000 were rural. Sterilization had proven to be acceptable in Madras and Maharashtra; some training was given in some university undergraduate courses, but the help of industry, trade unions, and village teachers should also be enlisted. Above all, to co-ordinate and improve the work, each state and district must set up a firm program. In confirmation of the failure of the family planning scheme to get off the ground so far, Dr. C. Chandrasekharan, then Director of the Demographic Training and Research Centre in Bombay, noted that although India was in the midst of her Third Five-Year Plan, no decline in the birthrate was evident. Induced abortion should be legalized, he said. Abortion and sterilization could be promoted in rural areas as more effective than ordinary contraceptives.

Improvements in the government program were made gradually, and more dynamism was injected, but it continued to
lumber slowly on, suffering from lack of political courage, scattered state co-operation, and inadequate promotion and services. In 1965, at India's request, the United Nations Technical Assistance Program sent a team of advisers, headed by Sir Colville Deverell, former Secretary-General of the IPPF, to study the Indian family planning program and make recommendations for its improvement. Their report concluded that, in spite of continued improvement and a reorganization in 1963, little progress had been made in reducing the birthrate. Some of their suggestions were already being implemented (nor were they all original), but it was recommended that the IUD, sterilization, and condoms be the main methods offered, and that incentives be given both the acceptors and the motivators. These services should be offered initially through hospitals, urban clinics and health centres where personnel were available, then taken to the rural areas through IUD and vasectomy camps. A post partum IUD program should be included as well. Condoms should be free or at very low cost, and distributed through health centres, tea shops, general stores, and chemists' shops. Long term plans to provide many more trained people should be made, and, in the meantime, short courses should be offered. Refresher courses should become permanent features of the training program. Incentives for doctors to give their services in this field, and to attract them to rural areas should also be given. Health educators and mid-wives should be trained, and teachers should be enlisted. Instead of emphasizing the burden of a big
family, the benefits of a small one should be stressed. Community development and local panchayat personnel should be enrolled. Industrial firms, plantations, government offices and armed forces could easily be reached. Constant research, review and evaluation should be undertaken. The entire Central and State government apparatus should be involved, voluntary agencies [italics mine] religious, and other professions, factory workers, trade unions and co-operatives as well. Above all, the entire program should be given autonomous status, much more financial support, and be upgraded to senior cabinet rank, both at the Centre and State level. Positive leadership should be given by all persons in positions of authority at every level. With these conditions, it should be possible to reduce the birthrate by about one third in ten years, and the growth rate to 1 percent per annum by 1985.

Without such true priority to family planning, which inevitably means the diversion of effort and resources from other desirable objectives, the programme will not succeed. With it, there is great hope that it will.82

India now had guidelines for the program she had long needed.

In 1966 the new plan began to take shape. To speed it, the government offered to pay all state and local costs - an invitation which did much to remove a serious roadblock which had existed in the past.83 The Union Department of Family Planning was set up, 6 regional centres for liaison with the states and representative state, district and local bureaux were established. The voluntary organizations were given
full support. A mass communications program was put into
action using all media – including press, radio and TV, films,
film strips, songs, dramas, push carts and posters – with a
symbol consisting of an inverted red triangle, and cartoon
figures of a man and wife and two children with the slogan:
"Two or Three Children ... Enough!"^84

In mid-1967 Dr. Chandrasekhar was appointed Minister
for Health and Family Planning, reporting direct to a Cabinet
Committee consisting of the Prime Minister, the Ministers of
Planning, Finance, Health, and Food and Agriculture. His
Central Family Planning Council was comprised of States Min-
isters for Health and Family Planning, Health experts, and
representatives of voluntary family planning organizations.
On the services side, was a Secretary, Department of Family
Planning, a Commissioner for Family Planning, and six Regional
Family Planning Officers. Their task was set out in a very
concise little handbook, backed up with a set of frightening
statistics. In addition to the fundamental problems of 14
major languages, more than 200 dialects, low literacy and
non communication, there was a net increase annually of 13
million Indians, and each year they would require

| 126,500 schools | 188,774,000 metres of cloth |
| 372,500 school teachers | 12,545,300 quintals of food |
| 2,509,000 houses | 4,000,000 jobs |

Although food production had increased from 55 million tons in
1951 to 72 million tons in 1965, per capita food consumption
had decreased from 12.8 ounces to 12.4 ounces per day. Unem-
ployment in 1951-52 was 3.5 million, but, by 1961, in spite of
31 million new jobs, it had reached 10 million. In 1950/51 23.49 million children were in school. Facilities had increased by 300 percent, and, in mid-1967, there were 76.5 million in school, but 63.8 million were not yet accommodated. *A detailed plan of action was included and targets set: 17 million loops to be inserted, 6 million sterilizations done, and 400 million condoms distributed by 1970/71.*

In the meantime, instead of the usual periodic conference, the amateurs took charge of the organization of the Seventeenth International Conference on the Family, which was held in December, 1966, in New Delhi. The meeting was sponsored by the International Union of Family Organizations, and the theme was, *Changing Family Patterns in Asia.* FPAI participation indicated its growing interest in family life education. 27 countries were represented by 773 participants. Population problems, marriage, family living, social services, and research were among topics discussed.

The FPAI reverted to its usual pattern in 1968, however, holding its Sixth All-India Conference at Chandigarh in November. Nine foreign countries were represented. For the first time in the history of family planning, representatives of the World Health Organization (WHO), and the United Nations Educational, Scientific and Cultural Organization (UNESCO) were present, and addressed the meetings. The blockage at the UN had been, at least partially, cleared by the Declaration of Human Rights and the World Leaders' Declaration on Population in 1966 and 1967.
scientists, doctors, volunteer social workers and others had gathered to "highlight progress so far and identify needs" in order to achieve a birthrate in India of 23 by 1978. News was good and bad. The rate of sterilizations had more than doubled since 1966, and was still increasing, but the government IUD program had run into serious problems (outlined on page 151). Condom distribution was just beginning to build up. The government representatives urged the volunteers to continue their efforts, and to mobilize support among the people. Family Life Education in the schools was a new challenge in which they were needed.

In September, 1969, the FPAI met for a special three day conference to analyse its activities and consider its future role. It was agreed to continue to comment and recommend regarding government policy and program, to continue FPAI action programs, to increase to the utmost its promotional work, to carry out pilot projects, to forge links among related disciplines, and to promote contacts with family planning or similar organizations abroad. The FPAI would continue to organize congresses to promote an exchange of information nationally and internationally. Population and family life education in the schools would be a new pursuit. In other words, there was still a catalytic role for the volunteers.

After more than two years of intensive work on India's population problems, Dr. Chandrasekhar, as Minister of State for Health and Family Planning, stated in October, 1969 that
the three most important remaining needs were communication to more than 500,000 villages, an ideal contraceptive, and the means to motivate the poor to use it. The following month, the Central Family Planning Council met at Bhopal. Many aspects of the work were considered in detail, including education, administration, the role of the voluntary organizations, private medical practitioners, and recruitment of local opinion leaders. It was agreed that targets should be more realistic and geared to capability, but the objective should still be to reduce the birthrate, believed to be 39 per 1,000, to 32 by 1974, and to 25 by 1979. The need to fulfil training targets was stressed. Mass education and extension training, including information on methods, should be further expanded. Population education in schools and colleges should be promoted, and involvement of private doctors and homeopathic practitioners sought. The private practitioners could be offered incentives comparable to government staff members. If homeopathic personnel were given basic courses in anatomy and physiology, they could become motivators and act also as depot holders for conventional contraceptives. The participation of newly-weds and young couples with one or two children should be promoted, using the theme, "Next Child Not Now ... After Three, Never." It was agreed also to establish primary health centres in 400 remote Blocks. Immunization against children's diseases should provide another inducement to the small family norm everywhere in India and a useful contact with multiparous
women. Assessment of the voluntary organizations should be based on the performance of other "established and reputed local centres". In research, training and services, government programs were improving. While details are scarce, the volunteers, on paper at any rate, also had a creditable record.

From the beginning the FPAI realized that accurate data were important, not only for research purposes, but for evaluation and planning. And it would seem that, to some extent, the aim was achieved. Unfortunately the published reports made available to me do not give much statistical information or a clear picture of the performance of the volunteers in the country as a whole. A good deal of comment on activities at Headquarters in Bombay, and in the Bombay area is included; and a few branches (for example, New Delhi, (Old) Delhi, Calcutta, and Hyderabad), have been selected from time to time for special mention. But comprehensive figures on the whole organization and its financing, are lacking.

The FPAI did pioneer work in infertility services, marriage guidance and sex education. It also pioneered mobile vans, and male motivation through industrial and commercial enterprises. Home visiting was undertaken on a limited scale, but whether these ventures can be classed as research is not known. However, while associated with the Kutumb Sudhar Kendra, Dr. G.M. Phadke did do considerable research in vasectomy; and special studies on genital tuberculosis, ovulation detection, the effect of scrotal suspenders on male fertility, and the effect of testosterone were also made. Tests of foam tablets
were conducted for Dr. Clarence Gamble, founder of the Pathfinder Fund. In the past few years, studies financed by the Victor Fund (a voluntary organization to raise money in the United States of America for the IPPF) in the Bombay area have included motivation through mobile teams, promotion through labor unions and other organizations, and propaganda through village school teachers. Female sterilization in Indore was also surveyed. In 1969 work was being done on a follow-up of 900 sterilized male industrial workers in Bombay, the family planning status of 2,500 married Air India employees, and Knowledge and Attitudes of 280 teachers of adult literacy classes, and of 340 of their pupils.91

In government research, besides the KAP studies, it was shown that, where special programs had been introduced, birth rates had declined. At Gandhigram (Madras) the birthrate had been reduced from 40 in 1952 to 36.3 in 1965. In another project, the Demographic Training and Research Centre at Bombay had induced a decline in fertility of 12 percent between 1964 and 1966. At Singur, the All-India Institute of Hygiene and Public Health in Calcutta had achieved a reduction from 42 in 1958 to 34.2 in 1966. In Chotla, the rate had been 29 in 1961, but was reduced to 24 in 1966. The Central Family Planning Institute, in New Delhi had reduced the rate at Mehrauli from 52 in 1964 to 48 in 1966.92 These projects demonstrated that it could be done. One of the requirements, of course, was training, and in training, the FPAI filled a vital role.
In spite of repeated urging by the volunteers, for the first ten years of the government program in India, all training was left to the Family Planning Association. Static courses were given in Bombay, and touring training teams gave seven to ten-day courses in other areas. For example, between 1951 and 1961, more than 250 doctors and about 650 other personnel were given instruction. The need was so massive, however, that after the 1963 reorganization of the government program, with the exception of a few courses run on contract with the Union government in such cities as Hyderabad, the work was done by the tax-supported program.  

By mid-1967 the government had set up five Central Training Centres, and 28 more in States, with 335 District cells. By the end of 1969, 13,000 doctors, 125,000 field workers, and 375,000 part-time field workers had been trained. The Association was still able to hold seminars and symposia on such special subjects as sterilization, sex and family life, and the physiology of reproduction, which filled a useful purpose in support of the government. There were similar developments in the field of clinic services.

These were started by the FPAI in Bombay in 1952, and, by 1957, twelve branches were organized. By 1959 there were eighteen - in Agra, Ajmer, Andhra Pradesh, Bombay, Bengal, Delhi, Indore, Jalpaiguri, Kalchini, South Kanara, Madras, Manipur, Mysore, Punjab, Tiruchirapalli, Trivandrum and Vidarbha. By the end of 1969, the FPAI had 35 branches and was running 175 clinics. Figures were available for 52 of
these, and, in the year ending March 31, 1969, 123,973 new
patients had been served, including 14,000 sterilizations and
11,476 IUD insertions. Most of the patients in the FPAI
clinics had incomes of less than Rs. 100 per month, were
between 20 and 35 years of age, and those with the most
children were the most frequent visitors. It was recommended
that clinics remain open at night so that men could visit as
well. A mobile van was distributing simple contraceptives
and providing facilities for vasectomy on a regular basis.
The Indian Tea Association (in Bengal and Assam) had had the
services of an organizer, and some state and local governments
had been assisted. In addition, the Associated Cement Company,
textile mills, and the Reserve Bank of Bombay were now spon­soring family planning services organized with FPAI help.
Their numbers grew until, by November, 1968, 56 industrial
and commercial firms had introduced their own programs,
covering 111,700 people. The government program had increased
greatly, and, by the end of 1969, 1,779 urban and 29,675 rural
hospital, clinic and health center family planning programs,
and 256 mobile teams were also in action.95

Contraceptives were not made in India until recently.
In 1952 the FPAI was given a license to import them for distrib­
ution to recognized agencies. From the beginning, the Asso­
ciation urged as wide a choice as possible, on the ground that
any method, used regularly, is better than no method at all.
It also advocated that contraceptives be made in India and
distributed free. Diaphragms with jelly were known to be the
most reliable method, and some women used them very successfully, but there was general agreement that an equally reliable method was needed which would be simple, cheap and easily available without the need for a doctor's services. Rice powder and salt mixtures with vaginal sponge or pad were found to be messy and unsatisfactory for aesthetic reasons. Foam tablets came closer to the need, but involved problems of storage in damp weather. Sterilization had always been approved, and many had been done both by the FPAI and some government personnel, but all were equivocal about induced abortion. Some people felt it was a problem of ethics; others that common sense made it a poor substitute for contraception; still others, that medical facilities were inadequate. The law forbidding abortion had been introduced 160 years before, and amendment seemed far in the future. When the Pill was made available in 1960, there were reservations about it too. Recalling the rhythm fiasco, the possibility of costly confusion, and realizing the need for medical supervision, little interest was shown by either government or FPAI. Price was another factor. By the end of 1969, however, 119,000 women (mostly IUD drop-outs) were enrolled in government approved test programs, but the Indian Council for Medical Research had not yet released the pill for widespread use. It was claimed that side-effects were serious, the most likely being reduction in breast milk for nursing mothers.

IUDs were introduced in mid-1965, and sterilization
had been provided since 1956 in some states. All-India cumulative totals in thousands at the end of 1969 were: IUDs, 2,989, and sterilization 5,513. (See Table I, page 152). The reduction in the rate of IUD acceptors from 1967 was due to a combination of unfortunate factors. Doctors were not given sufficient instruction in inserting them, and patients were not often warned that the IUD might cause irregular bleeding, pain, and, in some cases, might be expelled. The failure rate, though small, was also overlooked. Of these problems, bleeding was the most serious. Most low income Indian women are anaemic and can ill afford the extra loss of blood. There are also taboos relating to menstruation which require that a woman be isolated. In addition, it is rumored that one of the pharmaceutical houses, hoping to promote the use of the pill, circulated a rumor that, during intercourse, a man became entrapped in the nylon threads attached to his wife's IUD, and, to free him, her life had to be sacrificed! As improved varieties are now available and doctors are better trained, there is hope that it will recover its initial popularity, but known in India as the "loop", the IUD may also have to be re-named. Sterilizations have also fallen off, partly because some states are not pressing the program, partly because the majority of the most receptive patients (men with an average of 4.5 living children) have now been operated on, and, also, because, in a few cases, the operation has failed. In other cases of pregnancy, it has been found that the wife strayed from the path of rectitude.
<table>
<thead>
<tr>
<th>Year</th>
<th>All Methods</th>
<th>IUD</th>
<th>Oral</th>
<th>Sterilization</th>
<th>Other</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1964</td>
<td>u</td>
<td>0</td>
<td>0</td>
<td>u</td>
<td>u</td>
<td>1,000</td>
</tr>
<tr>
<td>1965</td>
<td>u</td>
<td>318</td>
<td>0</td>
<td>u</td>
<td>u</td>
<td>u</td>
</tr>
<tr>
<td>1966</td>
<td>u</td>
<td>971</td>
<td>0</td>
<td>778</td>
<td>u</td>
<td>u</td>
</tr>
<tr>
<td>1967</td>
<td>u</td>
<td>728</td>
<td>0</td>
<td>1,545</td>
<td>u</td>
<td>u</td>
</tr>
<tr>
<td>1968</td>
<td>u</td>
<td>547</td>
<td>0</td>
<td>1,821</td>
<td>u</td>
<td>u</td>
</tr>
<tr>
<td>1969</td>
<td>u</td>
<td>425</td>
<td>0</td>
<td>1,369</td>
<td>u</td>
<td>u</td>
</tr>
</tbody>
</table>

Estimated cumulative acceptors through 1969 as percent of ever-eligible women = 7.5

Estimated Percentage of Married Women Users, 15 - 44 years: January, 1970

<table>
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<tr>
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<th>1.1</th>
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<tbody>
<tr>
<td>12</td>
<td>1-2</td>
<td>0.1</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Estimated Current Users (Male and Female): January, 1970

<p>| | | | | | |</p>
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11,200</td>
<td>1,330</td>
<td>119</td>
<td>8,711</td>
<td>1,029</td>
<td></td>
</tr>
</tbody>
</table>

The number of condoms (Nirodh) distributed is not known, but, at the end of 1969, the IPPF estimated that .7 million couples were using them. They were being manufactured in India and distributed either free through health services, or 3 for a fraction of a cent through commercial channels. Federal civil servants were even getting a package of 3 each month with their pay checks. Antidotes for pregnancy had been sought in indigenous medicine. Government research had failed to turn up anything reliable except, possibly, the seeds of the wild papaw; but results of the research were not yet final.

By the end of 1968, organization, training and facilities for delivery of family planning services had been greatly improved and the structure for further development existed. Though it was so well organized and so many had accepted a method, the IUD-Sterilization-Condom plan of the government had not yet made any significant difference in the birthrate. More drastic measures were needed. The call went out to the UN for a second Advisory Mission.

Led this time by Leo Mates of Belgrade, the group visited India in the first quarter of 1969. Again, some of the suggestions had already been put into effect. While the Commission did not doubt that the program would succeed in time, it was pessimistic about early results. The continuing problem was to establish family planning as a priority, a permanent program, from Union cabinet and other Central government levels through state and on to local administrations. Facilities, personnel,
vehicles, equipment, supplies and training were still in short supply. Abortion should be legalized, and the teaching of population dynamics and family life education should be universal in the school system.98

But political troubles in India were increasing, and the Congress party became divided into a conservative and a more socialist group – the latter led by Mrs. Gandhi. The Jan Sangh party attacked the family planning program as a threat to the numerical superiority of Hindus, trading on the possibility that, if Muslims continued to be allowed four wives, they would soon outbreed them. Other political opportunists climbed on the bandwagon, so the publicity was soft-pedalled, although the work went on.

Of the 90-100 million couples in the reproductive age group, a total of 11.2 million had been enlisted in the family planning program, and the female component represented 12 percent of married women aged 15 – 44.99 The total population of India is estimated to be 547 million, increasing by 18 million a year. The overall annual growth rate is 2.5 percent, and, if this rate continues, the population will double in 27 years. 41 percent are now under the age of 15 years, and, when this youth group moves into the reproductive years, the population increase will be staggering.100 The birthrate may be as low as 39 per thousand now, but it is unlikely that it will reach 25 by 1980 – the latest scheduled target – unless a monumental effort goes into the promotion from now on.
Dr. Chandrasekhar, who believes that there are 9 million illegal abortions a year in India, persuaded the Cabinet to approve a draft bill to legalize this procedure. It has been approved by the Council of States, but action in the Lok Sabha has not yet been taken. The load on medical facilities would be increased, but it is an essential adjunct to population control, and techniques and being simplified.

Chandrasekhar has also appealed for a higher legal marriage age – 18 for women and 21 for men. (Average age at marriage at present is 14.5 years for girls and 20.0 for men. If the age at marriage could be raised, reproductive years would be shortened.) He believes that incentives for sterilization should be increased. Tata Industries, one of the largest industrial complexes in India, is now paying its employees Rs. 250 each to be sterilized, and he has suggested to Mrs. Gandhi that government inducements of Rs. 10 – 40, depending on the State, are too small to entice younger people into the program. Sterilization after two children would be desirable, and Mrs. Gandhi should use the $100 million in United States counterpart funds in India to offer as much as Rs. 500 as an incentive. To supplement this program, Chandrasekhar suggests a greater effort to improve nutrition, to do away with the parents' fear that children will die, leaving them without security. He has also suggested that religious leaders promote the idea that once a man has fathered one son he has done his duty by his ancestors and the race. The target of reducing the birthrate to 25 by
1980 has been amended to read "as soon as possible". He, too, says that a total effort must be put into the birth control program.101 (See Table XI, Appendix, for supplementary data on India).

Realizing the critical state of India's population problem, "All the king's horses and all the king's men" are working hard to help India stem the flood of babies - the International Planned Parenthood Federation is helping the FPAI; the Pathfinder Fund, the Population Council, the Ford Foundation, the Rockefeller Foundation, Church World Service, Christian Medical Association of India, World Neighbors, Oxfam, Lutheran World Relief, CARE, the Swedish International Development Agency (SIDA), Denmark, the United Kingdom, Canada and the United States, and the United Nations Fund for Population Activities are also helping India.102 India's own expenditures to help herself have multiplied 3,000 times since the start of the program in 1951, and represent an ever-increasing percentage of the national budget.
TABLE II

Family Planning Component of National Budget
(in millions)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Allocated</th>
<th>Expended</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951-56 Plan</td>
<td>Rs. 1 * ($U.S. 200,000)</td>
<td>e</td>
<td>0.005</td>
</tr>
<tr>
<td>1956-61 Plan</td>
<td>Rs. 22</td>
<td>e</td>
<td>0.05</td>
</tr>
<tr>
<td>1961-66 Plan</td>
<td>Rs. 249 ** ($U.S. 31 m)</td>
<td>e</td>
<td>1.0</td>
</tr>
<tr>
<td>1966-71 Plan</td>
<td>Rs. 3150 ($U.S. 394 m)</td>
<td>-</td>
<td>2.0</td>
</tr>
<tr>
<td>1966-69</td>
<td>Rs. 694</td>
<td>e</td>
<td></td>
</tr>
</tbody>
</table>

* R = $U.S. .21
** R = $U.S. .13

Annual per capita budget, all sources, in U.S. cents = 7.72


In the meantime, the FPAI remains part of the whole program, receiving its subsidy from the government and the IPPF for innovative projects. Its branches run 175 voluntary clinics, and it promotes services through business and industry. It is pursuing the question of population and family life education for children and adults, and its members continue to attend Indian Ocean Region and IPPF general meetings. The FPAI realizes the urgency of the population program, but universal support is not yet a fact in the country. Much has been accomplished - first by the FPAI and later much more by government - but whether it will be
effective is a question only time can answer.

To sum up, as in the more industrialized countries, the leaders of the family planning movement in India were educated social reformers, but they had the special additional motivation of service to their newly independent country. They realized from the beginning that population growth was a threat to its chances of social, economic and political progress, but they knew also that, in a country where conservative tradition was the rule, the only possible approach was through "spacing". If the time between pregnancies could be lengthened, fertility and infant and maternal mortality would be reduced. Because infertility was also a tragedy, they offered treatment for this problem as well.

In addition to adopting an official program, the government supported the FPAI financially almost from the beginning, but the effectiveness of both bodies was complicated by the enormity of the challenge, the lack of really dynamic political leadership, lack of previous experience, lack of incentives for mass acceptance, and the logistical problems of communication, training, physical facilities, and suitable methods of birth control for those who wanted them. Knowing the dimensions of the task, the volunteers were frustrated, from the start, with government lethargy and red tape. Little real progress was made until the mid-1960s.

Because it was always a relatively small organization, it is unlikely that the FPAI made any impact on the Indian fertility rate, but its efforts did test the climate and lay
the foundations for dynamic government action. The FPAI branches proved that a family planning program was acceptable and feasible, and their efforts in organization, training, research and services provided some background on which government activity could be built. Through publications and conferences, they provided information and a forum for informed discussion in which a growing number of professionals were pleased to participate and the careers of several people later prominent in the population field were assisted by membership in the FPAI. The voluntary organization still has a useful role in special studies, publicity and promotion of family life education, and continues to offer informed criticism of official activities. The introduction of birth control programs in the other countries of South Asia followed similar, though not identical lines. In Ceylon, leadership came first from a Canadian who became a Ceylonese by adoption.


7. B. L. Raina, Director, Central Family Planning Institute, New Delhi, "India", in Bernard Berelson, ed., Population and Family Planning Programs, Chicago, 1966, p. 112.


12. Ibid., p. 217; also S. Chandrasekhar, op. cit., p. 92.


15 Indian National Congress, Proceedings, Microfilm, UBC Library, R 582:6, p. 17.


18 Smt. Rama Rau was one of the first women in India to earn a University degree and to teach in a university in India. She was a lecturer in English, Queen Mary's College, University of Madras, and an advocate of women's suffrage. Kamala Rau to Mary Bishop, 24.12.69; also Dhanvanthi Rama Rau, "The Need and Promise of Planned Parenthood", Together, Methodist Publishing House, Nashville, January 1965, p. 16.


20 C. B. Mamoria, op. cit., p. 150.

21 Kingsley Davis, op. cit., p. 228.


23 Ibid.

24 B. L. Raina, op. cit., p. 113.


27 Savitri Thapar, op. cit., p. 6.


29 Savitri Thapar, loc. cit.


32 Ibid.


From a budget of Rs. 50/- in 1949, the budget in 1963 was Rs. 363,612/-.

38 "Women's Meeting...22nd March 1968", 15th Annual Report, Family Planning Association of Ceylon, Colombo, 1968, p. 16; Questionnaires to Ceylon and Nepal; Conversation with George and Barbara Cadbury, Toronto, 6.12.68.


44 According to Hindu doctrines, the ideal life consists of four asramas (stages): brahmacarya, the period of discipline and education, garhasthya, the life of the householder and active worker, vanaparasthya, retreat for the loosening of bonds, and finally sannyasa, the life of a hermit.


India and Foreign News, 1 September 1968, pp. 5-6.


Ibid., pp. 4-5.


Ibid., pp. 6-10.


68 S. Chandrasekhar, "Family Planning in an Indian Village: Motivations and Methods", ibid., pp. 101-08. A. S. Kaufman to Mary Bishop, 15 October 1968. Mr. Kaufman told me that the experiment proved to him that home visiting, or the mobile team, was the most effective means of delivering family planning.


70 C. Chandrasekharan, "Cultural Factors and the Propagation of Family Planning in the Indian Setting," ibid., pp. 67-72. Dr. Pincus's interest in Asian acceptability trials of the Pill was noted in Chapter IV, p. 89.

71 FPAI Brief, dated 23.10.59, mimeographed.


74 Ketayun H. Gould, "Sex and Contraception in Sherupur", Economic and Political Weekly, Vol. 4, No. 49, Dec. 6, 1969, p. 1890. The author suggests that the diaphragm is impractical for village women, but Dr. Marian Hall states that some women in Rajasthan used it successfully; and some low income women in Ceylon were similarly motivated; see also Report of Work, op. cit., p. 81.
Planned Parenthood in the United States, and Family Planning in the United Kingdom and Canada make no distinction today.


"Resolution Passed Unanimously at the Plenary Session Held on 3rd February 1961", Fourth All-India Conference on Family Planning, Bombay, 1961, p. 181.


Shri Ashoka Mehta, "Inaugural Address" Fifth All-India Conference on Family Planning, op. cit., pp. 8-10, 18-24.


The Quiet Revolution, op. cit., p. 5.


Programmes and Activities, FPAI, Bombay, 1968 (recent undated leaflet), pp. 8-9.


Situation Report, op. cit., p. 5; also Canada India Times, 4.12.69.


Dorothy Nortman, op. cit., p. 68.


S. Chandrasekhar, lecture, op. cit.

Figure 4: Three Projections of Ceylon's Population Growth

Though the leaders from the start of the family planning movement in India were Indian, the first known family planner in Ceylon was a determined little Canadian, Dr. Mary (Irwin) Rutnam, a graduate of Trinity Medical School in Toronto, who arrived in the Island under American Methodist auspices as a medical missionary in 1898. Somehow the job she had expected to fill in Jaffna was not available, so Dr. Irwin found work in a government hospital in Colombo. For some obscure reason, the British administrators decided that her qualifications were not satisfactory; so she became the first woman doctor in private practice in Ceylon. At first, most of her patients were Muslim women in purdah who would not accept the services of a male doctor and Dr. Irwin acquired considerable experience in obstetrics and the realities of maternal and child health.

Much against the wishes of her parents in Clinton, Ontario, she married a Tamil school principal in Colombo and by him she had five children. The combination of British disapproval of her medical qualifications, the misery of her Muslim woman patients, and family disapproval,
must have been the catalysts which led her to devote the rest of her life to improving the status of women in her adopted country, to encouraging middle and upper income Ceylonese women to give time to "social service", and to improving maternal and child welfare services. Mary Rutnam founded no less than six women's organizations, including a transplanted version of the Women's Institutes — the Lankan Mahila Samiti — a Women's Christian Temperance Union, and the Family Planning Association. In addition she was an active member of ten other social welfare organizations. Dr. Rutnam was Ceylon's first woman city councillor, sitting for a short time as a member of the Colombo Municipal Council. She also wrote pamphlets on health, homecraft, and nutrition for Ceylon schools.

Members of the Donoughmore Commission, who drafted the 1931 Constitution of Ceylon, encouraged Dr. Rutnam to promote women's political activity. She organized the Women's Political Union, and, through it, brought pressure on the Ceylon Medical Council to introduce birth control and eugenics in the curriculum of the Ceylon Medical College. The request was refused, but Dr. Rutnam was not defeated.

When Mrs. Edith How-Martyn visited Ceylon in 1935, on behalf of the Birth Control International Information Centre in London, Dr. Rutnam supported her lectures to doctors and social workers. In 1937, with the approval of the Ceylon Social Service League, Dr. Rutnam opened a birth control clinic known as the "Family Welfare Society". Through
a donation of £100 from Sir Julian Kahn, a visiting cricketer from England, she was able to finance imports of diaphragms and jellies; but, as overt propaganda to promote birth control was risky, patients were referred by word of mouth.

There was opposition to Dr. Rutnam's activities not only medical but on religious grounds. Indigenous faiths had little influence on the government in Ceylon before World War II, and, in any case, included no prohibitions against birth control; but Christian opposition inspired someone to break into her surgery, and destroy her furniture and equipment. She persisted with the work, but, when World War II started, was forced to discontinue as imports of supplies were cut off.

After World War II, with the assistance of two other Ceylonese doctors who offered both services and office accommodation, Dr. Rutnam renewed her family planning activities. The cause was further advanced by the organization in Bombay of the IPPF in 1952, and a visit to Ceylon by Margaret Sanger, Dr. Abraham Stone, and Mrs. Dorothy Brush, all of Planned Parenthood in the United States. They were followed soon after by Dr. Clarence Gamble, also of the USA, representing the American National Committee on Maternal Health, but soon to found his own organization, the Pathfinder Fund.

The Family Planning Association in Ceylon (FPAC) was organized in January, 1953, by sixteen charter members. Nine were doctors, including four women, and seven of the sixteen
were men. Dr. Rutnam was elected president, but, as she was now eighty years of age, meetings were led by Dr. (Mrs.) L.O. Abeyratne, as Vice-President. Two of the founders, Prof. C.C. de Silva, a paediatrician, at the University of Ceylon, and Mrs. E. C. Fernando, are still active. The group was soon joined by Dr. (Miss) Siva Chinnatamby, now Honorary Medical Director of the FPA, and a Vice-President. This group was representative of the western-educated Ceylonese professional class, anxious to share in the work of modernization in newly independent Ceylon, and particularly concerned for maternal and child health and family welfare. Dr. Rutnam may have been a feminist, but her successors were not. Nor did Professor Stycos's other criticisms, discussed in Chapter V, apply — unless, perhaps, they too could be faulted for prescribing the diaphragm in the 1950s in preference to less reliable methods. The only financing available was the small amount of money left from the cricketer's pre-war gift, and from their own pockets but the FPAC also received the support of Mr. M. Rajanayagam, then Commissioner of Labour. He was interested in promoting family planning in the plantation areas because it was becoming difficult to absorb the offspring of the Indian Tamil workers in the estate economy. As the problem was urgent, Mr. Rajanayagam wanted cheap, simple methods which could be easily and quickly introduced. Support of trade union leadership in the plantations was also forthcoming as was that of estate management. In 1954 the Planters' Association set up a program to dispense foam
In 1953 the World Bank (International Bank for Reconstruction and Development) published a study of the Ceylon economy, in which family planning was urged because the extra acreage which was available for food production would not accommodate the expected population increase. A western-style demographic transition would be impossible, for there were neither new territories to exploit, nor sufficient natural resources within Ceylon to assist economic development on a large enough scale. Family Planning should be offered in existing health facilities; and voluntary organizations, such as the Red Cross, Lanka Mahila Samiti, CNAPT (Ceylon National Association for the Prevention of Tuberculosis) should be funded through government grants-in-aid, to assist the program. Dudley Senanayake, then Prime Minister for the first of three terms, supported the idea because he had been Minister of Agriculture and knew any problem of food supplies would be serious. But no official action was taken as he was forced out of office for accepting another of their recommendations, a reduction in the rice subsidy.

About this time also, Dr. Gamble decided to send his own field representative to Ceylon, another Canadian, Mrs. Margaret Roots. She arrived in 1954 and remained for two years. During this time she travelled to many of the outlying centres and rural areas, explaining family planning to health officers and village leaders, and giving instruction in the use of salt-and-sponge or foam tablets, two simple tablets and the sponge.
methods supplied by Dr. Gamble. Toward the end of her stay, Mrs. Roots was working closely with the Executive Committee of the Family Planning Association, who assigned a Ceylonese woman assistant to accompany and assist her. She was also sending regular reports to Smt. Rama Rau as President of the IPPF. Though there has been no open criticism, it appears that, for all their good work, Dr. Gamble's program was not popular with the FPAC at that time because it did not at first seek their support, appeared to rival their organization and was funded generously from abroad, while they were struggling to develop their own program. As their reaction was similar to that of the FFAI, it seems to have induced a shift in Pathfinder Fund policy toward working in countries where no family planning program existed and merely supplying contraceptives in countries in which there was an FPA.

Also in 1954, Mrs. Barbara Cadbury visited Ceylon, on behalf of the IPPF, and, at a meeting of political leaders arranged by the FPAC and Mr. F. H. Jayawardene, then M.P. for Colombo South, suggested a government-to-government pilot project might be set up. Through Dr. Hanna Rydh and Mrs. Ottesen-Jensen, of Sweden, Mrs. Fernando of the FPAC made preliminary inquiries of the government of Sweden. Sweden approved the idea, provided that the request came from the government of Ceylon; and Sir John Kotelawala, then Prime Minister, set the plan in motion. Arrangements were made through Mrs. Alva Myrdal, Swedish Ambassador, and
finally, in 1958, the Sweden-Ceylon Pilot Project went into operation under the joint supervision of the then Director of Health Services, Ceylon; Dr. Chinnatamby, representing the FPAC; and the Swedish project supervisor (then Dr. Jan Asplund, later, Dr. Arne Kinch). This project will be described in detail on page 188.

To assist its own activities, the PPAC was given a government grant of Rs. 2,000 in 1954. By 1963 this was raised to Rs. 75,000 and in 1969 remained at this level. Though somewhat sotto voce, every Prime Minister since has supported the movement, and supplementary assistance has been given by the Health Ministry. Government doctors and nurses who wished to take FPAC training were assisted in doing so, and allowed to distribute FPA-supplied contraceptives. Some hospitals, Public Health Units and health centres gave space for clinics, and Health Department educators assisted with displays. The government also financed the publication of leaflets on methods in Sinhala, Tamil and English. The IPPF has continued to support the organization with funds, as has Oxfam, the Population Council and the United States Agency for International Development (A.I.D.).

Further economic studies by experts invited from abroad were published in 1959 by the Planning Secretariat of the government of Ceylon. They confirmed the IBRD warning of 1953. Visiting economist Joan Robinson said that population growth would absorb any advances in economic productivity, and that the welfare of the people would dete-
riorate. Gunnar Myrdal urged that a Population Commission be set up to promote birth control, stating that, even if the task were undertaken at once, no impact on the work force would be evident for twenty years, and political unrest would result. But, like governments elsewhere, the government of Ceylon trod softly in the matter, hoping, no doubt, that by some miracle the economy might expand sufficiently without it. It did not adopt a public family planning policy until 1965 when unemployment had reached crisis proportions.

In 1960/61 George and Barbara Cadbury visited Ceylon as special representatives of the IPPF on the tour mentioned in Chapter IV. Vera Houghton, former secretary of the IPPF in London, spent two months in the Island helping to set up an office organization commensurate with the FPAC's growing needs. IPPF grants were also forthcoming to assist in film production, to finance a film projector, tape recorder, and a travelling van for promotional work, and to provide travel funds to assist Ceylonese delegates to attend international conferences. The Government of India donated a family planning film in the Tamil language, and Tamil language promotional literature. The family planning movement was further assisted when a regional conference and medical seminar was held in Colombo in 1963 in honour of the FPAC's tenth anniversary. In speaking to the delegates, Hon. P. B. Kalugalle, Minister of Education in Mrs. Bandaranaike's cabinet (1960 - 1964) praised the FPAC for its years of hard work in spite of unkind criticism and lack of public understanding of what
family planning could contribute to health and happiness.

By the time the Association achieved charitable status in May, 1965, it could boast 150 regular members, two branches and 116 clinics, many of them in government health premises. Policy followed much the same direction as that of family planning associations in Western countries and India. All methods were offered on the basis that any method used regularly was better than none at all. The main objective was spacing of children for better health and family happiness or limiting the number if desired family size had been achieved. An infertility service was also built in. As in India, British law had made induced abortion illegal in Ceylon, and, as it was frequently confused with birth control the PPA opposed it as an undesirable alternative to contraception. Only if it was for urgent medical reasons, and performed by a recognized doctor, was abortion approved. If adequate support for family planning were forthcoming, they said, abortion would decline. The slogan "Every Child a Wanted Child" was the accepted motto. As over-population increased, the PPA began to introduce the idea of a small family norm by incorporating from 1963 on the cover of the annual report, a sketch showing a three-child family group and including articles on population growth and economic development.

By 1965, population growth and unemployment - the latter officially 200,000 but estimated to be nearer 500,000 - forced the newly elected Senanayake government to adopt
family planning as a national policy, and as an essential element in planning for development. As in India, a national advisory committee was set up by the Minister of Health. The Director of Health Services was to be chairman, and other members were representatives of the FPAC, the Sweden-Ceylon Project, the Planters' Association, the Planning Secretariat and the Department of Health Services. As training was one of the most urgent requirements, the task was shared among the FPA, the Sweden-Ceylon project, and the government. It was agreed that FPA clinics would be handed over to the Department of Health Services as soon as possible, but that the Association should keep some of its clinical operations in being for research, training, and innovation. Its major role in future would be education and promotion.

Although there was no time lag comparable to that which occurred in India between adoption of the policy and its implementation, the need for training and organization held up effective services until 1968, and the FPA phase-out was not complete even in 1969. The volunteers still retained 20 clinics in the Colombo area and one in Kandy, but the road ahead seemed fairly smooth.

Cultural attitudes toward children and control of the passions are similar in Ceylon to those in India, but, as in India, there is no organized opposition to family planning and no law against it. Until recently, obstruction was solely of western medical and religious origin. 10

Dr. Rutnam made a second attempt in 1949 to persuade
the medical profession to include instruction in birth control in the medical college curriculum, but was defeated, though only narrowly, by the Ceylon Branch of the British Medical Association (forerunner of the Ceylon Medical Association). However, the Family Planning Association continued to grow under the auspices of prominent physicians and, innovative from the beginning, it began to pioneer the use of the Pill, the IUD, and vasectomy. Critics in the profession were not lacking though each venture progressed satisfactorily under FPA auspices. With government participating too, activity through the FPAC and through private medical practice greatly increased after 1965.

Some religious opposition has persisted, but by 1969 its basis had shifted from Christian to Buddhist, and from religion to racism. Although Mrs. Roots told me that in her travels in Ceylon in the 1950s she met no religious opposition if she took time to "visit the local priest and explain" what she was doing, FPAC members have told me that undercover Christian obstruction did exist for a time. Dr. Chinnatamby recalled recently that, in addition to damage to Dr. Rutnam's office, handbills were circulated in which the FPAC was pictured as a witch destroying babies in their cots, or a wolf in sheep's clothing, murdering the unborn. It was also accused of being the agent of genocide, but, after the 1965 government announcement of its family planning policy, a "Catholic leader" in Ceylon instructed Catholic doctors not to defy it. When the Papal Encyclical against
family planning was issued in 1968, the Secretary of the Catholic Doctors' Guild attacked it publicly.\textsuperscript{13}

From the start of the Association criticism has been offset by the fact that active leadership has been representative of Buddhist, Hindu and Christian elements of the population. While Muslim participation has been rare, Muslims themselves have not criticized the FPA, and Muslim attendance at FPA clinics has always been in proportion to population size. The organization has, therefore, always been able to withstand medical or religious attack. Unfortunately, communal rivalries have created another source of criticism, and an example of Family Planning Association defence is of interest:

All racial groups are represented in our clinics and we feel sure that the individual is much less concerned with whether his race may be decimated than whether he will have enough money to feed, clothe, and house unlimited children or whether his wife will grow old and sick before her time. He is more interested in his own future happiness and in trying to save a little money for a few of the amenities of life. The irony is that the Indian estate labourer leads the rest of the country in limiting his family.\textsuperscript{14}

Reference to the Indian Tamil arose out of the fact that many of this group - approximately 1.5 million strong and survivors of the days of indentured labor - were deprived of their citizenship by the first government of independent Ceylon, but still are thought to represent an economic threat as a closed community holding jobs which might be given to
Ceylonese citizens.

Next, communal criticism of family planning was taken up, not by one of the minorities, but, as with the Jan Sangh in India, by a few representatives of the religious majority. Ven. Madihe Pannaseha, Mahanayake Thero, a senior Buddhist monk, warned several times in articles in the press, that if Sinhalese fertility continued to decline, and the Tamil and "Moor" (Muslim) birthrates did not follow suit, in 141 years, the Sinhalese proportion of the population would have dropped from 71 to 49 percent, and the combined Tamil and Moor element would be 50 percent. Therefore Buddhism was risking extinction. Responding to this type of propaganda, the agricultural colonists at Elahera, whose families were reported to be from ten to fifteen strong, refused to take anti-malaria pills in fear that they were birth control pills and the Municipal Council of a Colombo suburb condemned the government Health Department for collaborating with "the Americans" to decimate the Sinhalese. It did not help matters when a cabinet minister, Hon. I.M.R.A. Iryagolle, Minister of Education in the Senanayake cabinet, was quoted in a Sinhala language paper as saying that family planning was "murder". In reply to a questionnaire sent by the writer an additional problem was noted by the FPAC. There is some belief among Buddhists that family planning might interfere with the process of rebirth. But this must be based on the misconception that "family planning" is abortion.
On the other hand, there is also Buddhist opinion favorable to the idea. Dr. G. P. Malalasekera, President of the All Ceylon Buddhist Congress, stated that, while children were welcomed for the traditional reasons, population pressures were creating problems. Contraception was a new idea to Buddhists; but, as it was the Buddhist view that life does not exist before conception (sic), they would accept it. 19

Some degree of feminine self-determination is also involved in acceptance of family planning, for, while I was in Ceylon, there were wives who adopted the Pill or had an IUD inserted without their husband's knowledge.

The 1973 Census should show how critical is the need for birth control in Ceylon, but the government of Mrs. Sirima Bandaranaike, elected once more in May 1970 after a term in opposition, continued the policy introduced by her predecessor, and announced that it would push the program in urban, rural and estate areas. 20

 Except for the "Moors", the birthrate in Ceylon declined steadily from 1961 to 1967 and, because the start of the decline coincided roughly with the founding of the Family Planning Association, it was easy to assume that birth control was having some effect.
### TABLE III

Birthrates per 1,000 by "Race", 1951-61
and Percentage of Population, 1963

<table>
<thead>
<tr>
<th>Races</th>
<th>Annual Average</th>
<th>1951-60</th>
<th>1960</th>
<th>1961</th>
<th>1963 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinhalese</td>
<td>37.7</td>
<td>36.5</td>
<td>35.7</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Ceylon Tamil</td>
<td>38.2</td>
<td>38.8</td>
<td>36.4</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Indian Tamil</td>
<td>36.1</td>
<td>33.1</td>
<td>31.4</td>
<td>10.6</td>
<td></td>
</tr>
<tr>
<td>Ceylon &quot;Moor&quot;</td>
<td>41.5</td>
<td>42.7</td>
<td>42.9</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>30.3</td>
<td>25.4</td>
<td>22.4</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>All Races</td>
<td>37.6</td>
<td>36.6</td>
<td>35.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Influences toward spontaneous fertility declines must have been similar to those in India - continence, abortion, or "unconscious" infanticide, and the limited use of coitus interruptus and other birth control methods.

In addition, there was growing attendance at Family Planning Clinics; as shown by patient visits for the years ending June 30th, 1963 - 1965:
TABLE IV

Attendance at FPAC Clinics

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Clinics</th>
<th>New Patients</th>
<th>Re-visits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>63</td>
<td>--</td>
<td>--</td>
<td>12,387</td>
</tr>
<tr>
<td>1964</td>
<td>78</td>
<td>--</td>
<td>--</td>
<td>17,134</td>
</tr>
<tr>
<td>1965</td>
<td>97</td>
<td>45,157</td>
<td>19,098</td>
<td>64,255</td>
</tr>
<tr>
<td>1966</td>
<td>116</td>
<td>14,634</td>
<td>29,408</td>
<td>44,042 *</td>
</tr>
<tr>
<td>1967</td>
<td>93</td>
<td>12,166</td>
<td>30,474</td>
<td>42,640</td>
</tr>
<tr>
<td>1968</td>
<td>54</td>
<td>8,291</td>
<td>25,534</td>
<td>31,825</td>
</tr>
<tr>
<td>1969</td>
<td>20</td>
<td>6,996</td>
<td>17,091</td>
<td>24,087</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>116,765</td>
<td>119,605</td>
<td>236,370</td>
</tr>
</tbody>
</table>

* Beginning of phase-out to government program.

Sources: Annual Reports, FPAC, Colombo, 1963 - 1969, pp. 28-9, 28-9, 26-7, 26-7, 22-3, 8-9, 11 respectively.

In the early years of the Association's activities, most patients coming to the clinics had an average of 8 or 9 children, and incomes of Rs. 100 per month or less. By 1963 the majority were coming after 3 or 4 children and the largest age group was between 25 and 35 years. By June 30, 1969, in four Colombo area clinics, of 1,908 cases, more than 1,100 patients were from both unskilled and skilled labor groups, more than 700 were under 30 years of age, the largest number were in the 25-29 year age group, and had come after second and third pregnancies. It was noted, however, that the sample was small, and the patients were urban
Abhayaratne and Jayewardene conducted detailed studies, from 1963 to 1966, of knowledge, attitudes and practice of family planning in 78 villages, and concluded that,

... those who were future oriented, who planned for the future of their children, were the people who had the lowest fertility and had used contraceptives to achieve this end. These people do not come mainly from the upper classes nor do they come mainly from the lower. They are usually educated people with a limited income, in public service doing clerical jobs. Their wives are also educated and employed gainfully outside the home. They are perhaps people who have realized that though the good things of life are apparently beyond their reach they need not be beyond the reach of their children.23

Fertility was influenced by the average age at marriage — which had increased from 21.0 years in 1900 to 23.1 in 1960 for females, and from 27.3 for males to 28.3. This was not only an older age range than in India but had the effect of shortening the number of reproductive years for females.24 Also contributing to fertility decline were the relatively smaller numbers in the reproductive age group, but this percentage was increasing in the 1960s because of the sharp decline in the death rate between 1945 and 1950 due to malaria control and other health measures.25 (See Appendix for detailed discussion).

The Government family planning program, announced in 1965, began to deliver family planning services the following year and the cumulative total for 1966-1969 was 160,000
DEMOGRAPHIC PATTERNS: CEYLON AND SWEDEN
1840 - 1960

Figure 5. New demographic pattern is appearing in the nonindustrial nations. The birth rate (solid line) has not been falling significantly, whereas the death rate (broken line) has dropped precipitously, as illustrated by Ceylon (gray). The spread between the two rates has widened. In nations such as Sweden (black), however, the birth rate dropped during development long before the death rate was as low as in most underdeveloped countries today.

patients, many of which represented patients already enrolled or attracted by the Family Planning Association, at least up to 1966 and 1967. The total number of women in the reproductive age group (15-44) for 1963 was 2,151,000, and for 1967, 2,392,000, an increase of approximately 11 percent. This was a formidable threat to the target of a birth rate of 25 per 1,000 by 1975-1976. The combination of the FPAC program and the government's efforts have increased the practice of birth control, however, and, considering the relatively high literacy and good communications, could achieve the target if it were given maximum promotion.

The social, economic and political consequences of over-population for the country as a whole are better understood by the majority of Ceylonese, than in India, but, as in India, the FPAC has found that an approach based on individual and family needs is the most effective. In other words, the spacing of pregnancies and smaller family size will improve maternal and child health, family happiness, and make possible a higher standard of living.

The FPAC has been fortunate not only in its widely representative leadership, but also in having had the collaboration of both government and private doctors, nurses and social workers to promote family planning. Pre-natal clinics, talks with mothers in hospital (where 60-65 percent of Ceylonese babies are delivered), well-baby clinics, and milk and cod liver oil distribution centres have been used. Home visiting has been another means of contact by female
employees, and specially trained Public Health Inspectors have been able to influence male attitudes as well. Promotion of birth control among government employees and trade union leaders has been another route and, of late, an effort has been made by the FPAC to urge family planning in business and industrial establishments. The FPAC has also introduced family life education techniques to teacher training colleges and lectures on human sexuality have been given to groups of students when requested. It has also sponsored open seminars on all aspects of family welfare, including family planning. In addition, considerable publicity has resulted from Indian Ocean Region (IPPF) Seminars and Conferences in Ceylon in 1963 and 1968.

An information and publicity unit has been organized for press, radio and film publicity. By 1968 the FPA was employing two full time education officers fluent in Sinhala, and one fluent in Tamil. Unfortunately, although such organizations as the YWCA, the Lanka Mahila Samiti, and the CNAFT agreed to promote family planning in their programs, and a few lectures were given, up to the end of 1969, effective programs by these agencies were still to come.

The Association realizes that family planning is not the only solution to social, economic and political problems in Ceylon, and that even if all couples adopted a small family norm at once, the fact of over-population would still remain. It does believe, however, that any progress to improve the standard of living of Ceylonese must include a
vigorous campaign for birth control. It would be harder to "sell" were it not for other supporting factors which characterize the Ceylon scene—good communications, high literacy, population mobility, modernizing intentions and rising expectations. The joint family system is disappearing, the marriage age is rising, female employment outside the home is increasing, and birth control is becoming better known and understood. Serious unemployment may be another factor. By agreement with the government the FPAC will continue to operate a few clinics for special services and research, but its main role will be in public education and in promotion of more information through the school system. The burden of delivery of birth control services rests with the government but it is worth noting especially that two research projects of importance—the Sweden-Ceylon pilot project, and acceptability trials of the Pill—provided essential information and were FPA inspired.

As was noted earlier, at the request of the FPAC and the government of Ceylon, Sweden agreed to set up a pilot project to study attitudes to family planning and the prospects for its adoption, to provide limited services and to assist in training public health personnel. This was the first such project in the world, and was started in 1958 among the Sinhalese population of a Colombo suburb, and on a tea estate where the population was wholly Tamil. In 1963 the project was expanded to include government hospitals at Point Pedro and Velvettiturai in the north, using medical
staff and a female social worker. Tea estates in Mousakelle were also included, as well as another project in the Polonnaruwa-Matale district. Training was given to midwives, nurses and Inspectors concerned in the ordinary health services in those areas, and to dispensers and midwives on the estates.

But soon after the first projects were set up, relations between the project staff and the original sponsors, the PPAC, cooled over lack of communication, and it was rumored that contacts with the Director of Health Services were also strained. A subsequent Swedish critique of the program undertaken by the Demographic Institute, University of Goteborg, at the request of the Swedish International Development Agency (SIDA), identified other weaknesses as well: The choice of Bandaragama and Diyagama by Ceylonese authorities had not been wise as neither location really was a representative of the Sinhalese or Tamil population. No control areas were set up, professional advice in statistics and sociology promised by the government of Ceylon were not provided, and other help was not requested until almost the end of the project. The reports of the Swedish Director that a decline in the birth-rate due to family planning had occurred, were misleading. Fertility was reduced in the first of the two project areas, but this was more likely because the mean age of marriage rose from 17.2 to 19.2. In the other area, the project had no effect whatever.

After the Ceylon government adopted family planning
as national policy in mid-1965, the Swedish program was reorganized and assistance became much more effective. From the end of 1965 to the close of the entire pilot project in August, 1968, 400 clinics were equipped, 3,000 doctors, nurses, midwives, public health inspectors and health educators were trained, and contraceptives, vehicles and educational materials were provided. The Swedish project office in Colombo was turned over to the Ministry of Health, and became the Family Planning Bureau, headed by Dr. Terence Perera, Assistant Director of Health (Maternal and Child Health). Under a further arrangement between SIDA and the Ceylon government, to run from 1968 to 1970, one Swedish consultant in training and communications was to be financed, further clinics equipped and contraceptives (condoms) provided. Dr. Gösta Nycander, an educational psychologist was to fill the advisory role. Paralleling this program was research on the acceptability of the Pill.

In 1961, with the assistance of the late Dr. Gregory Pincus, Dr. Siva Chinnatamby undertook trials of several varieties of oral contraceptives. The pills were supplied by the drug houses concerned. Tests had already been made in the United States and Puerto Rico for about five years, but there was also the question whether Ceylonese women could manage to take the Pill successfully. As conventional contraceptives were not widely used, it was considered to be worth the experiment. Most of the research was done in the Colombo area, and three approaches were used: one through clinics,
where routine pelvic examinations were made, cervical smears taken, and careful instructions given by the doctor; the second was the issuance of the pills by a social worker through a suburban clinic attended by a doctor only when problems arose; the third was distribution through home visiting, with the doctor's services only available when a difficulty occurred.

Of 2,528 women patients in the four-year study to June 30, 1965, 67.7 percent used it regularly. Headaches, nausea, dizziness and other symptoms disappeared within a few weeks, so reassurance about side effects helped a high proportion of the women to continue. A pill with a smaller progestagen content produced fewer side effects. There was no evidence of thrombosis or embolism, but 30 percent of the patients found lactation reduced. A few abandoned it either because they found it difficult to come for replacement supplies, because they decided to use another method, or because they were frightened by rumors. It was concluded that routine pelvic examinations should be performed periodically. The suburban clinic and house-to-house distribution were satisfactory routes as well, provided medical assistance was available when needed. A 28-pill regimen was preferred, and it was expected that decreasing costs would make it a very popular birth control method. The high acceptability rate seems to have been due to higher literacy than in other countries, the care taken by the doctor in reassurance, and systematic checking of side-effects. The trials also proved that women with little or no education could take the Pill
successfully, provided they were sufficiently motivated. Motivation was highest among those with the largest families. Dr. Chinnatamby hoped that she would be able to follow up these cases after a suitable interval. 

She also conducted research for the Pathfinder Fund, on the IUD, and confirmed the need for reassurance, especially during the first 24 hours after insertion. Retention was approximately 70 to 76 percent. 5 percent had the IUD removed, mostly due to excessive bleeding. The failure rate was 2.8 percent. A subsequent report showed that continuation after 42 months was 63.2 percent of first insertions, and 65 percent of first expulsions reinserted. Dr. Chinnatamby also undertook investigation of long-acting injectables, but when the 16th Annual Report (1968-69) was published, she considered it too early to analyse the results.

The FPA also undertook other research. Through Dr. Christopher Tietze of the Population Council, a year's trial of foam tablets delivered through home visiting was conducted. Of 306 women, only 125 practised the method regularly, indicating that it was not particularly popular. Eight FPA clinics were used for a study in motivation conducted by the University of Ceylon and financed by the Population Council. This was part of the study of fertility trends undertaken by Professor CHS Jayewardene. Villages originally studied for the book written in collaboration with Professor O.E.R. Abhayaratne, Fertility Trends in Ceylon, were re-surveyed and the evaluation and follow-up done by Family Planning
Bureau (government) personnel. A number of other studies have been carried out by other agencies, the new Family Planning Bureau and the Population Council, and a fertility survey and evaluation by a United Nations Population Fund team was requested by the government for 1970.

As in India training of doctors, nurses, midwives and social workers was done by the Family Planning Association exclusively until 1958, when the Sweden-Ceylon project undertook a share of the task with paramedical personnel. This work continued until mid-1967 when the government of Ceylon began to take increasing responsibility. Up to June 30, 1967, the FPA, in co-operation with SIDA, had trained 279 doctors, 169 nurses, 1,125 midwives, 479 Public Health Inspectors and 24 Health Educators, 324 Estate Medical Assistants and 60 estate midwives. Two thirds were trained by the FPA; one third by the Sweden-Ceylon project. Since August, 1968 and the end of the Swedish project the FPA, in collaboration with government, has conducted training where needed. The United Nations International Children's Emergency Fund (UNICEF) has financed a re-training program for 700 nurses per year in child welfare, nutrition and family planning, and has also provided equipment and transport. It is of interest that family planning is now part of the routine training of all health personnel in Ceylon - medical students, student nurses, practising doctors, nurses, public health inspectors, midwives and Health Educators. The delivery of birth control services followed a parallel course.
In 1953 the newly organized FPA had no money for premises, so, as has been noted, two doctors who had helped Mary Rutnam to organize family planning services before World War II offered their surgeries. A post-natal clinic run at De Soysa Maternity Hospital in Colombo by Dr. (Mrs.) F.K. Ram Aluvihare, was also pressed into service for family planning. In addition, because a childless woman is scorned in Asian countries, diagnosis and treatment of both infertile husbands and wives were also provided. Assistance in both family planning and infertility was also given by Dr. Chinnatamby. This clinic was dubbed the Mothers' Welfare Clinic. It suffered from the beginning from lack of privacy for male patients. Hormone treatment was found to be too expensive an item, and better facilities, more time for the work, and a means of keeping costs low were other challenges. More such facilities in other parts of Ceylon were also needed. Up to June 1967, 228 couples were interviewed but only 32 allowed investigations to be completed. Many of the men were reluctant to undergo sperm tests. Nonetheless, 25 percent success was achieved with those couples who did take treatment. It was found that the rate of infertility in Ceylon - 10 percent of married couples - was the same as in other countries, and that the more or less equal ratio of male to female problems also pertained. 39

Family planning services were increased gradually in public health units, hospitals and health centres, where government doctors who had taken FPA training were permitted
to provide them if they wished. Contraceptives were supplied by the Family Planning Association.

After the Association acquired its own premises in 1959, marriage and premarital counselling for men and women were introduced on a regular weekly basis at the Headquarters Clinic, some sessions being devoted to men only, with male doctors.

Support from TB hospitals was also forthcoming, and the Colombo and Kandy Municipal Councils ran their own services with supplies provided by the FPAC.

By the tenth anniversary of the FPAC in 1963, the organization had 57 clinics and 9 centres. By 1966 there were 116 clinics and centres. Only two doctors were being paid, but these were serving full time. Headquarters staff numbered 10 in 1963 - 5 clerical help and 5 social workers, including two home visitors for low income areas. Government sponsorship began in 1965 and Family Planning Association services began to be phased out. By September, 1969, the government was running 415 clinics, including many of the former FPAC locations, and expected to add 50 more within a year. The FPAC retained twenty clinics for services and research, and a cytologist was added to the Headquarters staff. A mobile clinic donated to the FPAC by the people of Scotland was given to the government, and was operating in the Gal Oya Valley, a rural development area. A special program was also started in the Eastern Province where the Muslim population is numerous and the birthrate high. In 1969 a clinic
was also opened in the Ayurvedic (indigenous medicine) Hospital in a Colombo suburb. Special note must be taken of the program mounted by the Planters' Association of Ceylon.

Family planning services were started in tea and rubber estates by the medical officer of the Planters' Association in 1954, using the sponge and foam tablets. The latter were supplied by the Commissioner of Labour. From 1958 these efforts were increased, and, from 1963-1964 condoms were added. The following year oral contraceptives were introduced, and, from 1965, IUDs were inserted with the cooperation of nearby government clinics. In return for a fee of Rs. 25 from each of more than 450 estates, the PPAC employs a full time propaganda worker who visits 80-90 estates a year, holding 3 to 4 meetings a day, with two days at each estate, lecturing to the labor force and minor staff. Selected men and women are enrolled to distribute literature, and the estate medical attendants distribute methods. Medical officers, dispensers and midwives have been given training by the PPAC and Sweden-Ceylon project.

The Indian Tamil population of the Estates has shown a steady decline in birthrate from the inception of the program, and has consistently maintained a lower birthrate than the rest of the country.
### TABLE V

Births per 1,000 population, Ceylon

<table>
<thead>
<tr>
<th></th>
<th>All Races</th>
<th>Indian Tamil</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1953</td>
<td>1953</td>
</tr>
<tr>
<td></td>
<td>38.7</td>
<td>38.8</td>
</tr>
<tr>
<td></td>
<td>35.7</td>
<td>38.1</td>
</tr>
<tr>
<td></td>
<td>37.3</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>36.3</td>
<td>36.6</td>
</tr>
<tr>
<td></td>
<td>36.4</td>
<td>37.0</td>
</tr>
<tr>
<td></td>
<td>35.8</td>
<td>35.8</td>
</tr>
<tr>
<td></td>
<td>37.0</td>
<td>35.5</td>
</tr>
<tr>
<td></td>
<td>36.6</td>
<td>34.1</td>
</tr>
<tr>
<td></td>
<td>32.2 *</td>
<td>33.1</td>
</tr>
<tr>
<td></td>
<td>31.6 *</td>
<td></td>
</tr>
</tbody>
</table>

* Provisional


Whether this decline has been a genuine one as a result of good administration of the family planning program, the growing inability of the estates to absorb the children into their own labor forces, and male desire for the income earned by their wives (who do the tea plucking), or whether – as the
Department of Census and Statistics suggested - there has been some false registration in order to qualify the children as Ceylon citizens, was still unresolved at the end of 1969. The Ceylon Tamil birthrate in northern Ceylon is higher, but the FPA states that this is because many there have been influenced by "doctors who profess a certain religious faith" and that the birthrate of Sinhalese labor in comparable types of work has also declined. It is certain that the high acceptability of IUDs and oral contraceptives from 1965 and 1966 must have had some effect in any case. The evolution of methods followed a course similar to that in India except that the Pill was used at an earlier date.

In the early days of the movement, the diaphragm-and-jelly was the most reliable method, and many patients, especially those in urban centres, were equipped with it. Foam tablets and the sponge were also distributed, but the latter was abandoned as a messy procedure. As has been noted, from 1961 the pill was distributed - at first on a strictly controlled basis in two Colombo clinics for research on acceptability and side effects, but later on the two other bases already described. Oral contraceptives were also given out in out-station clinics. Condoms were distributed in increasing numbers. The rhythm method was taught whenever it was requested. IUDs were added from 1964. Female sterilization was also done, but not often unless the woman had at least five living children. Male sterilization was urged, and a few operations performed by the FPA from 1966 on men who had
fathered four living children, but vasectomy is not yet a popular method with the government. Among sources of equipment and contraceptives were Dr. Gamble’s Pathfinder Fund, the Brush Foundation, the IPPF and various pharmaceutical firms. All methods have always been given out according to a sliding scale of charges — depending on the patient’s ability to pay — and free if necessary.

Acceptors under the FPA program have already been listed, but the government program is also of interest:

TABLE VI

<table>
<thead>
<tr>
<th>Year</th>
<th>All Methods</th>
<th>IUDs</th>
<th>Orals</th>
<th>Sterilizations</th>
<th>Other</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>15</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>1967</td>
<td>36.7</td>
<td>18.5</td>
<td>8.9</td>
<td>3.6</td>
<td>5.7</td>
<td>52</td>
</tr>
<tr>
<td>1968</td>
<td>48.1</td>
<td>20.6</td>
<td>16.0</td>
<td>5.2</td>
<td>6.3</td>
<td>100</td>
</tr>
<tr>
<td>1969</td>
<td>60.3</td>
<td>20.2</td>
<td>28.0</td>
<td>6.1</td>
<td>6.0</td>
<td>160</td>
</tr>
</tbody>
</table>

Cumulative acceptors through 1969 as percent of ever-eligible women = 6.7

Estimated Percentage of Married Women Users, 15-44 Years of Age: January, 1970

8.2

3.3

Personnel and Facilities Specifically Allocated, Current

Doctors 112
Other medical personnel 727
Field Workers 1,935

Government Facilities 437
(Hospitals, clinics, centres)
Mobile teams 1

Financial assistance for the Family Planning Association has been given regularly by the IPPF for general purposes, and for special projects. In addition to the Pathfinder Fund, Oxfam has also assisted. For the government, the Population Council has provided advisers, and the Ford Foundation substantial grants. SIDA had also assisted. The UN Fund for Population Activities and the International Labor Organization have also given special grants. In 1969 the government allocated Rs. 242 million (U.S. 40 million) which represented .01 percent of the national budget.43

In summary, unlike India, family planning was introduced in Ceylon by a feminist from abroad; but, from the beginning, Dr. Mary Rutnam had the support of educated Ceylonese men and women. Although the family planners were concerned about over-population, like their Indian counterparts, they focussed on maternal and child health, and family welfare. They strove to have the service accepted as an ordinary function of government health services, and were fortunate in having the cooperation of the Health Department almost from the first. Opposition was mainly centred in Western-induced medical and religious prejudice, but this faded and by 1969, with unemployment reaching emergency proportions, communalism provided the last remaining obstacle to all-out effort. Attendance at FPAC clinics from 1963 to 1969 compared very favorably with later government performance, and it is possible that FPAC efforts had some slight effect in hastening the decline in
the birthrate. Other factors such as the rising age of marriage, the changing role of women and high literacy were more influential however. The family planners did make more Ceylonese aware of the possibility of birth control, and their propaganda defused opposition so that, by 1965, the government was able to introduce an official program with relative ease. In Ceylon, too, the experience of the volunteers was a useful foundation, particularly as much of the training and clinic service had been carried out from the beginning in close cooperation with government. However, as in India, the secret of long term and effective birth control in Ceylon is to be found in the following remark by a village woman to a family planning speaker:

Lady, you are quite right, and we agree with you, but... do you think you could talk to the MEN about it.

This question was even more pertinent in the story of family planning in Pakistan.
1 Although free health services were introduced in 1900 the British government did little to improve them until 1926 when prominent Ceylonese became politically active, but Dr. Rutnam kept herself up to date in medical knowledge on occasional trips home; N.K. Sarkar, The Demography of Ceylon, Government Press, 1957, p. 152; Mrs. Wilfred Graham, sister of Dr. Rutnam, conversations in October, 1969, Vancouver. Dr. Rutnam's papers, now in the care of her daughter in Colombo, may contain some relevant information, but, for the present, at least, they are inaccessible.

2 C.C. de Silva to Mary Bishop, 20.2.68.


6 Margaret Roots to Mary Bishop, 18.11.68.

7 The Pathfinder Fund, Boston, 1966, pp. 2-3.

8 Barbara Cadbury to Mary Bishop, 6.12.68; C.C. de Silva, op cit.; also 10th Annual Report, FPAC, Colombo, op. cit., p. 15.


10 Mary Bishop Questionnaire, 21.5.69

11 C.C. de Silva, op. cit.

12 Margaret Roots, op. cit.


16 Ceylon News, 11.9.69; 15.10.69.

17 Dinamina, 29.3.68.

18 Mary Bishop, Questionnaire, op. cit.


20 Ceylon News, 13.7.70.


24 Ibid., p. 116.


26 Statistical Pocket Book, op. cit., p. 22.

27 Mary Bishop, Questionnaire, op. cit.

28 Sylvia Fernando to Mary Bishop, 17.4.69.


34 Siva Chinnatamby, "Research in Control of Conception", 16th Annual Report, FPAC, 1969, pp. 7-9; due to re-organization problems, a 17th Annual Report was not published.


36 Situation Report, loc. cit.


40 Hospitals and registrars of vital statistics were not in the habit of checking whether parents were Ceylon citizens or stateless.

41 Ceylon News, 8.8.68.


44 Ray Blazed to Mary Bishop, 19.12.68.
Figure 6

GROWTH OF PAKISTAN'S POPULATION 1901-1965 PROJECTED TO 2000 A.D.

- HIGH PROJECTION (continued trend)

If there were attempts to promote family planning among Indian Muslims before Independence, they are difficult to trace. After Partition, however, a group of educated women set up elementary family planning services in relief programs for refugees from India. By 1952 these services were being given in Karachi, Lahore, and Dacca; and, the following year, Family Planning Associations were officially formed in each of these centres. In 1953 they were united as the Family Planning Association of Pakistan, (FPAP) and in the following year, this national organization was in turn affiliated with the International Planned Parenthood Federation. The new movement was also assisted by such organizations as the National Council on Social Welfare, the Red Cross Society, the Rotary Club of Karachi and, in 1957 in East Pakistan, by the Pathfinder Fund in the person of Mrs. Margaret Roots.

The objectives were "to encourage a system of family planning which satisfies the natural desire for parenthood and ensures reasonable prospects of health and useful lives for the children so that they become an asset to the Nation". Spacing for "good upbringing" and for protection of the
health of the mother was essential. As in India and Ceylon, in addition to contraception, diagnosis and treatment of sterility was also provided. Training, research, public information, and the gathering of reliable statistics were other aims; and it was also policy to build contacts with other organizations with similar goals in Pakistan and abroad. Population control was not a primary objective at the time, nor was the initial effort supported by the government.  

Conforming to the pattern in other countries, in 1957 the Family Planning Association forwarded to the government a plan to provide family planning services in government hospitals, maternal and child health centres (MDH), and dispensaries. It was accepted and in the budgets for 1957-1958 and 1958-1959 the government approved provision of Rs. 500,000 ($U.S. 100,000) for the purpose. In February, 1958, with the support of President Mohammed Ayub Khan, the Director-General of Health called a two day meeting which set up the National Family Planning Board. Membership comprised the Director-General, the Directors of Health Services of East and West Pakistan, representatives of Military Headquarters, the National Social Welfare Council, the All-Pakistan Women's Association, and three representatives of the Family Planning Association. Similar Provincial Family Planning Boards were set up in each province, and District Boards followed.  

In the meantime, as in India, the drafters of the First Five Year Plan (1955-1960), using the 1950 census reports, had forecast an annual population growth rate of 1.4 percent. It
was thought the increase could be absorbed in economic ex-
pansion, so family planning remained a health and welfare
service with no special agency in charge and it was finally
decided to leave active work to the volunteers.

The Family Planning Association was given Rs. 85,000
($U.S. 15,000) and sole responsibility for implementing a more
effective program through its own urban clinics, and through
the military and West Pakistan railway hospitals, and, subject
to the approval of the provincial Board, Rs. 130,000 ($U.S.
26,000) to support its projects in each province. The rural
population was to be approached through the Village Aid
Administration. The FPAP projects in Lahore, Karachi, Dacca
and Chittagong received a share of the grants. In addition,
through a model clinic in Lahore, the FPAP was to conduct
research and training. Equipment was donated, and the FPAP
imported the necessary contraceptives. The FPAP of East
Pakistan opened 30 rural clinics, setting up District Family
Planning Associations to support them and recruiting motiva-
tion officers to interest the low income literates living in,
or with roots in the villages. The First National Conference
on Family Planning was held in Lahore in March, 1958, and,
for the benefit of both volunteers and government, the agenda
was oriented toward health and welfare. The volunteers seemed
to be off and running.

Subsequent demographic studies indicated a real popu-
lation growth rate of 2.3 percent, and this exceeded the 2.1
percent annual increase in per capita income. Population
itself was now recognized as a serious threat to economic progress, and the Second Five Year Plan (1960-1965) set aside Rs. 30.5 million for family planning and shifted the main burden from the voluntary organizations to government health services.

It was proposed to set up 4,000 clinics, and to train doctors, nurses, Lady Health Visitors (Public Health Nurses), and dais (midwives) to staff them. As the government facilities became equipped to take over the task, FPAP clinics, and satellite family planning services organized through the other voluntary organizations would be phased out. Approximately 1,700 medical and paramedical staff were trained, but, as existing health personnel were already overburdened, supplies and field workers were inadequate, and too much reliance was placed on conventional contraceptives. Accordingly, government performance fell far short of the goal.

Useful research in communication and birth control methods was accomplished, however, and, in order to provide better sources of vital statistics, demographic training was introduced. The Population Council, the University of California, Johns Hopkins University, SIDA and the Ford Foundation began to give assistance. The National Research Institute of Family Planning was established, and five Training cum Research Institutes were organized. The Pakistan Academy for Rural Development (PARD) at Comilla, undertook special studies in such fields as home visiting and small group teaching. Village wives, school teachers, midwives and
practitioners of indigenous medicine were enrolled in a program to distribute condoms and foam tablets through home visiting. But purdah, low female literacy, the problem of record-keeping and personnel shortages seriously handicapped the experiment. It was decided then to try to motivate men, using singers and shows in the market places, and other means of advertising, and to use commercial outlets for distribution of conventional contraceptives such as condoms. This scheme was more successful.

The FPAP was having its vicissitudes as well. Though its work had expanded, particularly in research, motivation, and publicity, administrative problems had arisen and local branches were not pulling their weight.

It has become the fashion for practically everyone, technical and non-technical to express their keen interest in Family Planning without the slightest effort to acquaint (sic) themselves with the accepted plans and procedures (sic) in Family Planning. All the above observations go to prove our emphasis on education at the three levels ... [medical and paramedical, education for the educated, education for the masses].

Finances were also a problem. Though it had registered as a voluntary social welfare agency in 1961, and was still receiving some government support through a grant of Rs. 125,000, Greater activity has unfortunately not been rewarded by government with greater funds. Our working capacity is more due to the high achievement motivation of the workers, and our programmes are seriously hampered due to the lack of regular, timely and adequate grant-in-aid.
Nevertheless, at the Family Planning Association Model Clinic in Lahore, for example, birth control and sterility services were provided, and training was given medical personnel. Vasectomy was becoming increasingly popular, as was the IUD, and a trial was also started with oral contraceptives. Well-baby services completed the picture, and the Model Clinic at Dacca had a similar record. 7,112 patients were served in 1964.

Family Planning Association representatives were able to attend the Indian Ocean Regional Conference, IPPF, in Colombo, 1963, the 7th Conference of the IPPF at Singapore the same year, and a medical conference in Kathmandu, in Nepal. They also attended conferences of related organizations in Pakistan.

At a national seminar, *Pakistan's Population Quake*, organized by the FPAP in March, 1964 (see p.226), President Ayub Khan warned again of the danger of over-population.

> If nothing is done to check the rate of [population] growth, I shudder to think what will happen after a few decades. My only consolation is that I shall not be there to face that situation. But my country and my people would be faced with it. And the coming generations would not forgive us for landing them in such a bad mess.

In fact, at a food conference soon after, the President suggested that in ten years cannibalism could occur.\(^{11}\)

Mr. Enver Adil was appointed Commissioner of Family Planning for the Pakistan government in September, 1964, and
a Pakistan-Sweden-United States Advisory Co-ordinating group of professionals was given the task of setting up a revised government family planning scheme. The President of the FPAP, Karachi continued to sit on the Family Planning Advisory Council, and the Executive Director became one of a team to train family planning supervisors, but, evidently, wider participation of the national FPA was not sought.

The Association in keeping with its traditions stepped out to assist the government as far as possible.... We presented Memorandums, attended Meetings, and sub-committee Meetings through the various stages and phases in the preparation of the Third Five Year Plan Scheme.13

In the end the National Family Planning Advisory Board of which they were members, was replaced by a Central Family Planning Council charged with the implementation of a vigorous official government scheme.14

A detailed, massive plan was published in which personnel training and delivery of services in both provinces was delineated, but it involved only government employed personnel. Targets aiming to reduce the birthrate from 50 per 1,000 population to 40 by enrolling 25 percent of the 20 million fertile couples by 1970 were established. Rs. 284 million (#U.S. 60 million) were allocated, representing 3.6 percent of the total plan budget. Basic Democracy and Thana leaders as well as 1,000 family planning officers would assist in motivating males, and 35,000 *dais* (most of whom were untrained, illiterate midwives) would be used for IUD referrals
and insertions in the rural areas. A reporting system, and evaluation teams, would be set up to function continuously, and monetary incentives in IUD and vasectomy cases would be given to doctors, paramedical workers, motivators and patients. Patients would receive some remuneration for transportation and wages lost. Mass media would be used for "discussion" of family planning, and would include bus panels, brochures, television, posters, films, and filmstrips, newspaper advertising, pamphlets, hoardings, radio, cinema slides, flash cards, kiosks, exhibitions, and family planning weeks.

The Family Planning Association became resigned to its reduced role and agreed with government to undertake projects in research, health education, adult education and mass communication.

We believe that one of the primary functions of a voluntary Association which is working in an area where the problem can only be tackled by a large-scale Government programme, is to advise direct and inform Government; to complement and supplement their efforts; to support them and get support in return; for no Government can administer successfully a programme so personal as the family planning campaign without using the voluntary movement as its handle and mouthpiece.... We wish the Government all success in its Third Five Year Plan and assure it of the continued support of the Association. We are but a drop in the ocean; our finances and resources are the limiting factor, moreover we do not wish to overstep ourselves; we have a role to play, but a small one.

In July, 1965, at a press conference organized by the Family Planning Association of East Pakistan in Dacca, the
new Family Planning Commissioner, Enver Adil, announced the new scheme. Lip service was paid to the work of the volunteers. President Ayub Khan, and the Governor of East Pakistan would become Patrons in Chief of the FPA of Pakistan and East Pakistan, respectively; financial support (a grant-in-aid of Rs. 250,000) would be given, and the FPAs would be asked to devote their main effort to running model clinics and mobile van clinics, to motivation and communication, information and publicity, and to research. After deducting headquarters expenses, each branch received Rs. 103,000. In addition, IPPF support was maintained through a gift of $161,500 in 1967, infertility equipment was provided, a river boat information and clinic service was started in East Pakistan, two mobile vans were put into service in West Pakistan, and a special study of dais undertaken. Travel of foreign delegates to the Population Quake conference was reimbursed, and travel costs for FPA delegates to the Indian Ocean Regional Conference in Kathmandu were provided.

Volunteer noses might well have been out of joint when, speaking to their Eighth International Conference on Planned Parenthood in Santiago, Chile, in 1967, Mr. Adil gave all the credit for starting family planning services to President Ayub Khan, and even borrowed the volunteer terminology: the government program was a "movement" for "quality, not quantity"! In her report for the Indian Ocean Region, Mrs. Sylvia Fernando noted that the government program was the "direct result of the pioneering work of the Family
Planning Association of Pakistan, and the President of Pakistan's personal interest in Pakistan's population explosion, but she did not deny the magnitude of the problem or the need for massive official organization and action. Professor Frank Notestein of the Population Council reminded government, family planning administrators and voluntary groups that they needed each other, and that the latter had a continuing role in moulding public opinion even when its clinic activities were taken over.

Political stresses between the East and West Wings of Pakistan were becoming more acute. Economic problems were so serious and the two provinces were so different in their economic bases and in racial characteristics, that the unifying force of Islam was insufficient to maintain equilibrium. These stresses were evident in the Family Planning Association as well, for a Second National (FPAP) Office was set up in Dacca to provide for "expansion on a more autonomous basis and for better orientation to the needs of the government program," in that Wing. Because political difficulties were threatening the family planning program, it was decided to try to build non-governmental support in both provinces.

Leaders of public opinion, particularly writers, university faculty and students, were invited to "Seminars for Intellectuals" in both Lahore and Dacca in 1968. The volunteer family planners were included. In his keynote address at the Lahore meetings, Mr. Adil praised the volunteers for their determination in spite of opposition, and
urged them to continue their efforts. However, he hinted rather broadly that their work could be improved. The Central government organization, and the provincial and district family planning boards were expanded once more to include "non-officials". The FPA reaffirmed its support of the government program and the attempts to build public approval, and noted that,

It is firmly convinced the greater the public participation and backing for the Family Planning Programme, the greater will be its success.

As in India in 1965 and 1969, a United Nations Team of experts, including three from the IPPF, was invited to make a detailed evaluation of the family planning program, and, as in India, it recommended greater status for its leaders and budget in government, and that the delivery of family planning services should be integrated more effectively with health services. Among specific ideas, it suggested the installation of Chief Male Organizers for each Union Council to improve the work of the dais, to keep sales records and to assist in motivational work. Education and training should be given to teachers, social workers and agricultural extension workers; and refresher courses should also be part of the program. Field personnel should be given bicycles, motor bikes and jeeps to improve their mobility. Distribution of supplies should be improved, and the objectivity of multilateral and other agencies should be used to a greater extent. The Family Planning Association should be given more money and encouraged
to work more in the public education and welfare field, particularly, and with rural women's organizations.\textsuperscript{24}

The FPAP decided to continue its existing services where practical, but to concentrate on education and promotion "through private and public discussion." In addition, it began to see itself in the role of "ombudsman", in which "deficiencies in the service of this vast Government Organization" could be identified, and brought to the attention of the authorities. The members' experience would equip them to keep the official program under constant review. But, at the same time, they would maintain their support. Through the IPPF their contacts with other FPAs would be a source of valuable information which they could pass on to government, and they could report to other countries the successes of the Pakistan government program. They were pleased that such financial support as the government had given them in the past would continue.\textsuperscript{25}

To mobilize further support, an International conference on Pakistan's family planning program was held in Dacca from 28 January to 4 February, 1969. 400 delegates, including representatives from international agencies, as well as FPAP members, were included. The FPA contributed a special exhibit showing their work in public education and motivation. Two outside experts, Philip Hauser of the University of Chicago and Dr. Malcolm Potts of the IPPF, recommended the liberalization of abortion to supplement other methods of birth control. However, in April political unrest forced the
resignation of President Ayub Khan. Though it continued the program, the Martial Law administration of General Yahya Khan soft-pedalled family planning publicity. The UN study was published in June, and on July 1, 1969, Dr. A.M. Malik was appointed Minister of Health, Labour, Social Welfare and Family Planning. Enver Adil was replaced as Secretary and Commissioner of Family Planning by Wajiuddin Ahmad, and, in October, a revised proposal for family planning in the Fourth Five Year Plan was submitted to the Planning Commission. Rs. 606 million ($U.S. 121 million) were allocated to prevent 9.6 million births during the period and reduce the birthrate to 40 per thousand in 1974-75.26 Illiterate dais were to be gradually replaced by literate male and female field workers who would provide any desired method and continuing follow-up and reassurance. These workers would be supervised by one family planning assistant for each three Union Councils. District level training would be improved. Group sessions on agriculture, health, education, and nutrition could include family planning, and more education in population problems was to be given to students in medicine and the social sciences. Training, research, and evaluation were to be combined and located in one centre in each provincial capital and be known as "TRECS". These were to be directed by representatives of the Family Planning Council and of the Provincial Boards. From an exclusively professional group, the Family Planning Council was once more to be broadened to include not only official representatives of the Ministries
of Health and Finance, but also of the Medical Association, Family Planning Association, the All-Pakistan Women's Association, Red Cross and other organizations, and the Universities. The wheel of sponsorship had come full circle! The logistics of the program were to be revised, but, by the end of 1969, few details were known, other than the fact that non-officials were to be in charge of the Districts, and a greater emphasis was to be laid on field work.27

The FPAP held a conference on public participation at Comilla in East Pakistan in December, 1969. Dr. Attiya Inayatullah, Vice-President could not resist hinting that the exclusively governmental program had been bureaucratized and target-oriented, and that inclusion of non-governmental agencies might have prevented this from happening. The new Commissioner of Family Planning, Mr. Wajiuddin Ahmad, urged the Family Planning Association to help to overcome the dichotomy by building communication with elites in related professions and with local opinion leaders. By building political support, the FPA could help prepare for the day when authoritarian government would be replaced by a democratic system. He said that the FPA could also act as a watchdog over the government program and pioneer new ideas and models which could be adopted by the latter.28 As 1969 closed, official statements by General Yahya Khan and others urged large scale voluntary participation in the huge task of social uplift. As social service was an essential element in the spirit of Islam, the Fourth Five Year Plan would in-
clude larger allocations for health, education, and housing and social welfare— a 250 percent acceleration in this sector. 29

At the same time the Family Planning Association announced its intention, in addition to promoting public education and public participation in the national program, to specialize in population education for the youth of the country— a new and potentially controversial family planning activity. 30 Its annual grant from government was slightly reduced to Rs. 190,000 ($U.S. 38,000) but, for 1970, the IPPF was supporting it with $162,000 for special projects to be described later. 31 It was expected that once family planning was acceptable to the public generally, the FPA would be able to confine its efforts to family life education.

As in other "developing" societies, initial acceptance of family planning in Pakistan was hampered by traditions favoring fertility, supported by religious precepts, and by the absence of old age security measures. Resistance was founded in many generations of high infant mortality, a tradition of early marriage, low status and low literacy of women, and fatalism— "All things come from God— including natural disasters and children." Taboos against the discussion of birth control, even between husband and wife, and a belief that it is forbidden in Islam, were also factors in decision-making. 32 They are still influential.

Overt opposition took the form of pamphlets and speeches against family planning at Friday prayer services. 33 But
volunteers and the government thought it was useful.

... it has given our programme even greater publicity, unravelled its mysterious image wherever that existed among the ignorant, and debunked the credibility of those who chose fantastic rumours to scare away the adopters.34

The Pakistan government sought support from "enlightened" theologians in Pakistan and other Muslim countries, and these declared themselves in favor of family planning. Books and pamphlets answering the critics were issued. A review of Islamic Attitudes Toward Family Planning, published by the Islamic Research Institute, Rawalpindi, stated that

Family size should harmonise with economic conditions and a family may seek protection against too many. Birth control reduces child neglect, maternal exhaustion, illegitimacy, abortions, crowding, infant mortality, and deformity. It helps prevent divorce, mental illness, poverty, delinquency and even war.35

Akhter Hameed Khan, another authority on Islamic theology and culture, wrote a pamphlet on the Islamic Opinion of Contraception, which included favorable opinions by two Muslim jurists. Other experts recalled that Ibn Sina (Avicenna 980 - 1037 A.D.), the famous Muslim physician, described various methods of birth control and, from time to time, different Muslim authorities, including the Prophet himself, had approved coitus interruptus, suppositories, pessaries, and abortion of a foetus up to four months after conception. Though not unanimous on all points, these opinions have been confirmed by fatwas (pronouncements on canonical law) by
Muslim theologians (ulema) in such countries as the United Arab Republic, Turkey and Iran, Pakistan and Indonesia. Begum Selim Khan, active in the Family Planning Association, noted that times were changing: in Pakistan it is now customary for a Muslim to take only one wife; it is agreed that divorce should not be pronounced without good reason; and the dowry system is on the way out – all traditions which support the idea of large families.

Yet, in practice it was not always so simplified. In Ten Years Against the Stream, the Karachi Branch of the Family Planning Association observed that it had been a constant struggle against the "so-called religious thinking" of influential people. What was needed was massive education, to warn the public that over-population required a colossal investment in education, public health services, housing, water supply, transportation, and the provision of jobs. It required the co-operation of all agencies, public and private, to pass the word.

As in Western countries, the medical profession stood on its record, explaining that accusations of opposition or indifference were unfair. Its training had been based on curative medicine not preventive public health programs. In addition, until about a decade before, the high incidence of disease and shortage of doctors had been the reason for medical inaction in the family planning field. The geographic division of the country, racial attitudes and population density were other obstacles.
Attendance at family planning clinics in the 1950s was disappointing. As has been noted, the services were initially offered in a few city clinics; opposition was vigorous, and the limited financial resources of the volunteers made the obstacles almost insurmountable. Education, favorable fatwas by the "enlightened" ulema, support by other opinion leaders, and government backing had to be mobilized. Besides building acceptability, trained medical and paramedical personnel, especially women doctors, were sadly lacking, and a simple, yet reliable method was not yet invented. The effect on the birthrate, if any, was miniscule. Age range, parity, income group and other relevant data were not included in the Annual Reports for 1964 and 1967, the only ones received for study, but totals were available:

| TABLE VII |

Attendance at FPA of Pakistan Clinics,
Year Ended June 30

<table>
<thead>
<tr>
<th></th>
<th>1964</th>
<th>1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lahore</td>
<td>7,112</td>
<td></td>
</tr>
<tr>
<td>Dacca</td>
<td>6,996</td>
<td></td>
</tr>
<tr>
<td>Karachi</td>
<td>6,049</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Lahore</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dacca</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Segun Bagicha</td>
<td>8,246</td>
<td></td>
</tr>
<tr>
<td>ii) Gandaria</td>
<td>2,041</td>
<td></td>
</tr>
<tr>
<td>Karachi</td>
<td>7,709</td>
<td></td>
</tr>
<tr>
<td>Mobile van</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) West Pakistan</td>
<td>750</td>
<td></td>
</tr>
<tr>
<td>ii) East Pakistan</td>
<td>2,048</td>
<td></td>
</tr>
</tbody>
</table>

Source: Annual Report, FPAP, Lahore, 1964, pp. 8-9; also 1967, pp. 24-29.
During the Second Five-Year Plan, when the government took primary responsibility for the birth control program, its work was very little more effective than that of the PPAP. But from 1965, when the official program was reorganized, the emphasis was shifted from clinics to dais and, finally, to educated field workers, progress began to be impressive. Through 1969 the total number of acceptors of IUDs and sterilization alone was 3,805,000, representing 15.9 percent of ever-eligible women.

**TABLE VIII**

Number of Acceptors, Government Program, 1965-1969  
(in thousands)

<table>
<thead>
<tr>
<th>Year</th>
<th>East Pakistan</th>
<th>West Pakistan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965 &amp; before</td>
<td>237</td>
<td>313</td>
<td>50</td>
</tr>
<tr>
<td>1966</td>
<td>449</td>
<td>377</td>
<td>827</td>
</tr>
<tr>
<td>1967</td>
<td>763</td>
<td>516</td>
<td>1,281</td>
</tr>
<tr>
<td>1968</td>
<td>736</td>
<td>399</td>
<td>1,135</td>
</tr>
</tbody>
</table>


Though efficiency had suffered from geographical, financial, and logistical problems, in both the volunteer and the government programs, the former was also reorganized in the mid-1960s, and was able to be useful in specific projects which were within its capability. Propa-
ganda, research, training and modest clinic services, were areas where action was possible.

Recognizing the universal expectation of children in the Pakistani agricultural milieu, the FPAP had urged, from the beginning, the spacing of pregnancies in the interests of child and maternal health; and, in addition to contraceptive services, it had provided marriage counselling and treatment of sterility. This was the usual basic policy of family planning organizations, and, when overpopulation became more and more obvious, the idea of the small family norm was added. When thirty member countries of the United Nations, including Pakistan, signed a resolution advocating family planning, the FPAP followed this action by adopting UN phraseology – that "family planning was a duty, and a basic human right". Although critics of the principle of voluntary birth control have attacked this phrase as encouraging fertility in a time of population explosion, the Family Planning Association of Pakistan, in step with similar groups in other countries, chose to interpret the statement as meaning that duty to one's family and one's country could only mean adopting birth control methods, and governments should provide them to all citizens, on a voluntary basis, as a human right.

Specific information on the early propaganda activities of the FPAP is not available, but the Annual Report for the year ending June 30th, 1964, noted that, when the Association was first formed, it was
... a time when Pakistanis in government or otherwise lived with the shutters of their minds drawn tightly (sic) against the very name of family planning. With this background what could be more commendable to the Association and gratifying to its pioneers than that Pakistan is today one of the few countries of the world where the Government is implementing a dynamic population planning programme. 42

In the early years, the FPAP led a hand-to-mouth existence for criticism was heavy, and, although government gave grants-in-aid, these did not arrive on a regular basis and were inadequate. However, a quarterly journal of information, Birthright was started, and a turning point came in 1964, when the Association was able to set up a national office in Lahore, with an executive director, an office assistant, a typist, and a peon (office boy). A "Motivation Officer" and liaison officer were soon added, and the office was properly equipped to serve as a demonstration unit for organization and methods. 43

In 1964 also, the Association organized a national seminar, Pakistan's Population Quake, to identify problems, evaluate its past work, and plan for the future. In addition, the session was intended to stimulate public support. The role of religion and the economic consequences of population growth were examined, and study groups on motivation, the role of government, cultural matters and clinical testing of contraceptive methods were held. It was agreed that religious opposition was no longer of any great significance, and that it had been possible to motivate the women in the
urban areas the PPAP had served. But it was now essential to take the service to the villages and, as Stycos had suggested, make a greater effort to persuade men to adopt the idea as well. Greater co-ordination among social workers, voluntary organizations and government was needed, and more should be done to involve the "Basic Democrats". To be effective, the government program should be reorganized, and given autonomous status, for it did not have the required prestige under its present administration.

In its own promotional activities, the PPAP had made a documentary film in English, Urdu, and Bengali, financed by the Asia Foundation and the government of West Pakistan. Along with cinema slides, it was circulated by the government screening unit. A filmstrip in Bengali and Urdu had also been made with the help of the Sweden-Pakistan Project. A school children's poster competition had been disappointing, but another, more professional poster had been made, and 3,000 copies distributed. A press campaign had been inaugurated, radio talks were being given, and a ten-minute monthly television program was planned. A ten-day family planning exhibit had drawn two thousand people a day in Lahore. Stalls and exhibits had been set up at fairs and exhibitions. Brochures on family planning and vasectomy had been well received. Flashcards on the IUD had also been produced for use by hospitals and other agencies, and for training and education. Three thousand calendars with family planning slogans had been distributed. Signs had been put on
kiosks as well. Articles in newspapers and magazines had been written, and the FPA quarterly journal, Birthright, had become bi-monthly in English and in Urdu. The Motivation Officer had lectured in government offices, factories, and business concerns, had given counselling to males, and had made contacts with other voluntary organizations to persuade them to incorporate family planning in their services. The officer in Lahore alone conducted 37 meetings, attended by 2,929 people, and counselled 1,341 clients in the year ending June 30, 1966. Answering letters of inquiry had also become a regular service.

By 1967 the Family Planning Association of Pakistan was better organized on a national basis, and its relationships with the branches in the two wings better defined. Each had more autonomy. Demonstration units were functioning in East and West Pakistan, and model programs for motivation and health education were being developed. Both wings had information centres, motivation officers were active, and an unspecified number of branch associations (10 in West Pakistan) were functioning. Support and co-operation was being given by industrialists, service clubs and other organizations.

In 1968 television spots were used, talks and jingles were broadcast on radio, and both static and mobile exhibitions continued to be popular. A special motivation scheme on the train running between Lahore and Saniwal had been undertaken on a trial basis.

The Family Planning Association was urged by government
to build communication with elites in politics, journalism, social work, labour, education and medicine, and to enrol them as members. This would be a good foundation for the day when authoritarian government was replaced by democracy. It was also urged to experiment with new ideas and develop models which could be emulated by the government program.

In response to its recovered prestige, the FPAP agreed that, in addition to its ordinary propaganda activities by means of films, posters, leaflets, puppet shows, folk-singing, push carts and give-aways (bed covers, pillow slips, and towels with family planning slogans) mobile exhibitions, its River Boat Project, mobile clinics and local motivation teams - it would sponsor population and family life education in three types of courses - one for 14–20 year olds, another for prospective married couples and newlyweds, and the other for parents and teachers.

Information on research before the 1960s is lacking, but those present at the Fourth All-India Conference on Family Planning in December, 1961, heard Begum Saida Waheed report that the Association had conducted an attitude survey among 10,000 families in West Pakistan which revealed that 62.5 percent favored family planning. Plans for field studies in the Lahore and Dacca areas, a research centre to co-ordinate statistical information and data on social conditions, and plans to do contraceptive testing, especially of orals, were also in hand.

By 1964–65 some four to five thousand record cards
were providing data for the Institute of Development Economics, research on IUDs for government had been undertaken, a foam tablet acceptability trial had been undertaken for the IPPF, 600 women were on an FPAP supervised oral contraceptives test, a study of the role and attitude of dais to family planning was undertaken in two centres, and attendance at the model clinic in Karachi was analysed. 48

In 1966-67 the state funded clinical and acceptability trials for foam tablets, IUDs and Orals. In 1970 an IUD retention study was done. Clinical trials of magestrolacetate - a micro-dose oral contraceptive - were also undertaken. A new study of the attitude of the dai to family planning, especially to the idea of an incentive payment for IUDs, was also done. An analysis of reactions to a press campaign in Lahore was undertaken as well. 49 A survey of post partum family planning propaganda in three West Pakistan hospitals was planned and the FPA was also to examine ways and means of introducing family planning through the Red Cross, the TB sanitoria, Day Nurseries and the All-Pakistan Women's Association. By 1970 the FPA was also helping with more government projects, including the testing of injectibles. Research methods and evaluation were improving, but programs in the universities needed strengthening and the gathering of statistics, especially vital statistics, was still inefficient. New pilot projects which the government could take over if successful were also needed. 50

Training was undertaken by the volunteers as early
as 1958, when an eight-day course was held for thirty doctors of the Directorate of Health Services. Women were among those attending. This course was followed by short courses conducted by the Directorate of Health Services itself. The following year, under the FPAP auspices, experts from the United Kingdom and the United States including Dr. Helena Wright and Dr. Abraham Stone, respectively, were able to give two-week courses for forty doctors in Lahore and forty health visitors and social workers in Dacca. Two training teams were able to benefit from the visitors' instruction as well. In 1959 the total trained was 1,000 – health department employees, volunteers and village aid personnel. The Family Planning Association of Karachi reported assistance to government in preparing training syllabi and organization and urged that standards be uniform, and that not only medical students but other undergraduates be instructed in family planning. The FPAP model clinics in Lahore, Karachi, Dacca and Gondaria (Dacca) became useful training centres for these purposes.

By October, 1965, the government had set up seven training-cum-research institutes for medical and paramedical personnel, and there were four mobile training teams in each province to concentrate on teaching Family Planning officers and Lady Organizers (dais). The latter group was large – 30,000 – and lack of education and motivation made them difficult to train, so the Family Planning Association secured funds for training dais and motivation officers.
as well. At the request of the government of East Pakistan, the Family Planning Association in that province trained 15 doctors in vasectomy techniques, gave lectures to final-year physical education students, 5 dais and 1 doctor. Two student social welfare workers and four detectives were given family planning training in 1968. Motivators' training was also undertaken. Clinical services were more limited but a review is of some interest.

In 1958 the model clinic in Lahore was holding two sessions daily. Mornings were for all comers, and afternoons by appointment. A sliding scale of charges based on ability to pay was used. In 1959 the government approved the use of Maternal and Child Health Centres, and it was hoped then that all such facilities would be used for family planning by the end of the Second Plan period in 1965. Municipal and government dispensaries were scheduled to distribute diaphragms and jellies, and home visiting was planned in order to give out foam tablets and condoms.

By 1964 the FPAP model clinic at Lahore had added well-baby services, marriage counselling, and infertility services. A lady doctor was in charge, with a staff nurse, dai, and part-time counsellor on salary. A volunteer surgeon was performing vasectomies, and two volunteer physicians were providing birth control information and methods for men. Similar activities had developed in Karachi and Dacca, and, by 1967 a second model clinic on the same lines was opened.
in Gandaria. The FPA had agreed with the government to continue to run its model clinics, mobile vans, propaganda and research projects. In East Pakistan, a long desired river boat educational and clinic unit, financed by a Western benefactor and the IPPF, commenced to operate in the many waterways of the delta country.

By July, 1969, government services had been extended throughout both provinces, including tribal areas, and were organized on a district basis with District Family Planning Boards. Incentives for both medical and paramedical personnel and for acceptors to promote IUDs and sterilizations had been introduced, and small charges had been instituted for condoms and foam tablets. Addition of orals to the government program was planned, liberalization of abortion was under consideration, and rewards for childless families were being contemplated. All these methods had been pioneered by the volunteers.

As in India, during the First Five-Year Plan, 1955-1960, the Family Planning Association of Pakistan was given responsibility for importing all contraceptives. These were conventional methods - unspecified in such reports as are available, but believed to have been foam tablets, condoms, diaphragms, jellies and creams. In 1958 the FPAP was also urging the government to promote sterilization and to raise the marriage age for all Pakistani men and women.

By the time of the Third Plan, in 1965, the government had adopted the IUD and sterilization as the main
methods in its campaign. As in India, high hopes of the former were held, though the latter was not expected to be very popular in such a tradition-bound society. As it turned out, the IUD acceptance declined from 1968, as in India and Ceylon, and retention rates dropped from 75 percent at the end of the first year to 47 percent at the end of the second. East Pakistan had a higher retention rate than West Pakistan. But the IUD was not the magic method so long desired. Condoms, foam tablets and aerosol foam were much favored. Oral contraceptives were, and still are, experimental only, though they are sold freely at a low price on the open market. Sufficient research has been done in both Ceylon and Pakistan, however, to show that continuation rates could be raised to more than 62 percent at the end of twelve months if distribution was on a house-to-house basis. By the time the Fourth Five-Year Plan was being drafted, sterilization had become very popular among men, and female sterilization was also being promoted. Acceptance of vasectomy was higher in East Pakistan too. Men were usually 40 years of age or more, and women 32 years and above. The average couple had 4 or 5 children, including two or three living sons. (See Table XI, Appendix for additional data).

No birth control methods were manufactured in Pakistan until 1967, when IUDs were made, and in 1969 materials for oral contraceptives were imported in bulk for tableting. Foam tablets were also manufactured from this time on. More than 250,000 cycles of orals were sold in the private sector
in 1968, and, by the end of 1967, 21,000 gross condoms, 16,000 dozen foam tablets, 9,000 tubes of cream or jelly, and 700 diaphragms had been purchased, indicating increased interest in family planning.\(^{58}\)

Modest help was originally given by the Pathfinder Fund and the IPPF to the Family Planning Association, but, by 1969, foreign assistance to Pakistan for birth control totalled more than $U.S. 32.1 million. The Population Council, Ford Foundation, Rockefeller Foundation, SIDA, US AID, UNESCO, UNICEF, the Netherlands, the United Kingdom governments had all contributed. The Population Council had financed estimates of population growth and given demographic training. Ford Foundation had given advisers, training, help in research, and had assisted the National Institute of Family Planning. Johns Hopkins University had helped in Lahore, and the University of California in Dacca. SIDA had given research, training, equipment and condoms, US AID had provided technical advisers, jeeps, motors and boat materials. UNICEF had given training in maternal and child health, including family planning, Oxfam had assisted the FPAP, and the British government had also contributed money and expertise. As in Ceylon, Sweden conducted a "Sweden-Pakistan Family Welfare Project", but it was more sophisticated, and included money, medical teams, mobile clinics, and media advisers. Three Pakistanis had been trained in Sweden in visual aid techniques, and the Pakistan training-cum-research institutes had also been aided. From 1961 through 1970
Sweden had given assistance valued at $U.S. 8.5 million.\textsuperscript{59} Japan was providing condoms. The IPPF was financing mobile vans, infertility clinics and other research projects through the FPAP, and had also paid travel expenses for foreign visitors to family planning conferences in Pakistan, and for Pakistani delegates to conferences in other countries. The government itself had allocated for the Fourth Five-Year Plan a total of Rs. 620 million ($U.S. 104 million) and this represented 1.4 percent of the total national budget, U.S. 17.8¢ per capita, per annum.\textsuperscript{60} Altogether, the Pakistani government family planning program was a creditable performance, even though it had not yet begun to catch up with the problem of population growth.

**TABLE IX**

Data on Pakistan Government Family Planning Program

(in thousands)

<table>
<thead>
<tr>
<th>Year</th>
<th>IUDs</th>
<th>Sterilizations</th>
<th>Orals</th>
<th>Other</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td></td>
<td>0.8</td>
<td></td>
<td></td>
<td>109</td>
</tr>
<tr>
<td>1966</td>
<td>483.5</td>
<td>28.6</td>
<td>1.3</td>
<td></td>
<td>537</td>
</tr>
<tr>
<td>1967</td>
<td>674.8</td>
<td>152.0</td>
<td>3.4</td>
<td></td>
<td>1,019</td>
</tr>
<tr>
<td>1968</td>
<td>864.9</td>
<td>415.5</td>
<td>0.9</td>
<td></td>
<td>1,418</td>
</tr>
<tr>
<td>1969</td>
<td>737.1</td>
<td>398.0</td>
<td>0.0</td>
<td></td>
<td>1,334</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>2,808</td>
<td>9,953</td>
<td>5.6</td>
<td>4,417</td>
<td>17,183.6</td>
</tr>
</tbody>
</table>

Cumulative acceptors through 1969 as percent of ever-eligible women: East Pakistan: 16.2; West Pakistan: 15.6; Total: 15.9

Estimated Percentage of Married Women Users, 15-44 Years of Age:

January, 1970

u 7 4
Personnel and Facilities Specifically Allocated, Current

Doctors certified for IUDs & Vasectomy  2,300
Full-time lady family planning visitors  500
Lady home visitors  600
Part time dais (village midwives)  37,000
Other family planning personnel:
  Executive  56
  Officers  1,370
  Assistants  3,700
  Part time agents  50,230
Hospitals, clinics and centres
  (including some mobile teams)  1,839
  Mobile teams  100

<table>
<thead>
<tr>
<th>By Provinces</th>
<th>East Pakistan</th>
<th>West Pakistan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors and other</td>
<td>1,385</td>
<td>2,307</td>
<td>3,692</td>
</tr>
<tr>
<td>medical personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Medical personnel</td>
<td>36,588</td>
<td>48,637</td>
<td>85,225</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


To sum up, as in India and Ceylon, the family planners were educated volunteers who saw the dangers of over-population but chose to put their main emphasis on maternal and child health as the more acceptable approach. Religious opposition was strong until President Ayub Khan lent support. Medical reaction was conservative as well. The same geographic and language stresses seem to have built up in the PPA of Pakistan as occurred in the political arena. While the volunteers made no impact on the birthrate of Pakistan they did provide the first training and organization, and this was useful to the government program when it was strengthened.
After some ambivalence on the part of government, the volunteers were recognized as essential to the success of the official scheme. While they retain some of their clinic and research activity, the FRAP's chief role is in education. Much more localized, but equally challenging is the family planning problem in Nepal, last of the Indian Ocean Region countries to join the IPPF.
Chapter VII

Wives of prominent business and government officials, led by Begum Raana Liaquat Ali Khan, wife of the first Prime Minister.

2 Under the presidency of Begum Saida Waheed, with a branch in East Pakistan headed by Dr. (Mrs.) Humaira Sayeed. A West Pakistan Branch was formed in 1959. Typewritten history by A.M.A. Kabir, February, 1969. Also J. Gilbert Hardee & Adeline P. Satterthwaite, Pakistan, Country Profile, Population Council, New York, March, 1970, p. 3.

3 Annual Report, Family Planning Association of Pakistan, Lahore, 1964, Foreword.


6 The 1965 Report of the Sweden-Pakistan Family Welfare Project does not mention any relationship with the FPA of Pakistan.

7 Hardee & Satterthwaite, op. cit., pp. 3-4.


22 Ibid., pp. 5, 6.

23 Ibid., Flyleaf.


26 Pakistan News and Views, No. 46, Ottawa, 1 March 1970.

27 Hardee & Satterthwaite, op. cit., p. 9.


31 Situation Report, op. cit.


40 Annual Report, FPAP, 1964, p. 3.


43 Ibid.

44 Ibid., passim; also, Sylvia Fernando, op. cit., p. 170.


46 Wajiuddin Ahmad, op. cit.


48 Annual Report, FPAK, op. cit., pp. 4-5.

49 Situation Report, op. cit.
50 Wajiuddin Ahmad, op. cit., passim.


52 J. Gilbert Hardee & Adeline P. Satterthwaite, Pakistan Country Profiles, op. cit., p. 5.

53 "Activities of the Family Planning Association....", Birthright, op. cit., p. 2; also IPP News, No. 176, October, 1968.


55 Sylvia Fernando, op. cit., p. 169.


57 Dorothy Nortman, op. cit., pp. 41-42.

58 Hardee & Satterthwaite, op. cit., pp. 6-7.


60 Dorothy Nortman, op. cit., p. 75.
CHAPTER VIII

Nepal

The family planning movement was introduced in Nepal in 1959 by educated volunteers. As was the case with leaders in the other countries studied in this thesis, they too were worried about the burdens of overpopulation on physical and human resources, and wanted to help their country telescope modernization into the shortest possible time.

... the unlimited population growth is bound to disturb the balance between population and resources of the country. It will also create problems regarding the development of educational, health, food, land and welfare facilities affecting ultimately the living standard of the general mass.¹

As in the other countries of South Asia, the Nepalese family planners focussed their initial efforts on the need for improved maternal and child health, and family welfare, adding the treatment of infertility as one of their other services. Actual contraception was not offered, however, until 1963, when in co-operation with the Women's Voluntary Society, a start was made at the Kathmandu Maternity Hospital. The same year, the Family Planning Association of Nepal (FPAN) became a member of the International Planned
Parenthood Federation, and sent a delegation to the Indian Ocean Region, IPPF, meeting in Colombo.

Not much more was accomplished, however, until 1965, when leadership changed and the movement was reorganized. The following year, the government was persuaded to accept responsibility for providing family planning services through maternal and child health facilities, and an Advisory Council, including three members of the Family Planning Association, was set up. King Mahendra gave his support to both the government and the voluntary movement. As in other countries, the Family Planning Association undertook to carry the more controversial load of propaganda and education. (See Table XI, Appendix, for data on Nepal).

The reorganized PPAN began to function in September, 1967, but, like the government, faced the problems which accompanied poor communications, limited health services and health personnel, limited training facilities, poor evaluation systems and inadequate methods of gathering vital statistics. In addition, there were the usual built-in obstacles peculiar to a society with strongly entrenched traditions. No law against birth control had ever existed in Nepal, but it was difficult to help the people understand its purpose. Hindu religious superstition and fatalism, low literacy, as well as the traditions of the joint family system also obstructed the program. The usual surveys had shown that the desired number of children was three, but the overwhelming need for at least two sons often made family size much larger. Filial responsibility for aging parents
was less important than responsibility in parental funeral rites.  

The leaders of the FPAN state that wives, husbands, mothers-in-law and village leaders all approve family planning for reasons of health, for family happiness and for its economic benefits; and state that the idea of spacing is a popular approach. Solutions to Nepal's population problems lie in informed self-interest, education and the emancipation of women.

The initial target of the government program was to be 100,000 women in the Kathmandu Valley. As this is the most heavily populated area of the country, their acceptance of family planning would keep the rate of population increase below 2 percent, and reduce it to 1 percent by 1985. Eventually a stationary population of between sixteen and twenty-two million would be achieved. The plan was to induce 50 percent of the women to accept the IUD, 25 percent of both males and females to accept sterilization, 20 percent of the males to use condoms and 5 percent of the women to accept oral contraceptives.

While government activity was developing, the FPAN followed up its assignment in public education and motivation through displays in honour of the King's birthday, and other festivals, posters, films, slides, brief leaflets and press publicity. A weekly radio series was also undertaken. A Nepali film, financed by the governments of the United Kingdom and Nepal, the IPPF, and the FPA, in both 35 and 16
millimetre sizes, was also produced. 8

The government set about the problem of training and, up to September 1969, nine government doctors and 45 nurses had been instructed, some in the United States, others in Korea, and all through US AID. The Population Council also financed 1 doctor, 2 public health nurses and 1 technician as local training staff. Incentives for doctors for vasectomies, IUD insertions, and oral prescriptions were also introduced. 9

Although the delivery of services was supposed to be the responsibility of government, the volunteers set up a clinic in Kathmandu which in three months became very popular, and, by the end of its first year, had served 365 patients. In 1968 another clinic was opened in Bhaktapur where the local Panchayat chairman gave it enthusiastic support. In 1969 clinics were also opened in Lalitpur and Dhulikhel – presumably in locations not yet reached by the government.

As an experiment, in 1968 the FPAN sent a team to the remote mountain village of Dharwang, in northwestern Nepal. This was made possible by a US AID helicopter. In a thirteen-day visit, 95 vasectomies were performed, 17 IUDs inserted, 87 people had accepted condoms, and another 11 accepted oral contraceptives. Other medical problems were also treated, and, in all, a total of 338 persons were served. Requests from other remote areas were received, and subject to sustained support for transpor-
tation and other needs, the FPAN agreed to respond. Mobile vans were also sent to five areas of the Bagmati Zone, as another innovation. Under a government grant the FPA was now employing 1 full time doctor, 1 nurse, and 4 part-time doctors and 1 part-time nurse, and, as of January 1969, the FPA program showed 837 vasectomies, 73 IUDs, 225 patients on oral contraceptives, and an unknown number of condom users. 10

By the end of 1967, 35 government clinics were operating in the Kathmandu Valley, and by October 1970, there were 57. From 1966 to 1969 these clinics performed 5,577 vasectomies and 5,993 IUD insertions. 365,605 condoms and 24,500 cycles of oral contraceptives were also distributed. 11

### TABLE X

Other Data on Nepal Government Family Planning Program

<table>
<thead>
<tr>
<th>Year</th>
<th>All Methods</th>
<th>IUD</th>
<th>Oral</th>
<th>Sterilization</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>0.6</td>
<td>0.6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1967</td>
<td>3.5</td>
<td>3.0</td>
<td>0</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>1968</td>
<td>4.6</td>
<td>1.4</td>
<td>0.2</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>1969</td>
<td>14.1</td>
<td>1.1</td>
<td>4.3</td>
<td>3.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Total</td>
<td>22.6</td>
<td>6.4</td>
<td>4.6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

**Estimated Current Users by Method, January, 1970**

<table>
<thead>
<tr>
<th>Method</th>
<th>Current Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>3.4</td>
</tr>
<tr>
<td>3.3</td>
<td>5.5</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Percentage of Married Women Users, 15-44 Years of Age:**

| January, 1970 | 0.7 | 0.14 | 0.14 | 0.2 | 0.2 |
### Personnel and Facilities Specifically Allocated: Current

<table>
<thead>
<tr>
<th>Role</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Public Health Nurses</td>
<td>2</td>
</tr>
<tr>
<td>Technician</td>
<td>1</td>
</tr>
<tr>
<td>Health Aides</td>
<td>35</td>
</tr>
<tr>
<td>District Family Planning Officers *</td>
<td>25</td>
</tr>
<tr>
<td>Technical Manpower</td>
<td>128</td>
</tr>
<tr>
<td>Non-technical manpower</td>
<td>31</td>
</tr>
<tr>
<td>Government facilities</td>
<td>40 clinics</td>
</tr>
<tr>
<td>Mobile units</td>
<td>unknown</td>
</tr>
</tbody>
</table>

* Recruitment of District Family Planning Officers began in June, 1969. All applicants were at least college graduates.


A choice of methods was offered at first in both the voluntary and the government programs, but, because the IUDs resulted in extra bleeding, backache and gossip, and the oral program also required follow-up, it was decided to restrict these two methods to the Kathmandu Valley, where supervision would be easier. Vasectomy and conventional contraceptives such as condoms were given priority in the more remote areas.

From 1966 US AID financed nearly 80 percent of government costs in training, research, contraceptives and other needed commodities. Up to the end of the 1970 fiscal year this totalled $413,000. Other sources of help were also tapped: the Population Council financed IUDs and inserters, the Pathfinder Fund gave contraceptives and a social
worker's salary, the Japanese Organization for International Co-operation in Family Planning provided more than $5,000 in contraceptives, and SIDA gave $4,000 worth. Church World Service and the British-Nepal Medical Trust gave family planning in hospitals. UNICEF also gave training. The IPPF has given most of the financial support required by the FPA, including a visiting team to help in the problems of organization. From its own resources the government of Nepal allocated Rs. 481 million to the program in 1969, and Rs. 875 million in 1970 ($U.S. 87,500), representing .12 and .14 percent of the total national budget, and 1.8% and 3.5% per capita respectively.

To conclude, the story of family planning in Nepal followed much the same course as in the other countries of South Asia. The program was introduced by educated volunteers who recognized from the start the dangers of over-population, and also the need for maternal and child health and family welfare programs. What they lacked in efficiency at first was made up by the mid-1960s when government and royal support was given to both the private and the public plan.

The main obstacles were traditional values, low literacy and poor communication, and insufficient data are available to assess whether either the voluntary or the government program has made much impact on the Nepali birthrate. The volunteers have, however, assisted the cause with their publicity; and their innovative schemes in the
more remote parts of the country have provided useful experience for broader programs under government auspices whenever the latter is ready to undertake them. Their traditional roles of propaganda and experimentation are providing information on how best to present the family planning message and give it effect. By the end of 1969 progress was being made, and the future looked encouraging for both the voluntary and the official programs.
FOOTNOTES - Chapter VIII


5 Mrs. Shanti Rana to Mary Bishop, 19.11.1968.

6 Dr. Jagadish P. Sharma to Mary Bishop, 26.9.1969.


10 Annual Report, FPA Nepal, op. cit., p. 3; also Situation Report, op. cit., p. 3.


12 Ibid.

13 Dorothy Nortman, op. cit., p. 75.
PART FOUR

CHAPTER IX

Conclusions

In analysing the role of the volunteers in the development of family planning programs, and in considering whether they can make a continuing contribution, a number of facts have emerged. The majority of individuals always have wanted to limit their fertility for individual reasons. They always have resorted to folk methods, such as magical formulae, coitus interruptus, abortion and infanticide if other means were not easily available. It has always been the well-informed and the well-to-do who have had access to and used the more sophisticated means. Besides these individual decisions, when resources have been threatened, different societies at different times have promoted and practiced population control. These are historical facts - not just recent phenomena.

"Family Planning" as a movement originated in the West in the late 18th and early 19th centuries and was adopted by indigenous leaders in South Asian countries early in this century. For example, it was openly discussed by Indians as early as 1911. Two concerns have been apparent throughout its history - the threat of overpopulation and the usefulness of birth control as a tool of social reform. Until the 1960s, the latter was the predominant theme, and
it is only in the past decade that overpopulation has loomed equally large in policy statements.

Since 1800, policy has incorporated a succession of ideas — increased working class wages, women's rights, maternal and child health, family welfare, genetics, national prosperity, world peace, the need to protect human and natural resources, preserve the environment and basic human rights. In South Asia service to country was an important post independence motive as well.

Though there may have been a few exceptions, the volunteers' concerns were not founded in fear of other races, or a feeling of "middle class" superiority over the "lower orders". Many studies in the past decade have confirmed their belief that the poor have the highest birthrates and the lowest education in every country, and that birth control is one way of helping them out of their poverty. They do not believe that procreation is synonymous with parental responsibility or skill in raising children in any income group. This is why they advocate the "wanted" child and "quality — not quantity." The volunteers believe, however, that the choice must remain voluntary, and that all methods of birth control must be offered on the ground that any method, faithfully used is more effective than none.

Because there was no backlog of previous experience, present schemes are the product of trial and error; and a time lag still intervenes between the non-official or official adoption of a family planning program and its
effective implementation because finances, training, logistical skills and motivation must catch up. No government has yet developed an all-out program, and no one has yet discovered the perfect means of motivation or the perfect method.

The early leaders in the family planning movement were men. With the exception of Annie Besant in the United Kingdom in the 1870s, women leaders did not emerge until the 20th century. All were educated, middle income reformers and, except for Marie Stopes, all were freethinkers. Most were pacifists and most drew their inspiration from the Utilitarian and humanitarian philosophies. Many were socialist. As in every movement, some were motivated by unhappy personal experiences and some were opportunists.

The volunteers "cut their coat according to the cloth" - adjusting targets to feasibility. Techniques of persuasion have ranged from peaceful but determined penetration to confrontation, and publicity has frequently been courted to draw attention to the issue. Whether the latter technique was as successful as the former is not easy to assess, but in any case, the movement is now acceptable to many people.

Opposition in the West was amorphous at first, and always amorphous in South Asia. As the movement in countries of European stock became better organized, however, opposition crystallized among people who thought they had something to lose by accepting it, notably politicians, business leaders, religious leaders and the medical profession. For example,
politicians resisted it because large defence forces were useful. Business leaders resisted because their goals were based on maximum consumption. Religious leaders opposed the movement because it was led by freethinkers and advocates of freedom of choice, and the medical profession resisted because it was trying to establish its credibility and status, because it was more oriented to curing disease than preventing it, and because it had had no training in this field since the Middle Ages. Male domination over women was also evident in all attitudes. Also injected into the dispute was the Marxist theory of the role of capitalism, and the question of whether asceticism in a diluted or extreme form was preferable to the use of artificial birth control methods. There were many misconceptions as to what was meant by "preventive checks" or "birth control" - some thought that it was abortion, castration or even infanticide - and these ideas were assiduously promoted by the opposition. Yet it was the opposition and their colleagues in the professional classes who were themselves practising birth control most successfully.

Opposition in South Asia differed to some extent. It was never organized, but the politicians showed the same caution as their Western counterparts, about ideas which challenged traditional values and they also knew the limitations of communications networks. In addition, few personnel or facilities were available to begin to tackle the problem. Medical attitudes were similar to those in the West, but there was no apparent opposition either on commercial or religious
Because their program was so controversial, the family planners suffered from the beginning from lack of financial support. In addition, they had to emphasize in their propaganda the angles which would make it most acceptable. In the West and in South Asia, spacing of pregnancies for better maternal and child health and family well-being were the most effective. Because, in the West, they also emphasized it as an alternative to induced abortion, it is only in the past few years that family planners have begun to adapt their views on this point - to agree that abortion may be justified in certain circumstances, but that it must always be accompanied by contraceptive counselling. Though it was not a very important part of their program, the treatment of sterility was also offered in the West in the 1930s - in response to fears about declining birthrates. This adjunct was of greater value in South Asia, however, where infertility is a serious social stigma, particularly for women. Premarital and marital counselling were also added, I suspect, to provide not only a useful service, but additional armor against the accusation that birth control promoted marital infidelity and breakdown. Genetic counselling was an outgrowth of a growing interest in eugenics, but, until after World War II it was not very well developed.

The volunteers discovered that even with publicity promoting birth control, and the provision of services, acceptability does not always follow. The individual must
be persuaded of the advantages. It must also be readily available, either through clinics and health centres, home visiting or mobile health teams. Industrial and Trade organizations are also useful in some countries and commercial outlets as well. As the most effective methods — the IUD, sterilization, the Pill and the diaphragm require the services of a doctor, in most programs condoms and other simple methods are also supplied through all channels.

What, then, has been the chief role of the volunteers? Though it is unlikely that they had much direct effect in reducing birthrates, they did help to build public interest and information, and in this way may have spread the practice of birth control. The trial of Bradlaugh and Besant greatly increased the sales of their birth control leaflet as did Margaret Sanger's confrontations with the Roman Catholic prelates and the law. The establishment of clinic services, however limited, also developed a nucleus of satisfied patients — visible proof that a clientele could be built and that the idea was welcomed by some, at least, of the population. The volunteers gradually defused criticism and established the respectability of the idea. That India was the first country in the world to support such a program is a tribute to the efforts of the volunteers and the logical course for a new nation in which the equal rights of women were recognized.

The family planners had no backlog of experience and made some mistakes, but they provided a point of take-off
on which governments could build more sophisticated programs. Their sponsorship of seminars and conferences promoted exchanges of information among the professionals as well as the amateurs. The family planning program also made possible new careers. Demography was one of the first. Biomedical research was undertaken, sociological, administrative studies made, and medical, paramedical and non-medical training were started. Studies in community involvement, motivation and communications were made. All these activities helped to legitimize the program, and no government would have introduced it without such preparatory work.

That they have a continuing role is unquestioned in their own minds and also in the minds of a number of professionals prominent in the field. But the areas in which they can still be useful require careful analysis and agreement among all concerned. In some cases, such as the United Kingdom, voluntary services are supported on an increasing scale, but in government facilities; in others, such as Ceylon, government takes over the delivery of contraceptive and associated services, leaving the problem of promotion and other unmet needs still largely in the hands of the volunteers, but assisted by grants-in-aid. In India, services and promotion are carried out by government, and the volunteers are studying ways of introducing "family life education" into the school system, as well as carrying out other innovative ideas. In some cases the transition has been accomplished smoothly, in others with hard feelings and frustration. In commenting
on the program, Frank Notestein suggested that the volunteers should support and nurture government schemes, and fill the role of friend, critic and advocate — as proud parents, and not as jealous fathers.

Unfortunately, too often disputes have broken out. New government personnel has (sic) sometimes tended to upstage the established planned parenthood workers, or the private organization has poorly concealed the fact that it considers government workers as inexperienced interlopers. Arguments have arisen over whether the government should operate its own birth control clinics or should simply finance the established planned parenthood services.... Forming local constituencies, planned parenthood chapters can advance government policy, be alert to push and praise and — most important — help mould a general climate of public opinion favourable to family planning.

Oscar Harkavy of the Ford Foundation noted that,

There is always a tendency for those of us who have been in a field for a while to consider that the next fellow coming down the track really does not quite know how to do it and he had better learn from us.

Actually there is no one who possesses the secret of bringing down a national birthrate that has not been falling already. So there is a lot for all of us to learn....

As is evident from the descriptions of aid in the population field in this thesis, there has been a multiplicity of effort and a good deal of overlapping. But the IPPF and the United Nations Fund for Population Activities are beginning to fill an indispensable co-ordinating role. In the case of the former the IPPF is helping to channel the
generosity of other voluntary organizations into areas where family planning help is most needed. It is also helping to promote new Family Planning Associations where no programs exist. These in turn can provide the necessary pressure for government programs to be started. Focus is on action programs, particularly in Africa and Latin America. The United Nations fund will help to co-ordinate the population activities of other UN agencies, and it is hoped that more and more foreign aid can be channelled through these two organizations. In addition to these roles, the volunteers in any country can promote training for volunteers and professionals in related fields such as teaching, social work, law, the church and other professions who, up to now, have had little idea how to handle family planning problems. They can press for population education, information on human reproduction and human sexuality in the educational system and for the general public. They can support further research in methods, the predetermination of sex, experimental incentive programs and other fields where real need exists. They can urge that family planning, private or public, be given sufficient prestige and funding. They can work for more education and the upgrading of women, and press for population policies in every country.

In one of his recent assessments of family planning programs, Bernard Berelson, President of the Population Council, observed that "family planning effort, like Christianity, has not failed, it just has never been tried." Though it
may be desirable, zero population growth will not be reached in the developing or the developed world by the year 2000. In some countries there is hope that a less ambitious goal may be won, but the chances not are good in some others.

Coercion is not feasible. Every existing program should be improved. There is also the need for social reform and the emancipation of women. Above all, it will be a long battle, so the donors and the recipients of foreign aid in this field must settle down to the "hard and difficult task of being partners over the long run". In another assessment he concludes:

In the last analysis, what will be scientifically available, politically acceptable, administratively feasible, economically justifiable, and morally tolerated, depends upon people's perceptions of consequences. If the "population problem" is considered relatively unimportant or only moderately important, that judgment will not support much investment of effort. If it is considered urgent, much more can and will be done. The fact is that despite the large forward strides taken in international recognition of the problem in the 1960's, there still does not exist the informed, firm, and constant conviction in high circles that this is a matter of truly great ramifications for human welfare .... Excluding social repression and mindful of maximizing human freedom, greater measures to meet the problem must rely on heightened awareness of what is at stake, by leaders and masses alike.³

The volunteers can help this cause along.


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**Articles**


Victor Fund for the IPPF, Reports, 1967-70.

## APPENDIX "A"

### TABLE XI

**Supplementary Data**  
**South Asia**

<table>
<thead>
<tr>
<th></th>
<th>India</th>
<th>Ceylon</th>
<th>Pakistan</th>
<th>Nepal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area: sq. mi.</strong></td>
<td>1,261,597</td>
<td>25,300</td>
<td>365,529</td>
<td>54,362</td>
</tr>
<tr>
<td><strong>1/3 Canada</strong></td>
<td>2 x Van.Id. &lt; Brit. Col.</td>
<td>&lt; 2 x N.B.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated population (millions)</strong></td>
<td>547,000</td>
<td>12.5</td>
<td>136.9</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>% rural dwellers</strong></td>
<td>82</td>
<td>81</td>
<td>84</td>
<td>96</td>
</tr>
<tr>
<td><strong>Crude birthrate /1000 population</strong></td>
<td>40-50</td>
<td>32</td>
<td>40-50</td>
<td>41?</td>
</tr>
<tr>
<td><strong>Crude deathrate /1000 population</strong></td>
<td>15-20</td>
<td>8</td>
<td>15-20</td>
<td>21?</td>
</tr>
<tr>
<td><strong>Rate of natural increase /1000</strong></td>
<td>25-30</td>
<td>24</td>
<td>25-30</td>
<td>20?</td>
</tr>
<tr>
<td><strong>% annual growth</strong></td>
<td>2.5</td>
<td>2.4</td>
<td>3.3</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>net increase per annum</strong></td>
<td>18 m.</td>
<td>312,500</td>
<td>&gt; 4 m.</td>
<td>22,000</td>
</tr>
<tr>
<td><strong>1985 projection</strong></td>
<td>807.6 m.</td>
<td>17.7 m.</td>
<td>224 m.</td>
<td>15.8 m.</td>
</tr>
<tr>
<td><strong>Doubling time, yrs.</strong></td>
<td>27</td>
<td>29</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td><strong>% of population under 15 yrs.</strong></td>
<td>41</td>
<td>41</td>
<td>48</td>
<td>40</td>
</tr>
<tr>
<td><strong>Dependency ratio</strong></td>
<td>79</td>
<td>79</td>
<td>105</td>
<td>72</td>
</tr>
<tr>
<td><strong>Infant mortality /1000 live births</strong></td>
<td>139</td>
<td>53</td>
<td>142</td>
<td>160-180</td>
</tr>
<tr>
<td><strong>Life Expectancy</strong></td>
<td>M. 1961 46.02</td>
<td>1962 64.10</td>
<td>1968 44.38</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>F. 44.03</td>
<td>64.42</td>
<td>42.45</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>F. (15-19) 23.8</td>
<td>(20-24) 77.5</td>
<td>(15-19) 13.4</td>
<td>(20-24) 2.4</td>
</tr>
<tr>
<td><strong>$ per capita Gross Domestic Product</strong></td>
<td>81</td>
<td>140</td>
<td>123</td>
<td>94</td>
</tr>
<tr>
<td><strong>% national budget on family planning</strong></td>
<td>2</td>
<td>.01</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td><strong>US $ per capita on family planning</strong></td>
<td>7.72</td>
<td>?</td>
<td>17.2</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Explanatory Notes, Table XI

Crude birthrates and deathrates are the number of births and deaths per thousand population. They are used here in preference to age specific rates (which give a more accurate picture) because they are most commonly mentioned in the information media, and are better understood by the average reader.

Population growth rates are percentage increases per year, assuming national boundaries are closed to migration.

Dependency ratios are derived by adding together the population in age groups under 15, and 65 and over, and dividing the total by the "producing" population, 15-64 years of age.

Population projections are not intended to be accurate forecasts (because accuracy is impossible), but are calculations of the possible size of a population if certain conditions prevail. They use high, medium and low hypotheses, and are only educated guesses as to what may happen over a period of, say, 5 to 10 years.

Population doubling times assume continued growth at the current annual rate: \( rt = 69.3t \) (\( r \) is growth rate, \( t \) is time in years).
The Birthrate of Ceylon

Ceylon's declining birthrate since 1957 has been the subject of considerable discussion. N.K. Sarkar noted in that year that economic and social factors might be inducing a decline among educated Ceylonese, but that family planning was not used on a wide scale. A study published in 1961 by Dr. Chinnatamby saw education and occupation as the critical factors. Imogen Kannangara confirmed the role of education in improving employment opportunities for women, especially in government service. World War II opened all avenues to women outside the home except the armed forces and the judiciary, she said; and, by 1966, nearly half the students in university in Ceylon were women. Educational levels were improving not only in urban but in rural settings. Abhayaratne and Jayewardene considered both education and higher marriage ages were important factors in the decline. Nicholas Wright, a Population Council adviser, stated in 1968 that female age structure and the marital status of women (15-49)-not marital fertility - slowed the rate of population growth between 1953 and 1963. Since 1963, it might have been due to declining fertility, and, possibly the efforts of the Family Planning Association, but the government birth control program had not had time to have any effect. Wright pointed out that, because of the lowered death rate since 1945 and 1946, women in the
20-39 year age group would increase. Sheer numbers would inflate fertility rates unless birth control overcame the tendency, unless marriage continued to be postponed, and unless more women remained spinsters. Since 1953 there had also been a "marriage squeeze" due to the malaria deaths in the late 1930s and early 40s. This could only be overcome if women married men their own age, not five years their senior, as was the custom. All things considered, however, the outlook for lower fertility rate was good, provided the government put a great deal of effort into the family planning program.  

G.H.F. Welikala, of the Planning Commission warned that 105,000 were being added to the work force every year, that already 500,000 Ceylonese were unemployed or underemployed, and that, as many were fairly well educated, this represented a threat to political stability. Urgency in the family planning program therefore, was indicated.

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