INTRODUCTION
Indian with a population of 843.93 million (1991) is the second most populous country in world with only 2.4% of world's land area. India is supporting 16% of the world's population. India's population is increasing at the rate of 16 million per year. If current annual growth rate of 2.4% continues unchecked, the population of India at the turn of century may well reach one billion.

The growing concern about the population explosion is equally increasing the problem of side effects by the means to control it. The contraceptive methods may be broadly grouped into two classes.

I. **SPACING METHOD**
   
   a. Barrier method
      
      i) Physical
      
      ii) Chemical
      
      iii) Combined methods

   b. Intrauterine devices.

   c. Hormonal methods and non hormonal oral contraceptive pills, hormonal injectible, implantable methods.

   d. Post conception method.

II. **TERMINAL METHODS**

   a. Male sterilization.

   b. Female sterilization.
Progesterone was postulated by Beard (1897) and isolated in 1934. Pinous (1956) reported that daily doses of 300 mg of progesterone may inhibit ovulation in women but that control of ovulation was not regularly achieved, probably because of variable absorption from GI tract.

Ironically the progestin that was first produced norethynodrel is converted by the body to an estrogen so that the first progestational agent actually had both strong progestational and estrogenic effects.

The first successful clinical trial of a combined oral contraceptive pills were launched in Puerto Rico by Pincus and Rock et al (1956), called Enovid (10 mg tab) a combination of 10 mg norethynodrel and 150 microgram mestranol.

Since 1960, there has been definite trend towards prescribing lower doses of both the estrogen and progestin in pills. The field of oral contraception developed further as lower doses of Enovid was found to be effective; the 5 mg tablet has been approved for use in 1961.

In 1952 a second oral contraceptive orthonovum a combination of norethandrone and mestranol was approved.

Since 1960 approximately 37 different preparations have appeared. But none of them was free of side effects which were dose and age related, were nausea, vomiting, depression, breakthrough bleeding, amenorrhoea, weight gain,
hypertension, thromboembolism, thrombophlebitis, endometrial hyperplasia, coronary artery disease, due to alteration of lipid metabolism and increased incidence of acceleration of growth of pre-existing malignant lesion in breast cervix, liver endometrium.

The logical approach therefore was to develop need based agent that would not disturb pituitary or ovarian functions but preventing pregnancy by interfering with preimplantation events. The knowledge that a critical balance between estrogen and progesterone is essential for development of fertilised ovum and preparation of uterus for implantation was utilised to develop the envisaged contraceptive.

Central drug research institute Lucknow and some centres in other countries including pharmaceutical industries designed and synthesized nonsteroidal estrogen antagonist with weak estrogenic activity aimed to prevent pregnancy by disturbing the delicate balance between estrogen and progesterone at uterine level but without interfering with their synthesis or blood levels.

Centchroman is outcome of these efforts which represent a major international breakthrough in contraceptive development.

Centchroman is a novel nonsteroidal moiety unrelated to any clinically used contraceptive and hence possesses no danger of cross sensitivity. Centchroman exhibit unique combination of weak estrogenic and potent
antiestrogenic properties which do not allow fertilised ovum to be implanted on endometrium thus avoiding pregnancy (Kamboj et al, 1971). It does not have side effects like nausea, vomiting, weight gain, breakthrough bleeding. (Population report No. 8, 1990) has no effect of platelet functions and no adverse effects on lipid profile (Nityanand et al, 1988) and no risk of cancer (Margveritte White James, Mc Gregor, Drug therapy, 1991).

More than two dozen oral steroid contraceptive preparations are currently marketed in world market. The majority of modification of first generation combined estrogen/progesterone formulation. The second generation or sequential pills was used clinically for approximately a decade it was removed from market in 1976 due to its lower efficacy and possible association with endometrial carcinoma (FDA Drug Bull, 1976). The third generation includes both the low dose combined estrogen progesterone pills (containing less than 50 microgram estrogen and less than 1.5 mg progesterone. They are among the most thoroughly studied drugs with over 25 new articles related to oral steroidal published each month.

While centchroman a new nonsteroidal oral contraceptive, although studies have shown that this is safe, effective drug in animals but has not been used extensively in human. Being nonsteroidal, non-hormonal there is high hope that it may be free from the most dreaded side effects
of hormonal pills i.e. IHD, and CVA mediated by their effect on lipoprotein coagulation and fibrinolysis.