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Family planning in the Malayan States of Malaysia

by

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Family Planning was started in Malaysia in the year 1949. A few interested persons got together and formed Associations in Singapore and Kuala Lumpur.

These citizens were motivated to start such a movement, not because of the population problem but by the suffering they saw.

They saw poor women, with very low incomes, giving birth year after year without rest to numerous children. This affected not only their own health, but the health of the family unit.

There was no money for proper food or clothing. The children succumbed to all sorts of diseases. Many died due to inability to pay for medical treatment.

Infant mortality and maternal mortality was high.

The Associations had very humble beginnings, and advanced very gradually due to lack of finances and lack of public suppot. Religious beliefs, superstitions and the old way of life continued to play a major role in the hampering of Family Planning activity.

The workers in Family Planning withstood all oposition and continued with their good work, and were not disheartened with the very slow progress made.

It is to these pioneers that we owe so much for the progress in Family Planning that has been made, and the most satisfactory situation that is in existence in Malaysia to-day with regard to Family Planning work.

To-day we have approximately 140 Family Planning Clinics distributed throughout the nation with hundreds of voluntary workers and paid staff.

Most of our work is at present confined to the urban areas, but the rural areas are not completely neglected.

With limited resources a decision has had to be made as to where we should operate. The urban areas undoubtedly, due to concentration of population, give the most satisfactory results. There are numerous indications that soon we shall have very active government participation and when this happens, there is every possibility that the extension of activity into the rural areas, where infant and maternal mortality is the highest, will take place.

In any Family Planning programme sustained effort is important. Occasional visits to rural areas will not produce effective results. The use of mobile clinics has a place in Family Planning programmes, but they have their limitations. Clinics of a static type, sited in M. & C.H. Centres have a far better effect and are more welcome to rural folk than a mobile clinic.

There is a certain degree of shyness still in the rural areas, with regard to Family Planning. The average villager would prefer to go to a hospital or Maternal & Child Health Centre for family planning advice, for the simple reason that as far as her neighbours are concerned she may be visiting the clinic or hospital for treatment of some ailment or being seen antenatally and not necessarily for Family Planning advice.

For this reason, we use less mobile clinics and hence more of our clinics are sited either

in hospitals or Maternal & Child Health Centres.

The structure of the organisation which deals with Family Planning work is as follows:-

There are 11 States in Malaya. Each State has a Family Planning Association. These State Associations are affiliated to the Federation of Family Planning Associations which in turn is affiliated to the International Planned Parenthood Federation.

The State Associations have been allowed a great deal of autonomy but receive grants, guidance and advice from the Federation of F.P.As.

Among the staff of the Central Organisation is the Administrative Secretary and the Field Adviser. The former deals with office matters and the latter pays visits to State Organisations to study their problem, give advice and render any help that might be required by them.

The clinics are manned by Midwives, Nurses and Doctors all of whom have received training in Family Planning at the Training Centres in Kuala Lumpur and Singapore.

Women requiring Family Planning advice arrive at these centres, motivated by medical personnel in Maternity hospitals, clinics, home visitors or by their friends who are already practising family planning.

Very often these women know something about the various methods available and actually make a request for a certain type of method they have heard about. Sometimes they come with an open mind willing to accept the method found most suitable for them. But in both instances the new arrivals are given a talk on all the available methods.

Over the years there has occured a change in the acceptance of various Family Planning methods. The earlier methods are still in use, but have tended to decline in popularity.

An analysis of the various methods shows that the decline has not been the same for all methods.

The use of virginal foaming tablets has declined considerably. Diaphraoms have lost their popularity to a lesser degree. Condoms are still widely used.

In recent years a considerable change has occurred in the acceptance of the population of the old methods. The advent of oral contraceptives has been received very enthusiastically by the women of our nation. Our clinics returns show that though the change was very gradual at the beginning the response to this contraceptive suddenly increased to enormous proportions.

The result of this change caused a certain amount of apprehension, because our stocks of the older types of contraceptives remained high and some had to be thrown away because of deterioration on keeping so long.

In the past with the previous type of contraceptives the drop out rate at our clinics was very high. With the advent of the oral contraceptive and the high rate of acceptance by the population the work load on our clinics has increased enormously. Many more persons return for further supplies. The drop out rate has reduced noticeably.

The work load is dependent to a very great entent on the frequency with which patients return to our clinics to replenish their supplies. One way of reducing this load is to offer supplies for longer periods, but here again there is the problem of such persons not being able to pay for large amounts of supplies.

The switch over to oral pills from the conventional types, has been so great that we are finding it difficult to obtain sufficient number of cases to teach trainees the fitting of the conventional types of contraceptives.

One thing is certain—the oral contraceptive is highly acceptable generally and has come to stay as a popular Family Planning method. It is the only truely 100% effective method.

Family Planning is complex and has numerous facets. Any Family Planning programme should include at least eight parts, *viz.*:-

Administration
Education of the masses
Service
Supplies
Follow-up
Evaluation
Research.

It is the lack of appreciation of this complex structure that numerous campaigns have ended in failure.

A strong central administration is an essential part of the structure. Central direction and control brings about the smooth running of the various facets involved.

Very often great enthusiasm shown in a mass publicity or mass education programme, results in a sudden increase in the number of persons seeking Family Planning advice, and unless the other facets, particularly that of service and supplies are tuned to this sudden increase, chaos can result, with many would be users of Family Planning methods being turned away with resultant dissatisfaction.

As far as the central administration is concerned the most important person is the director. He should be a person of proven ability and experience. A man of stature and repute, courageous, dedicated and ingenious.

It cannot be denied, as Family Planning is so closely allied to medicine, that the director should be a medical doctor. But this qualification is not so important as the other qualities mentioned earlier.

Training is a very important facet of a Family Planning programme.

Training should be available not only for medical and medical auxilliary staff, but also for numerous other groups of persons who wield an influence over the masses.

Training facilities should therefore be provided for Senior Government Officers, rural development officers, District Officers, Almoners, Social workers, Information Officers, Teachers, Religious leaders, Trade Union leaders, Women's Organisations, journalists, etc.

Family planning knowledge should as far as possible be integrated into the curriculum of medical students, Public Health Inspectors, Nurses, etc.

It is therefore not only the technical knowledge which is important in Family Planning, but also the know how about the other aspects.

In fact as newer and simpler methods of Family Planning became available, the medical profession will gradually become less and less involved and lay public will begin to play a bigger and bigger role.

We must now work towards a greater participation by the general public. Any drive which does not have the full participation of the public is doomed to failure.

The oral pill is of proven value and has been so, for a considerable period of time. Why is it then that it is not so widely used? The answer is that modern science moves far ahead of the social changes that occur in the community. This gap between modern scientific advancement and the passage of this knowledge to the general public must be filled and it can only be done through our leaders, who in turn must be equipped with the knowledge without any delay—hence the very urgent need for a training programme.

Though we are worried about the population explosion and all the resultant disturbance, I wish to say that that is not the main aim of Family Planning. Our aim is to alleviate human suffering. The suffering of women, undernourished and constantly bearing forth children. The lost of the children who cannot possibly hope to have a fair start in life. Lack of clothes, lack of education and most important of all lack of maternal care which such an important aspect of the psychological development of a child.

How can a mother who is constantly bearing children, feeding and clothing them, find the time or the energy to give the love and care to the child, which is, as we understand it, his birthright.

A Family planning programme which is successfully carried out will without any doubt, reduce this suffering and also bring down a marked reduction in maternal and infant mortality rates, and more important than these—reduce the illegal abortion rates.

We the medical profession have been contributing enormously to the alleviation of human suffering, by the discovery of vaccines, antibiotics, etc., but are unfortunately unwittingly bringing about a new type of suffering—that of large families with resultant poverty. We have altered the balance of nature and it is for us now to do something serious to put it right. We are obliged to do this. It is our duty.