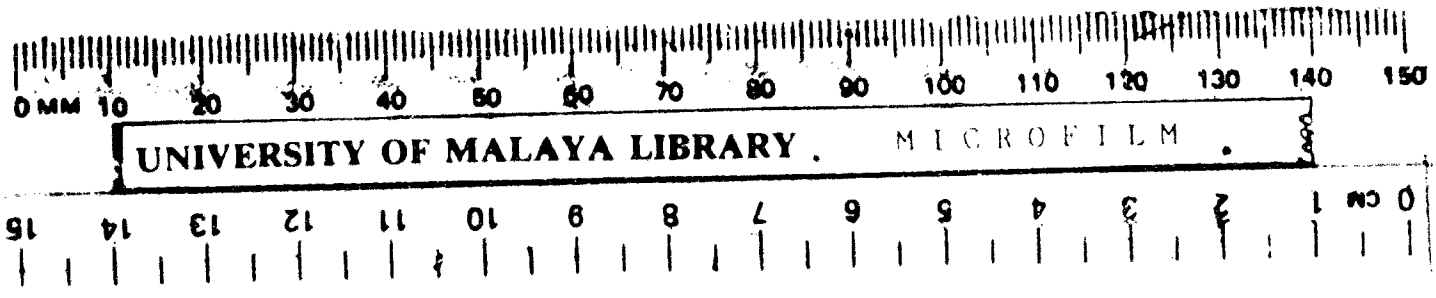

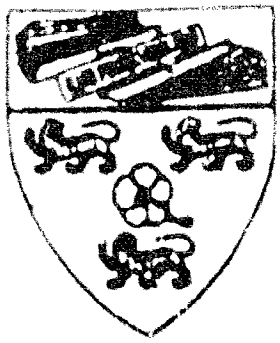

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FAMILY PLANNING MOVEMENT
in
MALAYA and SINGAPORE

by

S. Ganapathy

A Graduation Exercise presented to the University of Malaya in part fulfilment towards the Degree of Bachelor of Arts in Economics

Kuala Lumpur
August, 1965

ACKNOWLEDGMENT

I take this opportunity to record my thanks and gratitude to the following:

Dr. Saw Swee Hock, F.S.S., of the Economics Department, University of Malaya, for his help, advice and guidance without which this work would not be in its present form.

Dr. Visvanathan, D.P.H., D.I.H. of the Health Department, Kuala Lumpur and presently Honorary General Secretary of the Federation of Family Planning Association, Malaya and Inche Omar bin Abdullah, Administrative Secretary of the Association and his Staff for their help and kindness in placing at my disposal the available data on the movement in Malaya.

The Family Planning Associations of the States of Perlis, Penang, Perak, Selangor, Malacca and Pahang for their cooperation in supplying me with some of their annual and quarterly reports.

International Planned Parenthood Federation for supplying me with some reports and papers on the Federation.

S.Ganapathy

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CHAPTER ONE

POPULATION PRESSURE AND FAMILY PLANNING

The growth of population is becoming a serious factor in most of the underdeveloped countries and it should be given prominence when formulating policies of economic development. Population growth and economic development interact with one another and one should not try to treat population growth as an individual factor and separate it from the general problems of economic development. The attitudes of economists toward the demographic aspects of their problem has shifted from time to time. Malthus and Mill and other classical economists treated the population problem as an integral part of economic theory. But as theory refinement led to the importance of short-run problems, the long-run problem of population growth was left in the dim as in the short-run it will not be important. During the 1930s, however, the population growth aspect came back into the limelight as the then topical problem was unemployment but the return of the population factor was through the backdoor. Thus over the years population was gradually banished from the provinces of the economists' studies.

However, nowadays, much attention is paid to the problem of population growth especially in the developing nations and is treated as an important variable for economic development. The governments, public organisations, and in some cases religious organisations in these countries are trying to carry out a campaign to check this rapid growth and the one main cure being adopted is the popularising of the methods of birth control. Therefore, in studying the family planning movement in any country, it is essential that a brief study of the population aspect of the particular country is made. Keeping this in mind, this chapter will deal with the trends in population growth in Malaya and Singapore before going on to the study of response to the teachings of family planning in the two territories.

Table 1.1A: Population of Malaya and Singapore

STATE	1947 Census	1952 Estimate	1957 Census	1962 Estimate	1963 Estimate	1964 Estimate
Malaya	4,908,086	5,506,147	6,278,763	7,376,031	7,607,295	7,810,205
Singapore	938,144	1,127,000	1,445,979	1,732,800	1,775,200	1,820,000
TOTAL	5,846,230	6,633,147	7,724,742	9,108,831	9,382,495	9,630,205

STATE	% INCREASE					
	1947-57	1947-52	1952-57	1957-62	1962-63	1963-64
Malaya	27.9	12.2	14.0	17.5	3.1	2.7
Singapore	54.1	20.1	28.3	19.8	2.4	2.5
TOTAL	32.1	13.5	16.5	17.9	3.0	2.6

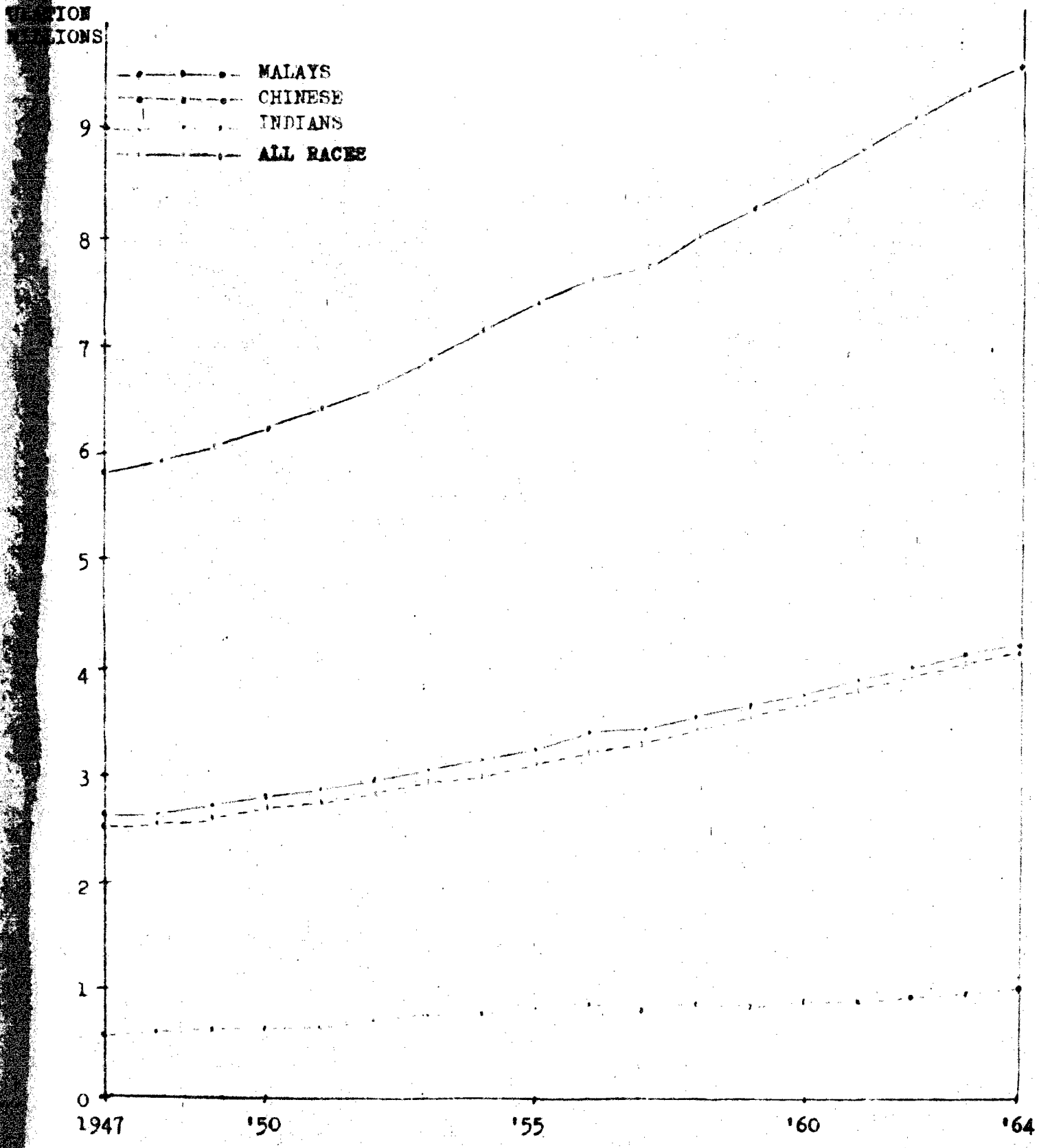
Table 1.1B: Population of Malaya and Singapore by Race

RACE	1947 Census	1952 Estimate	1957 Census	1962 Estimate	1963 Estimate	1964 Estimate
Malays	2,541,637	2,862,599	3,323,765	3,942,152	4,061,300	4,170,695
Chinese	2,614,007	2,955,018	3,423,532	4,021,128	4,138,121	4,244,486
Indians & Pakistanis	599,605	705,657	820,069	962,682	989,639	1,019,137
Others	90,981	110,173	157,326	182,869	193,435	195,887

RACE	% INCREASE 1947-57	1957-64	1962-63	1963-64
Malays	30.8	25.5	3.0	2.7
Chinese	31.0	24.0	2.9	2.6
Indians & Pakistanis	36.8	24.3	2.8	3.0
Others	73.0	24.5	5.8	1.3

CHART 1

POPULATION GROWTH IN MALAYA AND SINGAPORE, 1947-1964



pace of population growth in Malaya and Singapore and other developing nations has brought into sharp focus the need to adopt clear cut policies and dynamic programmes to promote the practice of birth control. It looks as if that the Malthusian fear of a population explosion will apply or have relevance to these countries if the present trend in population growth continues. While death rates have been reduced through the introduction of modern medicine for the prevention and control of diseases and by fighting against famines through the improvement in transport and the introduction of new methods of farming, fertility in these countries remain high with no prospect of any decline in the near futures. These countries including Malaya and Singapore, are in the 'high-potential' group, that is, having high birth rates and declining death rates. The Western countries at their initial stages of growth had high death rates due to poor and undeveloped medical facilities so that their annual growth never exceeded 2 per cent.

As far as Malaysia is concerned we are not yet faced with the problem of population pressure. The country is capable of supporting the present population and any increase in the immediate years. But at the present rate of growth which is maintaining itself around 3 per cent per annum there must be some concern. This figure represents one of the highest in the world today. We must prepare for the years ahead. For how long can Malaysia go on supporting an increasing population? We must not let ourselves to be in a position like India is in now. India which has an annual rate of growth less than Malaya, that is, 2.5 per cent, increases in population by about 10 million in terms of absolute figures per annum.

At the present rate of growth around 3 per cent per annum (Table 1.1A), the Malaysian population should double in the vicinity of 20 to 25 years from now and in the year 2,000 A.D. we should be having a population approximately more than 25 million. The annual rate of population increase has not been below 2.4 per cent since 1911 in Malaya (leaving out the war years) and since 1952 the rate is maintaining around 3 per cent as can be seen in Table 1.1A. Between the two census periods the Malayan population increased by about a third at a rate of 2.79 per cent per annum while in Singapore it rose by more than

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Table 1.2: *Population by States, 1962-1964

STATE	1962	1963	1964	% Increase 1962-63	% Increase 1963-64
Perlis	104,211	106,986	109,102	2.7	2.0
Penang	661,631	680,836	696,934	2.9	2.4
Perak	1,427,968	1,470,794	1,508,014	3.0	2.5
Selangor	1,200,893	1,240,931	1,276,198	3.3	2.8
Malacca	348,327	361,151	372,148	3.7	3.0
Pahang	365,636	376,886	387,368	3.1	2.8
Johore	1,105,727	1,144,761	1,179,175	3.5	3.0
Kedah	807,394	830,295	849,940	2.8	2.4
Negri Sembilan	438,521	453,057	466,295	3.3	2.9
Kelantan	588,519	604,727	618,925	2.8	2.3
Trengganu	327,199	336,871	346,046	3.0	2.7
Singapore	1,732,800	1,775,200	1,820,000	2.4	2.5
TOTAL	9,108,831	9,382,495	9,630,205	3.0	2.6

* Estimated Mid-Year Population

half at a rate of 5.41 per annum. However, in recent years the rate in Singapore is much less and, as can be seen in the table, is maintaining around 2.5 per cent per annum. But that of Malaya is still high though the rate of increase between 1963 and 1964 shows a decline than the previous year and it is hoped that this decline will keep up momentum. In absolute figures, the average annual increase for Malaya and Singapore is around 260,000 persons while that for Malaya is about 220,000 per annum and 40,000 for Singapore.

Table 1.1B shows increase in population in Malaya and Singapore by race. Between the two census years, the Indians have recorded the highest rate of increase, followed by the Chinese and the Malays. If Malaya is taken individually then the rate of growth is highest for the Malays. Between 1957 and 1964, however, the Malays have recorded the highest growth rate (25.5 per cent). In absolute terms, the Malays have an annual increase of about 114,000 persons, the Chinese 111,000 persons and the Indians 28,000 persons in Malaya and Singapore taken together.

Looking at Table 1.2, Malacca, Johore and Negri Sembilan have the highest rates of growth. However, the states of Selangor, Perak, Penang and Singapore, the most developed states in Malaysia have an average of only about 2.5 per cent.

Female population shown in Table 1.3A and Table 1.3B would have been more connected or correlated to our study of family planning if we had taken the female population for the reproductive period, namely, 15-49 years but due to absence of data female population as a whole has been studied. However, this study in female population would not be very far away from a study of increase in female population for the ages 15-49 years. In the 1957 census the female population of Malaya between the ages of 15-44 years was recorded as 1,277,367 out of which 682,467 were Malays, 466,459 Chinese and 125,401 Indians. Out of this the percentage of Married Women for Malaya was 72 per cent; for Malays 78 per cent; Chinese 62 per cent and Indians 81 per cent. The percent married from the ages of 15-19 for Malaya was 35 per cent; Malays 50 per cent; Chinese 10 per cent; Indians 52 per cent. This very clearly shows that the Malays and Indians have a high percentage of young-age marriages compared with the Chinese. The female population rose by more than

Table 1.3A: Female Population of Malaya and Singapore

STATE	1947 Census	1952 Estimate	1957 Census	1962 Estimate	1963 Estimate	1964 Estimate
Malaya	2,312,909	2,640,723	3,041,409	3,534,444	3,710,570	3,812,374
Singapore	423,181	523,500	683,169	829,500	852,500	875,100
TOTAL	2,735,690	3,164,223	3,724,578	4,423,944	4,563,070	4,687,474

STATE	% Increase			
	1947-57	1957-64	1962-63	1963-64
Malaya	31.5	25.3	5.2	2.7
Singapore	61.4	28.1	2.8	2.7
TOTAL	36.1	25.9	3.1	2.7

Table 1.3B: Female Population of Malaya and Singapore by Race

RACE	1947 Census	1952 Estimate	1957 Census	1962 Estimate	1963 Estimate	1964 Estimate
Malays	1,271,457	1,431,045	1,667,654	1,971,239	2,032,642	2,088,362
Chinese	1,188,061	1,395,114	1,656,782	1,965,143	2,024,407	2,077,977
Indians & Pakistanis	233,271	287,925	335,580	413,497	429,065	444,936
Others	48,901	50,139	64,562	74,015	76,956	76,199

RACE	% Increase			
	1947-57	1957-64	1962-63	1963-64
Malays	31.2	25.2	3.1	2.7
Chinese	39.5	25.4	3.0	2.6
Indians & Pakistanis	43.9	32.6	3.8	3.7
Others	50.5	18.0	4.0	-1.0

Table 1.4: Crude Birth Rate, Crude Death Rate, Rate of Natural Increase, for Malaya and Singapore by Race, 1957-1961

STATE	1957			1958			1959			1960			1961		
	Crude Birth Rate	Crude Death Rate	Natural Increase	Crude Birth Rate	Crude Death Rate	Natural Increase	Crude Birth Rate	Crude Death Rate	Natural Increase	Crude Birth Rate	Crude Death Rate	Natural Increase	Crude Birth Rate	Crude Death Rate	Natural Increase
MALAYA:	46.2	12.4	33.7	43.2	11.0	32.2	42.2	9.7	32.4	40.9	8.5	31.4	41.9	9.2	32.7
Malays	46.1	14.0	32.2	46.0	13.0	32.6	44.5	11.6	33.0	43.3	11.2	32.1	45.0	11.1	33.9
Chinese	42.3	8.8	33.5	38.4	8.3	31.0	38.5	7.8	30.7	37.5	7.3	30.0	37.6	7.2	30.4
Indians & Pakistanis	48.7	13.1	35.6	46.5	9.8	36.8	46.8	9.8	36.6	43.4	8.7	34.7	43.8	8.4	35.2
SINGAPORE:	42.7	7.4	35.2	41.3	7.8	34.3	39.5	8.4	33.1	37.8	8.2	31.8	35.5	5.9	29.8
Malays	47.3	10.0	37.3	48.3	9.3	38.8	48.1	8.2	39.9	46.5	7.7	38.8	46.5	7.8	38.8
Chinese	42.4	7.1	35.4	40.5	6.7	33.8	38.5	6.2	32.2	36.5	6.1	30.5	33.8	5.8	28.1
Indians & Pakistanis	48.8	8.4	38.1	38.5	6.1	33.4	37.7	5.6	32.1	36.9	5.8	31.3	33.6	5.8	28.8

one-third during 1947-1957 in Malaya and Singapore. Now the annual increase maintains itself around 2.7 per cent per annum. The Indians recorded the highest increases in female population from 1947-1964.

While fifty years ago, the major cause of the rapid population growth in Malaya and Singapore was immigration, in recent years immigration has ceased to be an important factor except for internal movement of people among the different states in Malaysia. At present the growth in population in Malaya and Singapore is almost entirely due to natural increase, that is, excess of births over deaths. It is not possible for the government to liberalise immigration laws when population is increasing. At the same time there is no possibility of any kind of large scale emigration anywhere as in the past.

It can be seen from Table 1.4 that the birth rate per thousand estimated mid-year population except for 1957, shows a decline throughout the period 1957-1961. However, at the same time, it should be pointed out that the death rate has also been decreasing and at a faster rate than the birth rate. The rate of natural increase, therefore, is maintaining itself around 32 per thousand mid-year population. In Malaya, the Malays have highest birth and death rates, as can be seen in Table 1.4, and a higher rate of growth than the Chinese. The Indians have recorded the highest natural increase in any year for the period 1957-1961. In Singapore again, the Malays have the highest birth and death rates and also the highest rate of natural increase.

It should, however, be remembered that birth rates have not gone up. In fact, they have changed very little, as can be noticed in Table 1.4, at least in the past 10 years and, if anything, have tended to decline slightly. This is because of the relatively steady fertility rates operating in a growing population base, though the number of babies born in Malaya has been increasing slightly in recent years. In 1958 there were 281,000 babies born compared with 299,000 in 1961. in Malaya. The explanation of the increase in population therefore is due to the decreasing mortality rate especially decreasing infant mortality rate. More children now survive the hazards of infancy and the first years

Table 1.5A: Births in Malaya and Singapore

STATE	1947 Census	1952 Estimate	1957 Census	1958 Estimate	1959 Estimate	1960 Estimate	% Increase 1947-57	% Increase 1957-60
Malaya	210,815	244,624	289,905	281,594	282,435	282,755	37.5	-2.5
Singapore	43,045	51,196	62,685	62,495	62,464	61,775	45.6	-1.5
TOTAL	253,860	295,820	352,590	344,089	344,899	344,530	38.9	-2.3

Births Per 1,000 Female Population

Malaya	91.2	92.6	95.3
Singapore	101.7	97.8	91.8

Table 1.5B: Births in Malaya and Singapore by Race

RACE	1947 Census	1952 Estimate	1957 Census	1958 Estimate	1959 Estimate	1960 Estimate	% Increase 1947-57	% Increase 1957-60
Malays	105,947	132,066	159,654	159,211	159,475	160,406	50.7	0.005
Chinese	116,491	128,062	147,285	141,379	141,253	140,611	26.4	-4.5
Indians	29,131	31,574	40,145	38,699	39,307	38,641	37.8	-3.7

Births Per 1,000 Female Population

Malays	83.3	92.3	95.7
Chinese	98.1	91.8	88.9
Indians	124.9	109.7	119.6

Table 1.6A: Deaths in Malaya and Singapore

STATE	1947	1952	1957	1958	1959	1960	% Decrease 1947-57	% Decrease 1957-60
Malaya	95,145	75,013	78,116	71,602	65,262	65,636	17.9	16.0
Singapore	12,511	12,060	10,647	10,576	10,175	10,210	14.9	4.1
Total	107,656	87,073	88,763	82,178	75,437	75,846	17.5	14.6

Table 1.6B: Deaths in Malaya and Singapore by Race

RACE	1947	1952	1957	1958	1959	1960	% Decrease 1947-57	% Decrease 1957-60
Malays	61,058	43,879	48,629	45,540	38,904	40,571	20.4	16.6
Chinese	36,336	33,385	30,523	27,799	26,641	26,941	16.0	11.7
Indians	9,260	8,738	8,660	8,005	7,900	7,526	6.5	13.1

of life and move into age groups where the risks of death are normally low. Further decrease in death rates is expected with emphasis on rural development.

In concluding this chapter it is perhaps relevant to observe how rapid population growth hinders economic development:

(i) When population grows faster than the growth in National Income.

(ii) When population growth adds to the labour force faster than the effort to create jobs.

(iii) When population growth adds to under-employment especially in the rural sector.

(iv) When high birth rates create a large number of dependent children per adult.

CHAPTER TWO

FAMILY PLANNING

I. What is Family Planning ?

Family Planning helps to restrict through modern scientific methods and personal guidance from family planning workers the number of babies born per woman from the point of view of the dangers of population pressure, health of mother and child and the welfare of the family unit as a whole. Though the question of checking the population growth is in the forefront of any Family Planning Movement, it should be noted that the other aims of the movement pointed out above are no less important.

Family Planning instruction is an integral part of health education for mothers and any nation pledged to better the health of the people should encourage and support such a movement. It should be remembered that no health service is complete if while laying stress on the control and prevention of disease and death, no parallel emphasis is laid on the control of birth. Unrestrained production of children in the face of an effective programme against disease and death results in population growth on a scale which embarrasses not only the government of any country but also individual families. Therefore any government should adopt a balanced health programme in which is advocated the control and prevention of disease and death and also an enlightened birth control programme.

The health and happiness of families all over the world depend greatly on the number of children a family has. It is of paramount importance for any couple to decide for themselves the number of children they want to have after taking into consideration of the health of the mother and the financial position of the family. It shall be advised that modern families should have children by intention and not by accident. Every child that is born should be a wanted child.

Family Planning also helps, by use of birth control methods, mothers to space out the bearing of children. Spacing out of child-bearing is important for the mother and a woman subject to continuous pregnancy for, say, about six or seven children is asking for chronic ill-health and for premature old age. Every woman or most women run through the 'age of motherhood' and pregnancy can be described as a normal physiological process. This process, of course, makes an enormous demand on the health of even the strongest woman. While carrying a child in her womb, the mother tolerates many discomforts and her patience and strength is tested severely. On top of this if the mother comes from a poor family and if her nutrition is poor, she is liable to suffer from various ailments such as anaemia, malnutrition, chronic debility, etc. and this nutritional insufficiency may at times affect the baby too.

Therefore, Family Planning promotes the welfare of the family by helping parents to space out the bearing of children, and advising them not to have more children /they than can afford to rear, love and educate. Responsible parenthood is the basic social service.

To make Family Planning successful, education on family planning is important because family planning is a discipline. The movement should, through education, try to motivate married people to adopt the modern methods of restricting surplus population and drive them towards a richer, healthier and happier living.

It should not be forgotten that Family Planning Movement also helps infertile couples to have children.

The pioneers of the modern Family Planning Movement were Margaret Sanger in America and Marie Stopes in Britain. Margaret Sanger was a young health nurse in New York and she was very much concerned with the dangers of abortions to which many women resorted to in order to limit their families. At the same time she found that excessive child-bearing had bad effects on the health of poor mothers. Her efforts led to the formation of the American Birth Control League in 1921 though the League was only approved in the 1930's due to official, religious, legal and medical opposition. In 1941 the League was renamed the Planned Parenthood Federation of

America. The aim of the Federation was stated as follows:-

> "To provide leadership for the universal acceptance of family planning as an essential element of responsible parenthood, stable family life and social harmony, through education for family planning, the provision of the necessary services and the promotion of research in the field of human reproduction."

In Britain Dr. Marie Stopes founded the Society for Constructive Birth Control in 1918 and in 1930 the National Birth Control Association took over.

In 1952, the International Planned Parenthood Federation was founded to co-ordinate help and advise national bodies in their humanitarian functions. In 1963 the Federation had thirty-five member countries, with its headquarters in London. Besides the member countries information and assistance has been given to more than sixty non-member countries. The Federation believes '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'.

Below are provided the main aims of the Family Planning Movement in Malaysia:

1. To educate the people in healthy family planning and to provide facilities for scientific contraception so that married people may space or limit their families and thus promote their happiness in married life and mitigate the evils of ill-health and overcrowding.

2. Every child a wanted child.

3. To encourage production of healthy children who are an asset to the nation, provided that their parents have the health and means to give them a reasonable chance in life.

4. To advocate and promote the establishment of family planning centres at which in addition to advise on scientific contraception, women can get advice on, and when necessary treatment for, any or all of the following:

(i) Involuntary Sterility,

(ii) Minor gynaecological ailments,

(iii) Difficulties connected with the marriage relationship

II. A brief history of the Family Planning Movement in Malaya and Singapore

States of Malaya:

Organised Family Planning Movement in most states in Malaya is only three or four years old, except for Selangor, Perak and Johore. The year 1962 saw the establishment of a Family Planning Association in every state in Malaya. Selangor was the first state in Malaya to form a Family Planning Association, followed by Perak, Johore. The table below shows the year of the establishment of Family Planning Associations in the states of Malaya:-

Table 2.1: Foundation Year of Family Planning Associations in All States.

State	Foundation Year
Perlis	1962
Penang	1961
Perak	1956
Selangor	1954
Malacca	1959
Pahang	1962
Johore	
Kedah	1962
Negri Sembilan	1962
Kelantan	1962
Trengganu	1962

Before the setting up of Family Planning Associations in these states, Family Planning Activity was confined to services rendered by individual doctors and nurses in conjunction with their routine duties in hospitals, maternal and child-health centres. The Singapore Family Planning Association, the first and only Family Planning Association in Malaya and Singapore then, helped in the encouragement, training, educational and contraceptive supplies through some of their officials.

Even after the setting up of the Family Planning Associations in the different states, the bulk of the work involved in the movement was done by voluntary workers which included doctors, nurses, social workers, lay workers, etc. As for Selangor, Perak and Johore the very and early beginnings of the Family Planning Movement were contributed entirely by voluntary workers who beside their normal duties sacrificed leisure to put forward to the people of this region the need for Family Planning. The Family Planning Movement still today is a voluntary, private body consisting of over 90 per cent of voluntary workers.

Singapore: Family Planning Movement was founded in Singapore in 1949 and as in the case of the States of Malaya, it started as a voluntary body. The immediate after-effect of the Japanese Occupation of Singapore was the problem of thousands of children roaming the streets without food and homeless and the Singapore government faced the task of feeding and housing these children. Feeding centres were established all over the island to cater for the problem.

It was realised then that if there was insufficient food for these little ones, not to mention education and the other necessities of life, their parents were in no position to add more children to the families year after year. With this in mind many meetings and discussions were convened which resulted in the granting of permission for family planning advice to be made available once a week at the six Municipal Maternity and Infant Centres. The founding of the Family Planning Association in 1949, of course extended the activities of the Movement to other parts of Singapore.

As was the case in Selangor, Perak, Johore, etc. the first stages of the Movement gained momentum through the voluntary services of certain doctors, nurses and welfare workers. From the time of its foundation, however, the Association was able to obtain regular aid from the government in the form of annual grants and money by devoted supporters have enabled the work to go steadily forward. The Singapore Government makes an annual monetary grant of $100,000 to the Singapore Family Planning Association.

III. Brief Summary of Family Planning in other Countries:

India began the Family Planning Movement in 1950 and though it started off with very poor response, as there were people who criticised the sponsors of the movement for even mentioning the words 'family planning' in public, now family planning as a means of population control is recognised as the burning issue of the day and is regarded on a basis that is rational, scientific and ethical. Even in the rural areas the message of family planning has penetrated. A Central Family Planning Board was set up in 1956 and Family Planning officers were appointed in different states. The Government of India gives active support to the Movement and contraceptives are given free in some states. Extensive training, research and programmes for medical personnel and voluntary agencies is being conducted.

In China the Government sponsored attempts to promote Birth Control in 1957 but in 1958 the policy was, however, reversed. But advice and materials are still available in the main hospitals and it is left to the discretion of the doctors to recommend it to mothers.

In Indonesia Family Planning is not yet widely accepted. The Birth Control Consultation Bureau was established in 1954. Presently owing to lack of foreign currency there must be great difficulty in the importing of materials to make the Bureau a success.

The government of Japan legalised the sale of contraceptives after the war but at the same time it also legalised abortions and sterilisations. But lately the government has again curbed on the latter two.

CHAPTER THREE

Methods of Birth Control and Promotional Methods

I. Methods of Birth Control

The ideal method of contraception should have the following qualities: simple to use, effective, harmless to both husband and wife and to future children, aesthetically acceptable, within the means of the poorest and free from religious or moral objections. Though no single method of contraception may have all these qualities, different methods may suit the needs of different individuals. But the most important role for the success of any contraceptive method is played by the person using it. As such that person should have a clear understanding of such a method and be regular and faithful in using the method. Personal consultation with a doctor skilled in the subject or alternatively instruction by a nurse trained in these techniques is essential.

In many of the underdeveloped countries the prospective users of contraceptives are, typically, poor and illiterate with little motivation to limit the size of their families. The number of available medical personnel is inadequate and medical facilities, such as hospitals and clinics, are few and far between. Under these circumstances the choice of contraceptive methods must be, and generally is, limited to those which are easy to use and do not require individual examination, fitting and instruction like the condom and oral pill. Besides ignorance on part of the people and social and religious barriers, the cost of purchasing the contraceptives is a factor for hinderance.

The methods taught and advised on in Malaya and Singapore include the following:

(i) Condoms

(ii) Oral Contraceptives

(iii) Diaphragms

Table 3.1: Response by Patients to Different Methods of Birth Control, Perak, Selangor and Singapore, 1962-1963

METHOD	PERAK		SELANGOR		SINGAPORE		TOTAL		TOTAL
	1962	1963	1962	1963	1962	1963	1962	1963	1962-1963
Condom	463	494	823	1,536	3,267	4,007	4,553	6,037	10,590
Oral Tablets	35	628	300	479	214	968	549	1,655	2,204
Diaphragm & Cream	1,962	631	435	306	1,554	2,279	3,951	2,216	6,167
Foaming Tablets	706	431	356	301	1,536	1,148	2,598	1,880	4,478
Applicator & Paste	108	89	197	117	368	310	635	516	1,151
Coconut	-	-	-	-	250	1,076	250	1,076	1,326

(iv) Foaming Tablets

(v) Creams and Jellies

(vi) Genexol

(vii) Intra-uterine device.

The condom is a thin rubber sheath worn by the male before intercourse and this method has been given little attention comparatively up to this time, not only in Malaysia but also in other parts of the world because of the historic association of the condom with prostitution, illicit sexual relations, and venereal disease. In addition, it is widely believed that compared with other methods of contraception, the condom is expensive and unreliable and less acceptable to couples in need of protection. The use of the condom has risen during the last two years in Malaya and Singapore and at the beginnings of family planning the condom was totally absent as in the case of Selangor. However, in the rural areas and estates the condom is preferred in quite large numbers. In Singapore, however, the use of condom is widespread. Table 3.1 shows the large figure for condoms of 10,990 for the two years and the major part of this figure is contributed by Singapore. In Perak and Selangor, there has been a considerable increase in the use of condoms in 1963 over the 1962 figures.

The oral contraceptives, as can be seen in Table 3.1 are not very much in demand compared to the response to the other methods. In all three states, mentioned in the table, there has been an increase in the use of oral pills. The lesser response to this method may be due to the cost and, secondly the oral pill has to be taken by a female for a period of at least 20 days per month regularly if it is to be effective. Though the use of the method is simple, the regularity in taking the pills is usually hard to follow by many females besides the cost of pills for 20 days every month. However, oral contraception is the main method preferred by patients in estates compared with other methods. Another drawback of this method is that many women conforming to this method, experience unpleasant symptoms such as nausea, vomiting, headache, dizziness, cramps and irregular bleeding. These unwelcome symptoms may cause the patient to give up the pill.

The Diaphragm consists of a rubber cap with a spring incorporated into the rim. This is worn by the female. At the beginning this method was very common among the patients but with the introduction of other methods there has been a decline in its demand. This is noticeable in Table 3.1 in all three states for 1962 and 1963. The Chinese patients in Perak tend to choose this method.

The same case applies to Foaming tablets which were in demand at the beginning but recently are declining in demand. The Applicator and Paste is not a very common method in Malaya and Singapore while Genexol is used only in Singapore clinics.

The Intra-Uterine Device is the most recent method introduced in Malaya and Singapore. The history of intra-uterine contraceptive rings reaches back over four decades. The device is a simple procedure involving insertion of a coil of nylon ring into the uterus and leaving it as long as desired. This method was condemned by the great majority of doctors, on theoretical considerations without giving it a scientific try-out, or follow up with investigations. In recent years, however, this method has been revived for a second look, with proper case studies for evaluation as to effectiveness, side-effects, safety and acceptability.

In Singapore the Intra-Uterine Device was started in October, 1963 and during this year about 40 cases were administered on this method. However, the number using the device is very small and the method is still at the experimenting stage here. Presently, only four states have started with this method, namely, Singapore, Selangor, Perak and Penang. With the introduction of this method and its subsequent prevalence, the number of patients is expected to rise considerably because of the low cost and reliability of the method.

II. Promotional Methods:

Promotional activities form an integral part of any Family Planning movement. It precedes the actual administering of the methods of birth control. It is vital to educate the people and orientate them on the methods of birth control and the aims and benefits of

family planning before taking strides in the programme. The people should realise themselves the need of such a programme.

In Malaysia, where we have a multi-racial society, the problem of motivating people toward family planning is great. But the problem is surmountable. The numerous difficulties encountered in motivation includes customs, traditions, religious beliefs, etc. Education for family planning like any other kind of education would be the slow achievement of successive generations, growing as the pressure of industrial progress is exerted on the population. The day every individual becomes aware of the importance of family planning in his life and acts according to this knowledge, all our problems relating to the economy, health and welfare of the family and consequently the community will get closer to solution.

The methods of promotion used in Malaya and Singapore include film shows on family planning, group meetings including seminars, exhibitions, posters and placards and through the press.

Film shows can be used in increasing factual knowledge, teaching skills, in some cases changing opinions and motivating behaviour. This is an efficient method of promotion. Film shows were also the main methods used in estates. In between the reels or before or after the film somebody from the Family Planning Association gave a talk on the discipline. But speakers of three languages for publicity was needed.

Family Planning seminars and group meetings for public bodies have been organised. Seminars were held to obtain closer liaison in the work of the movement in estates, for the estate hospital assistants. These seminars were well attended and lively discussions took place.

CHAPTER FOUR

Family Planning Attendance

I. Total Attendance (New & Old Patients):

A brief history of the setting up of Family Planning Associations in the different states in Malaysia has already been dealt with in Chapter One. This chapter will be mainly concerned with the actual attendance recorded in each state and the correlated study on the age structure of patients in terms of age on first visit and age at marriage. But it should be pointed out at the outset that material available to make such a study a complete one was limited and in many cases absent. Because of this shortcoming, this chapter has many omissions and exclusions. Furthermore, the different state Associations do not have a uniform method of recording various data so that a nationwide study is made impossible.

Though Family Planning activity started very recently in most states in Malaysia except for Selangor, Perak, Singapore and Johore, the progress in family planning teaching and advice is very encouraging and the progress made in this country can be said to be as rapid as that made in any other country in the world. Being a multi-racial country, with the presence of many cultures and religious and social beliefs and still being largely an agricultural country with a large rural population, the progress made by the family planning movement should be appreciated. Of course, at the beginning progress was extremely slow due to the lack of finance, shyness of the population toward this subject and due to social and religious barriers.

The number of clinics in Malaya and Singapore in 1961 was only 55 out of which 30 were in Singapore. In the following year, with the formation of the Federation of Malaya Family Planning Association, the number of clinics

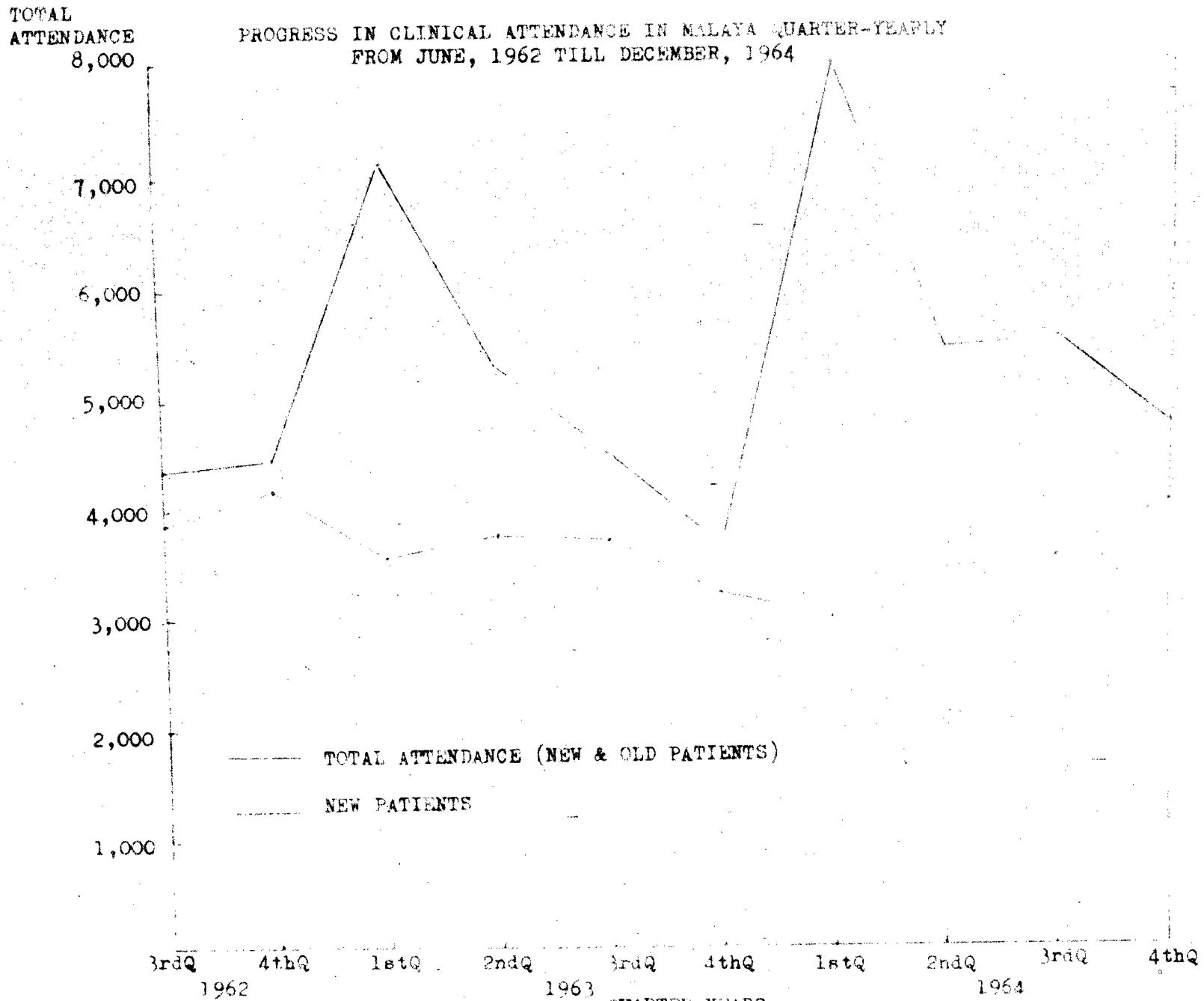
Table 4.1: Total Attendance (New & Old Patients) By State, 1962-1964

STATE	1962	1963	1964	% Increase 1962-1963	% Increase 1963-1964
Perlis	97	249	165	70.1	- 33.7
Penang	983	2,483	2,288	152.6	- 7.9
Perak	2,428	4,426	6,780	82.3	53.2
Selangor	3,426	4,618	5,920	34.8	28.2
Malacca	915	1,649	2,015	80.2	22.2
Pahang	663	868	769	30.9	- 11.4
Johore	1,052	3,504	2,934	233.1	- 16.3
Kedah	698	1,026	1,172	48.3	14.2
Negri Sembilan	437	1,424	1,473	225.9	3.4
Kelantan	232	1,330	675	494.8	- 15.1
Trengganu	359	613	490	70.8	- 20.1
Singapore	20,272	23,435	25,582	15.6	9.2
TOTAL	31,374	42,171	50,263	34.4	14.2

Attendance Per Thousand Estimated Mid-Year Female Population

	1962	1963	1964
Perlis	1.9	4.7	3.1
Penang	3.0	7.4	6.7
Perak	3.5	6.2	9.2
Selangor	5.9	7.7	9.6
Malacca	5.3	9.1	10.8
Pahang	3.8	4.8	4.1
Johore	1.9	6.4	5.2
Kedah	1.8	2.5	2.8
Negri Sembilan	2.1	6.5	6.5
Kelantan	0.8	4.5	1.1
Trengganu		3.6	2.8
Singapore	24.4	27.5	29.2
TOTAL	7.1	9.2	10.7

CHART 4



in the states of Malaya rose to 107 (Table 4.1) giving a total of 135 clinics for Malaya and Singapore in that year. Two years later, in 1964, the number rose to 163 clinics in Malaya and Singapore giving an increase of about 3 times over the number in 1961. Singapore, Selangor, Perak and Penang share among themselves more than half the number of clinics. Every state is trying to expand its activities rapidly but they have to limit their enthusiasm because of the cost factor.

From Table 4.1, which shows the total attendance in the different states in Malaysia, it can be noted that the number attending clinics in Malaya and Singapore has risen over 60 per cent in 1964 over the 1962 figure. It should be noted that many of the states started Family Planning Associations during the course of 1962 and as such the figures given for the year 1962 do not represent annual figures. At the same time, the figures for Penang, Malacca, Johore, Kedah and Negri Sembilan for 1962 represent the figures for the second half only. This is because there are no data available for the first half of 1962. The annual increase for 1962-1963 shows a higher increase than the increase for 1963-1964. This is because, as pointed out in Chapter Two, many of the states in Malaya started family planning activity during the course of 1962. Perak shows a very remarkable increase in attendance - over 200 per cent increase in 1964 over the 1962 figure. The large figures in 1963 and 1964 for Perak are due to the extension of the activity to estates and rural areas. The other state having a steady increase is Selangor recording more than 50 per cent over the 1962 attendance. Again in Selangor the large figures for 1963 and 1964 is due to the inclusion of estates and rural areas inside the family planning boundary.

Singapore contributed more than 50 per cent of the attendance (Table 4.1) during 1962, 1963 and 1964. This will indicate the efficiency of the Singapore Family Planning Movement. However, it should be remembered Singapore started its activities in 1949. All the East Coast states, namely, Kelantan, Trengganu, Pahang, Johore, Perlis and Penang show a decline in 1964 compared to 1963. This may be due to many reasons. Financial problems may have forced the associations to curtail further expansion and cut down the expenditure by closing down some clinics and reduce promotional propaganda. It could be that the

Table 4.2: New Patients (1st Visit) by States, 1962-1964

STATE	1962	1963	1964	% Increase 1962-1963	% Increase 1963-1964
Perlis	97	165	165	70.1	0
Penang	983	1,441	1,618	46.6	12.3
Perak	1,883	2,304	2,347	22.4	1.9
Selangor	2,457	3,009	3,968	22.5	31.9
Malacca	743	1,432	1,540	92.7	7.5
Pahang	662	861	697	30.1	- 19.0
Johore	745	1,646	1,383	120.9	- 16.0
Kedah	692	789	688	14.0	- 12.8
Negri Sembilan	437	1,289	908	195.0	- 29.6
Kelantan	440	1,228	282	179.1	- 77.0
Trengganu	357	481	472	34.7	- 1.9
Singapore	7,189	8,429	9,339	17.2	10.8
TOTAL	16,685	23,074	23,407	38.3	1.4

N.B. The figures for 1962 do not represent annual figures for many states due to their starting the movement later in the year or that no data available on the attendance during the 1st half of the year.

CHART 3

OLD AND NEW PATIENT ATTENDANCE FOR MALAYA AND SINGAPORE, 1962-1964

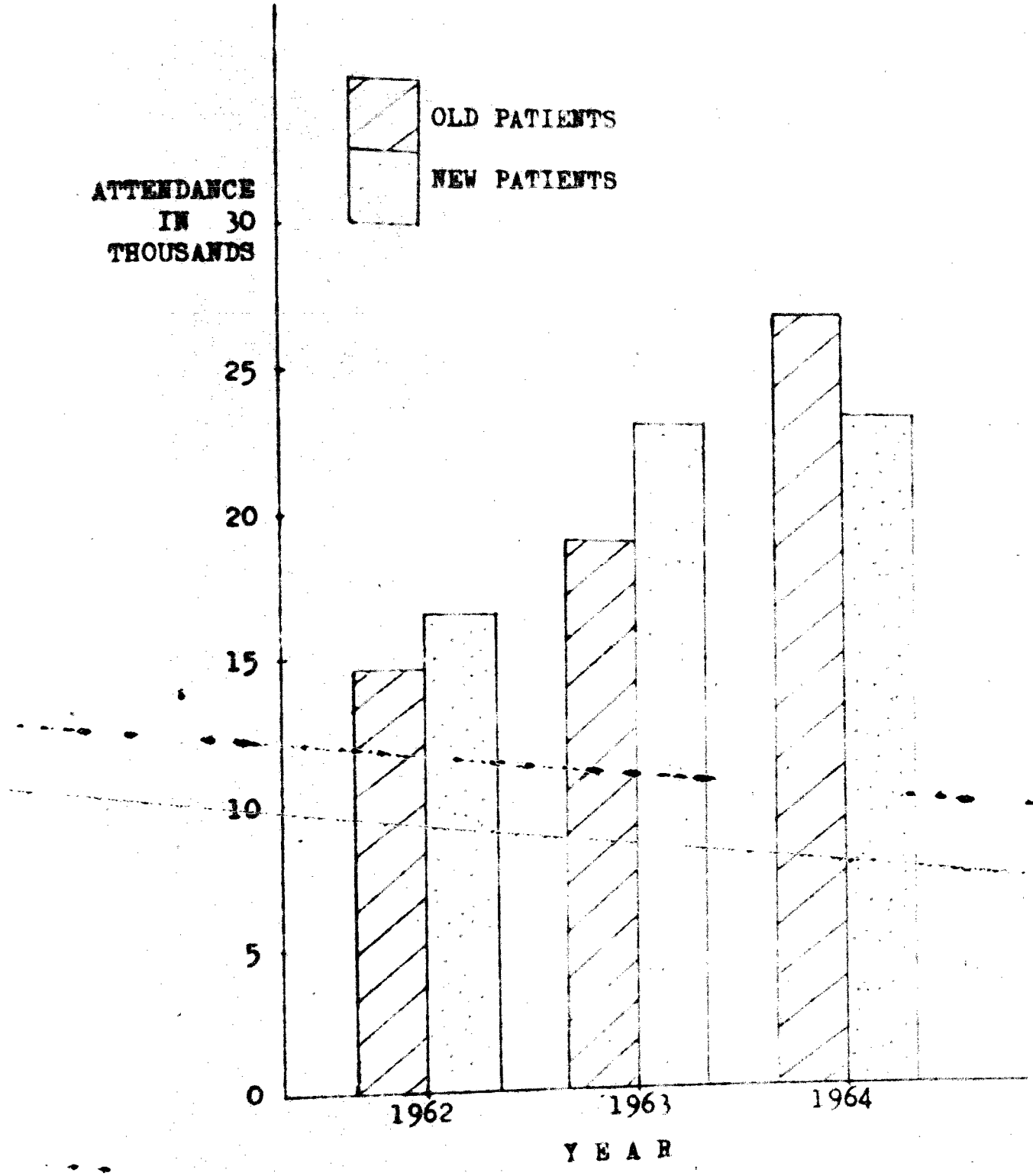


Table 4.3: New Patients (1st Visit) By State, Race, 1952-1954

STATE	1952				1953				1954			
	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others
Perlis	47	46	4	-	77	83	5	-	80	87	8	-
Penang	-	-	-	-	1,155	166	111	9	1,186	273	141	8
Perak	-	-	-	-	1,333	310	537	124	1,526	359	442	25
Selangor	1,803	441	316	22	1,838	588	477	27	2,553	885	471	48
Malacca	488	212	26	5	884	459	65	15	1,033	422	84	11
Pahang	536	113	12	1	853	144	55	8	507	122	67	1
Johore	550	147	37	11	1,064	352	136	154	735	275	182	271
Kedah	479	145	14	14	-	-	-	-	388	214	104	1
Negri Sembilan	338	65	32	1	858	273	152	6	575	234	85	14
Kelantan	281	143	13	3	548	841	31	8	143	136	3	2
Trengganu	105	248	3	1	182	312	8	1	138	314	138	8
Singapore	5,807	551	328	505	8,583	887	376	883	7,033	1,220	487	588
TOTAL	10,325	2,111	820	503	15,126	4,192	1,951	1,016	15,888	4,584	2,110	968

Table 4.3: (Contd.)

% INCREASE

STATE	1962-1963				1963-1964			
	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others
Perlis	62.8	80.4	25.0	-	- 22.1	16.9	60.0	-
Penang	-	-	-	-	3.5	04.5	27.0	0
Perak	-	-	-	-	14.5	14.2	- 17.7	- 70.8
Selangor	15.2	28.3	52.4	22.7	31.7	38.1	1.3	81.5
Malacca	70.5	116.0	122.1	200.0	15.5	- 5.7	- 1.5	- 28.7
Pahang	21.8	27.4	358.3	800.0	- 22.4	- 15.3	21.8	- 80.0
Johore	82.5	130.5	26.6	1,300.0	- 26.8	- 21.0	- 25.0	76.0
Kedah	-	-	-	-	-	-	-	-
Negri Sembilan	153.1	320.0	375.0	500.0	- 33.0	- 14.3	- 44.1	133.3
Kelantan	35.0	340.3	130.5	166.7	- 73.9	- 78.1	- 90.3	- 75.0
Trengganu	54.3	25.8	50.0	0	- 14.2	0.0	2,166.7	500.0
Singapore	12.0	61.9	15.3	31.3	8.2	37.5	29.7	- 9.7
TOTAL	46.5	98.6	137.9	89.5	4.9	5.9	8.1	- 2.8

N.B. The large percentage increase figures for 1962-1963 are due to the same reasons outlined below Table 4.2.

workers in the association were not as enthusiastic as those in the other states. At the same time, the activities in these states have been confined to the main towns, usually 2 or 3 and they are yet to explore the outskirts.

Looking again at Table 4.1, in 1962 about 7 females out of every thousand estimated mid-year population attended family planning clinics. This rate has increased since then and in 1964 the rate was 10.7. However, the rate would have been a more sensible one if it is calculated in terms of females in the reproductive age group, 15-49, but such figures are not available.

II. New Patients

In Table 4.1 we analyse the attendance of old and new patients because many of the old patients continue attending clinics in the following years. Table 4.2 studies the attendance of only new patients - those who have visited the clinics for the first time. Comparing Tables 4.1 and 4.2, it is seen that old patients form the major part of total attendance. Perak, Selangor, Singapore, Penang and Malacca show increases during the period 1962-1964 in the attendance of new patients. However, the other states show a decline for 1964. Taking Malaya and Singapore as a whole the figure for 1964 shows an increase of about a third over 1962. In the East Coast States and in Perlis, the number of old patients is very small. This indicates that in these states the length of period the individual patient continues to receive family planning advice is very short, whereas in Singapore there are patients visiting clinics for a period of 3 to 4 years.

The Chinese make up more than half the total of new patients in any one year for the period 1962-1964 (Table 4.3). Out of this Chinese total, Singapore contributes more than half over the same period, as can be seen in the table. The response to family planning teaching is most encouraging from the Chinese community. The Malays form less than one-third the total Chinese new patients and again Singapore is the largest contributor

Table 4.4: Revisits by States, 1962-1964

STATE	1962	1963	1964	Average Per Patient (New & Old Patients) 1962	1963	1964
Perlis	130	293	615	1.3	1.2	3.7
Penang	-	1,195	2,075	-	0.5	0.9
Perak	3,439	5,548	5,034	1.4	1.3	0.7
Selangor	4,066	9,764	19,130	1.2	2.1	3.2
Malacca	1,057	3,822	6,701	1.2	2.3	3.3
Pahang	398	1,587	2,967	0.6	1.8	3.3
Johore	950	3,312	3,835	0.9	0.9	1.3
Kedah	248	-	882	0.4	-	0.7
Negri Sembilan	216	2,229	4,333	0.5	1.6	2.9
Kelantan	129	928	638	0.6	0.7	0.9
Trengganu	209	917	2,001	0.6	1.5	4.1
Singapore	41,727	51,765	69,889	2.1	2.2	2.7
TOTAL	52,540	81,360	116,761	1.7	1.9	2.3

to the Malay total. However, the number among the Malays has been increasing since 1962. In Malaya, still a large part of the Malay population do not cooperate with the teachings of family planning. This may be due to the failure of the associations in penetrating into the rural areas and this is true in many states like Perlis, Kedah, Johore and the three East Coast states. Secondly, the poor Malay response may be because of social and religious reasons and it is vital that these people should be educated in the aims and results of the family planning movement. The Malays have very high birth and death rates and high rates of natural increase and, therefore, the Malays should orientate themselves to this idea of birth control.

However, in Singapore the increase in new Malay patients has been most marked. From 551 patients in 1962 the number has risen to 1,220 in 1964 giving a rise of more than 100 per cent. Even in the predominantly Malay populated states of Pahang, Kedah, Johore and Kelantan the Chinese figure is larger indicating that the associations are mainly operating around the main towns. Among the Indians the attendance of new patients is satisfactory. With more effort made in extending the services of the movement into the estates, the attendance among the Indians will show a sharp increase. In Singapore, the increase has been steady among Indian patients since 1962, and in Malaya the increase is encouraging with the number rising by more than 3 times in 1964 over the 1962 figure.

III. Revisits:

Revisit figures in Table 4.4 refer to the number of times the patients have revisited clinics in the course of the year in the different states. The average revisits per patient in Malaya and Singapore taken together is 1.7 in 1962, 1.9 in 1963 and 2.3 in 1964. In Singapore the patients revisit clinics on the average 2 or 3 times while in Perak the patients do not revisit the clinics more than once on the average. The figures for Selangor, Malacca and Pahang show increase in the average revisits from 1962 to 1964 and in 1964 the patients visited the clinics 3 times on the average for these three states. In Kedah and Kelantan, however, some of the patients do not revisit clinics at all as a result having an average of less than one.

Table 4.5: Revisits by State and Race, 1962-1964

STATE	1962 Chinese	1962 Malays	1962 Indians	1962 Others	1963 Chinese	1963 Malays	1963 Indians	1963 Others	1964 Chinese	1964 Malays	1964 Indians	1964 Others
Perlis	53	71	6	0	122	166	5	0	101	411	13	-
Penang	-	-	-	-	875	150	70	0	1,695	308	166	5
Perak	-	-	-	-	1,771	574	2,831	352	2,387	760	1,637	28
Selangor	2,018	674	587	37	6,650	1,865	1,184	76	12,864	4,084	1,097	182
Malacca	759	266	28	8	2,475	1,155	140	52	4,434	1,903	260	56
Pahang	320	68	3	-	1,214	301	88	4	1,828	563	150	15
Johore	693	108	31	27	1,585	1,814	431	301	1,787	1,117	336	876
Kedah	102	30	21	6	-	-	-	-	308	351	62	1
Negri Sembilan	183	22	11	-	1,858	419	148	6	3,101	958	210	66
Kelantan	76	47	4	2	462	421	28	17	310	276	21	31
Trengganu	91	117	1	-	348	981	7	-	641	1,229	39	19
TOTAL	5,184	1,301	640	78	17,230	6,826	4,012	808	29,578	12,085	4,833	1,031

Table 4.5 shows the racial breakdown of revisits and we note that revisits are in greater numbers among the Chinese than the other races.

Revisit figures will tend to be more in clinics in towns where there are fixed hours and days of family planning service supplied to the public. Moreover, the townspeople are usually more educated in the discipline of family planning and conform to regular administering of any particular method and regularly seek advice. In the estates and rural areas on the other hand, revisits are very seldom. This may be due to no permanent clinic and adviser in these places. Secondly, the people may be shy to seek advice or that they could not be bothered.

IV. Age of Patients on First Visit to Clinic:

A complete study on this topic for the states of Malaya and Singapore was made impossible by the absence of data. However, data was available for the states of Selangor, Perak and Pahang for the years 1962 and 1963 and this is shown in Table 4.6. But the totals for 1962 and 1963 will not tally with the totals for new patients in Table 4.2 for 1962 and 1963 for Selangor, Perak and Pahang. This is because some of the ages of patients were unrecorded.

During both years; the major part of the patients fall within the age group 20-30 years. The number of patients below the age of 20 remained almost the same in 1962 and 1963. The over 30 - patients in both years also contribute a large sector. The maximum number of patients was recorded at the age of 30 in 1962 and in 1963 at the age of 31. From the distribution of the figures, it may be said that most Malayan mothers visit family planning clinics after bearing a few children - this may be 4 or 5 or in terms of years 5 to 6 years. (See Table 4.8 and 4.9)

The racial breakdown of first-visit-patients in Table 4.7 shows that below the age of 20, more Indian mothers attend the clinics compared with the Malays and Chinese. The highest number of patients recorded in 1962 for the Chinese is at the age of 30, the Malays at 28 years and for Indians at 25 years compared with 31 years for the Chinese, 26 for the Malays and 29-30 for the Indians in 1963.

Table 4.6: Age of Patients on First Visit to Family Planning, Selangor, Perak and Pahang, 1962-1963

Age	1962	1963
15	0	1
16	9	18
17	17	15
18	28	38
19	56	41
20	108	111
21	149	143
22	273	219
23	283	283
24	310	345
25	356	391
26	313	370
27	329	388
28	339	388
29	285	385
30	375	405
31	223	422
32	295	389
33	206	336
34	117	218
35	186	255
36	139	174
37	106	164
38	130	136
39	82	88
40	136	101
41 & over	131	196

Table 4.7: Age of Patients on First Visit to Family Planning Clinic by Race; Selangor, Perak and Penang, 1962-1963

AGE	1962 Chinese	1962 Malays	1962 Indians	1962 Others	1963 Chinese	1963 Malays	1963 Indians	1963 Others
15	0	0	0	0	0	0	1	0
16	1	1	7	0	5	3	10	0
17	5	4	7	1	4	6	4	1
18	5	9	14	0	12	15	11	0
19	24	17	14	1	16	9	16	0
20	43	36	31	0	43	39	28	1
21	66	41	42	0	81	35	25	2
22	144	61	65	3	135	53	28	3
23	164	77	42	0	171	68	40	4
24	195	54	62	0	127	67	48	3
25	205	72	76	5	272	80	46	3
26	198	66	48	1	259	67	41	3
27	222	73	34	0	268	62	53	2
28	211	83	43	2	265	58	99	6
29	180	75	28	2	264	59	62	0
30	248	79	47	1	271	69	62	3
31	176	52	14	1	320	47	53	2
32	198	56	38	2	279	56	49	4
33	162	31	11	2	200	31	36	6
34	92	18	6	1	153	29	28	0
35	140	32	11	2	187	29	38	1
36	105	23	9	2	124	28	21	1
37	82	18	5	1	124	14	25	1
38	98	21	11	0	110	20	6	0
39	65	14	2	1	73	6	9	0
40	105	21	20	0	77	11	13	0
41 + over	104	21	2	4	147	5	7	0

V. Age at Marriage of First Visit Patients:

Here again due to absence of data the focus has been confined to the states of Selangor, Perak and Pahang for the years 1962 and 1963. Table 4.8 depicts this study. More than half of the patients in 1962 and 1963 married before the age of 20 and among the rest, most of them fall between the years 20-23. Late marriages, therefore, is very few. This study of a small portion of Malaysian females, may indicate that most Malaysian mothers marry at young ages. In Western Countries the majority of females will fall above the 21 marriage-age group.

It is regrettable to note that among so few females included in this study, there are many women who have married at very early ages, in this case 10, 11, 12, 13, 14 and 15. From Table 4.9, it is found that the Chinese do not contribute very much to this group but among the Indians and Malays it is high. Among the patients the number of Indian females who married during these ages in 1962 amounts to 351 compared to 348 in 1963. The Malays contributed 225 in 1962 and 246 in 1963. These early marriages are usually prevalent in the rural areas and estates where the parents try to transfer the burden of supporting an extra child due to poor wages. After the age of 25 the number of the Indians or Malays marrying is negligible.

If Malaya and Singapore is the universe of the study then the number marrying under the age 15 will be much larger. It is important for this group of mothers to lean towards the teachings and advice of family planning for they are the people who need such a discipline badly. When the family planning associations expand their activities to cover larger areas of the rural sector and estates, this group will record a very high number of patients.

Table 4.3: Age at Marriage of First Visit Patients, Selangor, Perak and Pahang, 1962-1963

AGE	1962	1963
10	5	8
11	11	14
12	65	57
13	115	116
14	183	178
15	244	321
16	293	409
17	519	438
18	703	803
19	516	640
20	764	821
21	410	476
22	381	457
23	224	332
24	177	287
25	131	146
26	88	117
27	47	67
28	45	43
29	20	17
30 & Over	27	23

Table 4.9: Age at Marriage of First Visit Patients by Race, Selangor, Perak and Pahang, 1962-1963

AGE	1962				1963			
	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others
10	0	1	4	0	0	1	7	0
11	0	0	11	0	0	1	13	0
12	2	7	36	0	2	17	38	2
13	6	39	70	0	3	27	84	2
14	12	72	97	2	10	71	86	1
15	31	106	113	0	61	129	120	1
16	121	116	154	2	174	141	95	2
17	289	115	114	1	312	123	98	4
18	457	102	143	1	573	137	89	4
19	488	69	44	2	526	80	39	5
20	639	65	69	1	673	93	53	5
21	351	42	14	3	406	40	25	3
22	333	31	13	4	393	47	14	3
23	193	20	7	2	307	25	7	4
24	151	15	9	2	236	27	10	2
25	116	8	3	4	131	9	4	0
26	81	5	2	0	107	7	3	1
27	59	7	1	0	63	3	0	0
28	38	2	3	2	40	2	0	1
29	16	1	1	2	17	0	0	0
30 & Over	21	1	2	3	19	1	2	4

VI. Number of Children Living at Patients First Visit to Clinic:

In this study only Selangor and Pahang have been included because the other states have no such data. This study will be interesting because it will reveal the number of patients turning to birth control with successive number of children. Table 4.10 studies this aspect for the year 1962 for Selangor and Pahang. In the two states in 1962 most patients visited the clinics for the first time after having 3 to 6 children.

VII. Family Planning Activity in Estates:

Family Planning activity in estates was begun very recently and the first states to commence it were Perak, Selangor and Johore. In 1963 there were 5 estate clinics in Perak, 14 in Selangor, 6 in Johore and 2 in Pahang. All these states are now making a vigorous effort to include all the estates in the respective states. Perak and Selangor are especially stepping up their expansion into the estates because these two states have a large number of estates.

Though the estate programme has made progress yet the desired results have not been achieved due to many reasons and is proving an uphill struggle to achieve any lasting results. The success of the teaching of the discipline in estates is dependent on the great co-operation and active participation of some person of authority among the staff on the estates. Some estate managements agreed to cooperate while others could not be bothered. As the programme is closely connected with health, the medical assistants in the estates could be of great importance and presently they act as liaison between the patients in the estates and the family planning workers. These medical assistants are entrusted with some supplies of contraceptives to supply to patients, between visits of the mobile team.

In Perak, three lecture seminars were held for the medical assistants to gain their interest, to have

Table 4.10: Number of Children Living at Patients First Visit, Selangor and Pahang, 1962

No. of Children	1962	1962 Chinese	Malays	Indians	Others
0	58	36	13	10	3
1	286	212	44	28	2
2	341	251	43	40	7
3	415	287	83	38	7
4	418	287	74	54	3
5	379	268	77	33	1
6	335	239	65	31	-
7	261	198	45	24	-
8	187	131	39	17	-
9	147	120	15	12	-
10	73	51	16	6	-
11	30	22	4	4	-
12	15	10	4	1	-
13 & Over	8	5	2	1	-

Table 4.11 Total Attendance (New & Old Patients) and Revisits for Estates in Johore, Perak and Selangor, 1963-1964

STATE	Attendance		Revisit	
	1963	1964	1963	1964
Johore	257	357	1,012	1,080
Perak	1,690	2,721	2,523	1,069
Selangor	275	98	273	496
TOTAL	2,222	3,176	3,808	2,645

	% Increase 1963-1964	Attendance for Estates As % of Total Attendance For Whole State	
		1963	1964
Johore	38.9	7.3	12.2
Perak	61.0	38.2	40.1
Selangor	- 64.4	6.0	1.7
TOTAL	42.9	30.3	16.9

better liaison with them, and to point out to them the economic benefits and the health benefits the family unit could gain from Family Planning. In Malacca an instructional course on family planning was held for medical assistants in estates. However, in Malacca no visits were requested by the estates during 1962 and 1963.

The problems facing the estate programme are many. Firstly, the estate management should co-operate and participate in such a programme and where this is not done, it is impossible for the programme to operate. Then there is the poor response on the part of the estate people. They are either ignorant or shy towards birth control methods. Great promotional work is, therefore, required. At the same time there is much hard work by the mobile team in estates because they have to visit every home on the estate if the hospital assistant refuses to cooperate. Also, more often than not, the family planning workers are open to insults by some householders who deliberately mis-interpret their good intentions. It has been found that most of the hindrance come from the husbands. Besides many of the labourers cannot afford to buy contraceptives and on the part of the Association the programme also incurs great cost and time.

Some data on estate patients were available for Selangor, Perak and Pahang for 1963 and 1964. Table 4.11 shows total attendance and revisits in these estates. Perak has the largest estate attendance and the estate attendance in Perak represented 38.2 per cent of the total attendance for Perak in 1963 and 40.1 per cent in 1964. Selangor and Johore do not have a large estate response and the figures do not represent any significant proportion of the total attendance in the two states. The estate attendance for the 3 states rose by 42.9 per cent in 1964 over the 1963 figure; that of Perak being the highest with 61 per cent.

Since Indians form the major part of estate population, the Indian figure is the largest as can be seen in Table 4.12 and the number of Indian patients increased by more than 50 per cent in 1964 over the 1963 figure.

Table 4.12: Total Attendance (New & Old Patients) And Revisits For Estates in Johore, Perak and Selangor by Race, 1983-1984

STATE	ATTENDANCE								REVISITS							
	1983				1984				1983				1984			
	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others	Chinese	Malays	Indians	Others
Johore	28	138	91	-	48	100	124	5	58	558	378	2	123	677	277	3
Perak	187	187	1,238	98	288	288	2,288	-	198	217	1,786	342	122	128	818	-
Selangor	15	35	224	1	13	14	71	-	14	38	228	-	19	18	438	-
TOTAL	230	388	1,553	98	382	454	2,395	5	288	834	2,382	344	284	823	1,833	3
As % of Total Attendance in Johore, Selangor & Perak	1.8	2.7	12.4	0.8	2.1	2.8	15.3	0								

Table 4.13: Increase in Number of Clinics, 1962-1964

STATE	1962	1963	1964
Perlis	1	2	5
Penang	16	15	16
Perak	20	18	26
Selangor	17	18	22
Malacca	6	7	6
Pahang	12	14	11
Johore	11	11	10
Kedah	4	4	6
Negri Sembilan	2	9	10
Kelantan	12	18	11
Trengganu	6	7	10
Singapore	28	31	30
TOTAL	135	154	163

CHAPTER FIVE

Family Planning Activity in Selangor and Singapore

This chapter will present a thorough study of family planning activity in Singapore and Selangor and the period chosen is 1958 to 1964 and will be of help in supplying extra information to the study of family planning in Malaysia, to the reader. These two states were chosen because of their advancement in the discipline of family planning and because material was available for these two states for the above mentioned period. Perak would be an essential addition to this study as it started the movement quite early and presently is advanced in the movement. But material was not available for the earlier years and though request was made to the Family Planning Association of Perak for material, no genuine effort was made to supply them.

As in Chapter 4, this chapter deals with annual clinic attendance, both old and new patients; a study on revisits; age of patients on first visit to clinic; new patients' age at marriage. However, here a study on the number of children living at patients' first visit is included together with information on incomes of patients and methods favoured by patients.

I. Clinical Attendance:

The annual clinical attendance for Selangor and Singapore rose to more than 4 times in 1964 compared with the 1958 figure (Table 5.1). Before 1960 the rise is not marked but after 1961 the figure shows a very fast growth. In Selangor, the figure for 1964 represents more than 6 times the attendance in 1958 while in Singapore the increase is more than 3 times.

Table 5.1: Annual Clinical Attendances (New & Old Patients), 1958-1964

STATE	1958	1959	1960	1961	1962	1963	1964	Absolute Increase 1958-1964	% Increase 1958-1964
SELANGOR	837	2,211	1,712	1,457	3,436	4,618	5,920	5,083	607.3
SINGAPORE	5,280	5,938	7,472	8,070	20,272	23,435	25,582	20,302	384.5
TOTAL	6,117	8,149	9,184	9,527	23,698	28,053	31,502	25,385	415.0

PER 1,000 FEMALE POPULATION

	1958	1964
SELANGOR	3.7	9.6
SINGAPORE	7.4	39.2
SELANGOR & SINGAPORE	7.1	6.7

In 1958, 5.7 females out of every 1,000 females in the country attended family planning clinics and this ratio has gone up to 9.6 in 1964. Singapore shows a vast improvement with the ratio of 7.4 per thousand females in 1958 increasing to 29.2 per thousand in 1964. (Table 5.1)

The increase in new patients shows a much higher rate of increase in Selangor between 1958 and 1964 than in Singapore, though in absolute figures, Singapore shows a higher rise. However, taking the two states together, the figure for new patients has more than doubled in 1964 compared to that of 1958. (Table 5.2).

The Malays have the highest rate of increase between 1958 and 1964, with an increase of more than 4 times in 1964 over the 1958 figure. The increase has been more marked in Selangor. The Chinese and Indians have more or less doubled their numbers during the same period. Though the Malay population in Selangor is much greater than that in Singapore, the number of Malays conforming to the family planning teachings is much greater in Singapore than in Selangor in any single year between 1958 and 1964. This may indicate that the rural drive by the Singapore Family Planning Association is very effective. The Chinese also show a considerable amount of increase in attendance over the period in Selangor.

On the average an individual patient revisits a clinic twice for the year 1964, Selangor and Singapore taken as a whole (Table 5.4). In 1961 the ratio was 4 revisits per patient. This decline is due directly to the lowering of the ratio in Singapore from 4.4 in 1961 to 2.7 in 1964 and this is due to the increase in first visit patients but the number of revisits declining. However, in Selangor the ratio tends to improve over the period.

Table 5.2: New Patients (1st Visit), 1958-1964

STATE	1958	1959	1960	1961	1962	1963	1964	Absolute Increase 1958-1964	% Increase 1958-1964
SELANGOR	837	2,211	1,712	1,457	2,457	3,009	3,968	3,131	374.1
SINGAPORE	5,280	5,938	7,472	8,070	7,189	8,429	9,339	4,059	76.9
TOTAL	6,117	8,149	9,184	9,527	9,646	11,438	13,307	7,190	117.5

Table 5.3 : New Patients (1st Visit) By Race, 1958-1964

STATE	1958 C	1958 M	1958 T	1958 O	1959 C	1959 M	1959 T	1959 O	1960 C	1960 M	1960 T	1960 O	1961 C	1961 M	1961 T	1961 O
SELANGOR	539	118	156	24	1,383	204	404	28	1,247	190	287	16	1,614	183	241	19
SINGAPORE	4,558	297	303	122	5,175	346	322	85	6,223	596	432	221	5,867	746	457	400
TOTAL	5,097	415	459	146	6,758	550	726	113	7,470	786	719	237	7,481	929	698	419

STATE	1962 C	1962 M	1962 T	1962 O	1963 C	1963 M	1963 T	1963 O	1964 C	1964 M	1964 T	1964 O
SELANGOR	1,853	441	311	22	1,939	586	477	27	2,553	895	471	49
SINGAPORE	5,607	551	526	505	6,503	867	376	653	7,033	1,220	487	599
TOTAL	7,460	992	837	527	8,442	1,453	853	680	9,586	2,115	958	648

	Absolute Increase 1958 - 1964 C	M	T	O	% Increase 1958 - 1964 C	M	T	O
SELANGOR	2,014	777	315	25	373.7	658.5	201.9	104.2
SINGAPORE	2,475	923	184	477	54.3	310.8	60.7	391.0
SELANGOR & SINGAPORE	4,489	1,700	499	502	88.1	409.6	108.7	343.8

N.B.: C = Chinese, M = Malays, T = Tamil, O = Others.

Table 5.4: Revision, 1958-1964

STATE	1958	1959	1960	1961	1962	1963	1964	Average Per Patient 1958	1962	1964
SELANGOR	1,126	2,049	2,570	2,422	4,066	9,764	19,130	1.3	1.7	3.2
SINGAPORE	22,338	28,513	30,493	35,654	41,727	51,765	69,029	4.2	4.4	2.7
TOTAL	23,464	30,562	33,063	38,076	45,793	61,529	88,159	3.8	4.0	2.8

II. Age of Patients on First Visit to Clinic and at Marriage:

In compiling the data in Tables 5.5, 5.6 and 5.7, only Selangor is studied because no data on these were available for Singapore after 1958.

Looking at Table 5.5, a large proportion of new patients among the Chinese were older than the Malays and Indians and while the peak ages for the Chinese during 1958-1963 was 25-30, that for the Malays was 22-27 and for Indians 23-27. The commonest age for the Chinese during this period was 30, for the Malays 25 and for the Indians 30 too.

During the years 1958-1963, the number of new patients who married at ages below 16 was highest among the Indians, followed by the Malays. On the whole the Chinese patients married at older ages compared with Indians and Malays as can be seen in Table 5.6. While among the Chinese, the number of new patients who got married after the age of 25 is quite substantial, that for Malays and Indians is very few. The most common marriage-age for the Chinese over the period was 20, while that for Malays was 18 and for Indians 16.

III. Number of Children Living at Patients' First Visit:

From Table 5.7, it can be deduced that the greatest number of new patients for the period 1958-1962 had 5 children and the second largest group had 3 children. At the same time, it should be noticed that the number who had one child or two children at time of first visit is quite large showing advance in family planning. Over three-quarters of the new patients during this period had one to seven children.

Among the Chinese, the greatest number of new patients had 5 children, while among the Malays the number was 3 children and among the Indians 5 children. From the Table it can be deduced the Chinese patients had relatively more children.

Table 5.5: Age of Patients on First Visit to Clinic in Selangor by Race, 1958-1963

Years	Chinese	Malays	Indians	Others	Total
16	3	2	17	-	22
17	9	11	11	2	33
18	22	25	26	-	73
19	49	27	47	1	124
20	116	71	72	2	261
21	173	72	69	5	319
22	289	101	89	7	486
23	348	120	105	1	574
24	326	105	99	6	536
25	464	134	124	5	727
26	459	125	96	4	684
27	480	79	107	8	674
28	481	99	126	15	721
29	403	88	90	8	589
30	534	116	163	10	823
31	520	62	65	8	655
32	485	98	93	7	643
33	347	47	54	4	452
34	345	55	53	3	456
35	270	47	58	4	379
36	288	38	35	3	364
37	243	27	37	2	309
38	207	25	15	1	248
39	155	11	6	1	173
40	148	21	16	0	185
41	121	8	9	0	138
42	92	2	3	0	97
43	54	1	3	1	59
44	40	3	0	1	44
45 & Over	70	2	1	6	79

Table 5.6: New Patients' Age at Marriage by Race for Selangor, 1958-1963

Years	Chinese	Malays	Indians	Others	Total
10	1	3	10	0	14
11	0	1	24	0	25
12	3	17	58	0	78
13	5	58	120	0	183
14	27	129	157	0	313
15	96	196	214	0	506
16	337	208	242	2	789
17	624	196	184	1	1,005
18	1,048	232	223	4	1,507
19	948	131	96	6	1,181
20	1,213	125	114	11	1,463
21	842	70	50	13	975
22	760	58	29	18	865
23	496	38	21	5	560
24	316	27	24	8	375
25	251	11	13	15	290
26	178	7	6	4	195
27	113	12	8	3	136
28	77	1	5	2	85
29	44	2	3	3	52
30 & Over	57	3	4	6	70

Table 5.7: Number of Children Living at Patients' First Visit by Race for Selangor, 1958-1962

Number of Children	Chinese	Malays	Indians	Others	Total
0	52	21	37	11	121
1	604	102	82	13	801
2	689	115	146	34	984
3	662	153	182	29	1,026
4	653	129	192	7	981
5	766	147	198	2	1,113
6	703	121	171	3	998
7	562	104	133	0	799
8	458	75	92	0	625
9	279	44	55	0	378
10	181	19	31	0	231
11	77	8	12	0	97
12	44	3	7	0	54
13 & Over	23	4	4	0	31

IV. Income Group of New Patients

Table 5.8, which gives the income group of new patients, shows that more than 50 per cent of the new patients for the period 1959-1963 in Selangor fall into the $100 - $300 per-month-income group, and seems to indicate that greater efforts should be made to spread the knowledge of family planning among the lowest-income-group, less than $100 per month, who have relatively higher fertility rates. It is envisable that the poor response by this low-income group must be largely due to lack of money resource to purchase contraceptives. However, in Singapore and in other states of Malaya free supplies are given to certain patients and other patients are assisted in finance to purchase these contraceptives. (Table 5.11) The percentage figures provided at the bottom of the table do not add up to a 100 per cent because not all new patients have been taken into account in this analysis due to unavailability of information on income.

V. Methods Favoured:

In Selangor, the use of the Condom was totally absent as a method preferred by patients before 1961. After 1961, however, its use has been increasing steadily. However, in Singapore, the use of the condom as a contraceptive is widespread. Between 1959 and 1963, the number of patients conforming to this method rose more than 3 times in Selangor and Singapore. (Table 5.0) Oral Tablets was started to be used only in 1961 in the two states and since then there has been a considerable increase. In the case of the Diaphragm, Foaming Tablets and Applicator the trend has been the opposite. With the introduction of oral tablets and the increasing use of condoms resulted in the decline in their use and the most affected of the methods is the Diaphragm which has declined in use by more than 60 per cent between 1959 and 1963.

Table 5.8 Income Group of New Patients for Selangor, 1959-63

Year / Income Group	Less Than $100 p.m.	$100 - $300 p.m.	More Than $300 p.m.
1959	534	1,521	156
1960	487	1,087	138
1961	359	924	147
1962	323	1,671	262
1963	421	2,193	275
1959-1963	2,124	7,396	978
As % of Total Number of New Patients 1959-1963	15.8	55.1	7.3

N.B.: p.m. = per month

Table 5.9: Response by New Patients to Different Methods of Birth Control in Selangor and Singapore, 1959-1963

Method	1959	1960	1961	1962	1963	% Increase 1959-1963
Condom	1,263	2,447	3,509	4,090	5,543	338.9
Oral Tablets	-	-	147	514	1,027	-
Diaphragm & Cream	4,279	3,508	2,680	1,989	1,585	- 63.0
Foaming Tablets	1,570	2,421	2,267	1,892	1,449	- 7.7
Applicator & Paste	928	714	475	327	427	- 54.0
General	-	32	319	250	1,076	-

Table 5.10: Method Chosen on the First Visit in Singapore, 1961-1964

Year	Diaphragm & Paste	Condom	Applicator & Paste	Foam Tablets	Gemarmal	Oral Pill
1961	24.7%	41.4%	4.5%	24.6%	4.0%	0.7%
1962	21.6%	45.5%	5.4%	21.4%	3.5%	3.0%
1963	15.2%	58.2%	3.7%	13.6%	11.9%	6.7%
1964	7.2%	46.1%	2.7%	9.1%	14.6%	20.2%

Table 5.11: Free and Assisted Cases in Singapore, 1958-1964

Year	Free	Assisted
1958	5,489	7,337
1959	4,446	10,414
1960	4,331	11,041
1961	4,716	15,418
1962	5,259	14,969
1963	7,446	14,744
1964	9,657	18,302
TOTAL	41,544	92,225

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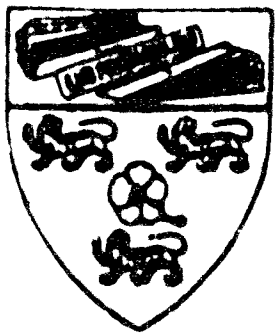

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