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Editorial

An Obstetrician Looks at Family Planning

Family Planning Programmes are indeed undergoing an exciting phase in all parts of the world and particularly in Asia, the necessity for and the problems encountered in Family Planning Programmes are most pressing. For ourselves, both in Malaysia and in our own Republic, the decisions of the Governments to take direct and strong measures for concerted actions on a national scale are greatly hailed. In Malaysia, a probe and a survey are in progress and in Singapore, the inauguration of the National Family Planning and Population Board on 1st January 1966 signalled the beginning of an earnest and what is hoped, an efficient family planning programme. The purpose of the Five-Year Plan is "to liberate our women from the burden of bearing and raising an unnecessarily large number of children and as a consequence to increase human happiness for all".

In many other parts of the world, much has been said and much has been written about family planning and anti-fertility programmes. Most, if not all, make comments from a demographic, political, economic, social or clinical trial point of view. An obstetrician however views family planning in a different light. The oath of Hippocrates binds him and indeed all physicians to place his or her patient first and foremost in all considerations — even above national and other interests.

Each and every one has the basic right to plan a family. Indeed, one of the basic biological functions — if not the most basic biological function of a woman — is the function of reproduction. Like most things in life, it is the proper utilisation of this function that ultimately decides a happy and contented life. When to marry, when to have a child, how to have a child and how many children to have are the oft prompted questions an obstetrician must find the appropriate answers for, in dealings with his or her patients.

Matthews Duncan (1866) had stated that fecundity is twice as great before 30 years of age in a woman and is greatest between the ages of 20 to 25 years. This statement has borne the test of time and therefore a woman who marries between the ages of 20 to 25 years is more likely to demonstrate her fecundity than if she marries at any other age. In Singapore, the bulk of marriages are contracted in women within the maximum fertility range but some 10 per cent of marriages (10.2 per cent in 1964) were contracted in women over the age of 30 years. The more elderly woman faces gynaecological and obstetric hazards — not to mention the hazard of decreased fertility. Such hazards include gynaecological problems of dysmenorrhoea, uterine fibromyomata, pelvic endometriosis as well as the greater pre-dispositions to spontaneous abortions. The elderly primigravida is associated with a higher incidence of pre-eclamptic toxaemia. Premature labours with prematurity risks for the infant is three times higher in the elderly primigravida. Prolonged labours are more the fashion than the exceptions with the elderly primigravida and the operative delivery rate is approximately four times than the average. An obstetric patient with an advancing age in a pregnancy faces an increased hazard of an obstetric death. Thus for example in 1964, a total of 18 obstetric deaths had occurred in the age group 40 years and over and this gives a rate of 6.1 per 1000 which is approximately 8 times higher than the prevalent obstetric death rate for 1964 at 0.78 per 1000. If this age risk is coupled with grande multiparity, the ratio is most certainly higher.

The hazards of grande multiparity are quite obvious to an extent that Bethel Solomons had described a grande multipara as a dangerous grande multipara. In Singapore in 1964, there remains still a large proportion of women in this critical parity group. Thus for example, if para 6 and over is taken to include a grande multipara, 11162 women qualified (28.2 per cent of all deliveries). Parity 7 and over listed 8251 women (20.7 per cent) and parity 8 and over had 5735 women (11.4 per cent). Over the years 1955 to 1962, a total of 117 obstetric deaths had occurred amongst this group of patients viz. para 6 and over and this was against an overall total of 208 obstetric deaths or 51.5 per cent. The risk of such a grande multipara meeting with an obstetric death was five times higher when compared to the lower parity group viz. 5 and under.

It is this tragic group of patients for whom family planning can be of maximum use and the risks they face have been constantly reminded over the past many years. In a similar vein in the Republic of Singapore,

the Malay Gravida faces an extremely high risk of an obstetric death. In 1964, there had been 58,217 births of which 11,709 were amongst the Indon-Malay community. The overall obstetric death rate in Singapore in the same year was 0.56 per 1000 (33 deaths) but 16 deaths had occurred amongst this high risk racial group giving an obstetric death rate of 1.35 per 1000 or nearly 2.4 times the overall death rate. Compared to the Chinese gravida at 0.27 per 1000 (11 deaths in 40,937 deliveries) the risk of the Indon-Malay gravida is clearly five times higher. It is pertinent to draw attention to the fact that compared to 1957 when the number of Chinese births reached 46,263, in 1964 — the number of these births had fallen by 5,326 births being only a total of 40,937. Amongst the Indon-Malays, however, there had been a rise of 1,691 births in 1964 (total: 11,008) as compared to 1957 with a total of 9,317 births. Clearly then it is amongst the Indon-Malay Community that family planning programmes need to be more emphasised.

It is thus apparent that from an obstetric view-point, the optimal time for a woman to embark on the adventure of a pregnancy and motherhood is during those years of maximum fecundity viz. 20 to 25 years. It is also apparent that the Grande Multipara faces a high risk of obstetric death and similarly the Indon-Malay gravida — not to mention the high incidence of morbidity and relative inefficient motherhood.

Turning attention to the measures available for the control of fertility, review and comments must necessarily emphasise that what is good sauce for the goose is not also necessarily good sauce for the gander. It is also obvious that the responsibility of an obstetrician must also include the interests of the male and husband. The male "Oral Contraceptives" involving the use of the bisdichlor-acetyl diamines and the Di-nitro-pyrrols are still in the experimental stage. Ligation of the Vas Deferens offers an effective and permanent method of control of male fertility but experience in many Asiatic countries show that the male response to this method is very discouraging for reasons very likely and largely psychological. Turning to the female anti-fertility agents and anti-fertility measures — the use of immunological agents like fertilisin and anti-fertilisin as well as the anti-zygotic agents like compound M.E.R. 25 (Seal and Nelson) and Ergoconin (Schelesnyak) are still within the realms of experimental control and much work need to be done before any measure of recommendation can be considered.

Permanent sterilisation involving surgical procedures on the Fallopian tubes are established procedures now perfected to reach 100 per cent effectiveness and can be recommended as an effective measure; but the present laws relating to this procedure border so closely to those of abortions in this country that it is only recommended to those only in whom another pregnancy has a high risk of obstetric disasters.

Let us now turn our attention to the more widely practised methods of contraception and see what would seem to be the best to be recommended to the female patient.

Effectiveness of Various Methods of Contraception
(A. Wiseman 1964)

(Average Pregnancy rate per 100 woman years)

Method	Percentage
Douche	31
Rhythm Method	24
Jelly	20
Coitus Interruptus	18
Condoms	14
Diaphragms	12
Intra-Uterine Device	2.6 to 5
Oral Contraceptives	0.1 to 1

From the above table, it would appear that except for the intra-uterine device and the oral contraceptives, the remaining methods of contraception have little to be recommended because of the high pregnancy rate. Besides, these methods are less aesthetic, more ritualistic, more messy and naturally more "unnatural". They may however be offered to those who for one reason or another is unable to tolerate either the intra-uterine devices or the oral contraceptives.

Of the last two methods, it is reasonable to make comparisons in the light of our present knowledge but in the end, it will be the individual herself who is best able to decide which of the two methods is best for her.

In terms of effectiveness, the oral contraceptives have now been perfected to reach 100 per cent effectiveness and there is a reasonable claim as to the total absence of "Pill" failures. Any failure of the oral contraceptives is perhaps a "Patient" failure. The intra-uterine devices have yet to claim this high percentage of effectiveness.

Both methods have their respective side-effects — some serious enough to make those using the particular method to drop it completely. It is felt however that the individual who is badly primed as to either method, is more prone to develop the undesirable side-effects; and this individual will similarly not do well with any method. A proper orientation and understanding of the individual method will appear to be a necessary procedure before putting any one on any method.

Much attention has already been paid to the respective modes of action. The actions of the oral contraceptives appear to have been very well established but much is yet to be learnt of the modes of actions of the intra-uterine devices.

The risks of carcinogenesis and cancer of the female reproductive tract have not at all been proven with either method and similarly the risks of thrombosis and liver damage by the oral contraceptives have not been substantiated. The intra-uterine device has the distinct advantage of a minimal cost and the oral contraceptives require a steady monthly expenditure.

It is thus important to state that there is still much to be learnt about the complex neuro-endocrine inter-relationships which underlie the effectiveness of the types of the oral contraceptives in use. Similarly much more need to be learnt about the mode of action of the IUD, and its optimal insertion time. In the state of our present knowledge, the doctor cannot completely recommend any one specific method but he can only advise. Their respective use is for the individual to decide and in any family planning programme, it is not only wise but imperative that whether it is the pill or the intra-uterine device, such must only be dispensed under direct medical supervision. The Family Planning and Population Board of the Republic of Singapore has a Medical Committee consisting of the most eminent people in the field of Public Health as well as Obstetrics and Gynaecology. This Medical Committee is the watch-dog of the practice of family planning in the Republic. The Public should rest-assure itself about the Republic's family planning programmes.

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