Balance in family planning

Family planning has been so effective in Singapore that a risk exists of there being too few young people to sustain the country’s economy in the twenty-first century. Relaxation of birth control policies and immigration laws offers hope that this problem will be averted.

Singapore’s rate of population increase fell from 4.3% in 1957 to 1.7% in 1971. Fertility has been well below the replacement level since 1975. If this trend continued it could lead to a declining population in 20 to 30 years, a source of concern to demographers and economic planners.

In 1819, when Sir Stamford Raffles landed in Singapore, its population consisted of 120 Malays and 30 Chinese. It increased mainly by immigration, and in 1850 there were 52,891 inhabitants. Large numbers of male Chinese and Indian immigrants arrived and in 1881 the population was 139,108. Further immigration caused a 35% increase in the population between 1901 and 1911. Between 1883 and 1939, 190,000 female Chinese settled in Singapore. This equalized the sex ratio and led to a post-war “baby boom”.

Stringent immigration laws have meant that, since 1960, population growth has largely resulted from an excess of births over deaths. If the current fertility rate were maintained, zero population growth would be achieved before 2030, the date originally set by family planners for this to happen.

Approaches to family planning

The Singapore Family Planning Association, a voluntary body, was established in 1949. It was allowed to offer its services to 27 maternal and child health clinics run by the government and to the outpatient clinics of the Kandang Kerbau Maternity Hospital.

A family planning campaign was conducted by the Association in 1960: an exhibition was attended by over 120,000 people, and subsequently officials visited rural community centres; a training course for lay workers was organized.

By 1963, family planning activities were on such a scale that the Association was unable to cope and requested the government to take over all those conducted in state institutions. The Family Planning and Population Board was inaugurated in 1966 as the sole agency for both policy-making and the dissemination of knowledge in matters relating to family planning. The aim was adopted of achieving replacement reproduction by 1990 and zero population growth by 2030, and the country went well beyond voluntary strategies.
Abortion laws

Before 1967, abortion was restricted to women whose lives were endangered. In 1967 the Family Planning and Population Board made abortion available on other grounds, among them congenital fetal abnormality, sexual assault, and maternal mental subnormality. The first Abortion Bill, introduced in 1968, was broadened to include women deemed unsuitable for continuing pregnancy on family, social and economic grounds. Abortion was restricted to women who had been resident in Singapore for more than four months. In 1974 the limit on the period of gestation was extended to 24 weeks and abortion was made available to any woman who requested it provided that it was performed under approved conditions.

During the period 1970-85, 222,161 legal abortions were documented. The proportion of legal abortions to live births increased progressively from 4.1% in 1970 to 57% in 1985.

Tax relief

Enhanced income tax relief for certain women was introduced in 1984. Normal tax relief for children was unchanged, but specially qualified women were given allowances on 5% more of their earned income for the first child, on 10% extra for the second, and on 15% extra for the third, up to a maximum of approximately US$ 5000 for each child (two Singapore dollars are about US$ 1). The main objective of this scheme was to encourage highly educated married women to have a second child and, possibly, a third. However, career women are still expected to care for their children and perform all the other domestic tasks with little or no help from their husbands. Recognizing this, the government has relaxed the rules on work permits for domestic help from outside the country, and has established child care centres. These measures may influence some well-educated women to have more children.

Cash incentive for sterilization

This has the sole purpose of discouraging poor and lesser educated parents from having many children. It takes the form of a grant of US$ 5000, which may be deposited in a woman’s central provident fund or used as an initial payment for a flat. The grant is provided under the following conditions:

- the mother should be under 30 years of age and sterilized after the first or second child;
- both parents should be below a specified educational level;
- combined family income should not exceed US$ 750 per month, and neither the wife nor husband should earn more than US$ 375 per month;

The decline in fertility, the decrease in family size, the birth of first children at more advanced maternal ages than formerly, and the spacing of children through family planning have contributed significantly to a reduction in mortality rates among mothers and children.

- both parents should be Singapore citizens or permanent residents;
- if the mother gives birth to another child, she has to repay the US$ 5000 plus 10% compound interest a year.
Accouchement fees

Accouchement fees for third and subsequent births in state hospitals were increased. The objective was to discourage relatively poor, ill-educated people from having numerous children. However, with a view to countering the excessive downward trend in fertility that has developed, the government is now considering the granting of paid maternity leave to women having their third child, and to permit the use of medical insurance to pay for the corresponding care. At present, tax rebates are given to mothers having their third child.

It is perhaps time to review and progressively diminish Singapore’s birth control measures with a view to having a stable population in the twenty-first century.

Fertility trends

The total fertility rate is an indicator of the number of children a woman will have during the whole of her reproductive life. In Singapore from 1957 to 1965 its value declined from 6.4 to 4.6; the introduction of the national family planning programme in 1966 led to an accelerated decline in fertility; by 1970 the total fertility rate had dropped to 3.1 and in 1985 it was only 1.6.

A more reliable indication of population trends in the long term is given by the gross reproductive rate, which projects the average number of female children produced by each woman during the whole of her reproductive life, assuming that all women survive until the end of this period. Following the Second World War, the number of births in Singapore rose rapidly and in 1947 the gross reproductive rate was 3.176; it reached a peak of 3.186 in 1957. Early marriage of women and large families were among the factors favouring this high reproductive rate. A downward trend commenced in 1958, some ten years after family planning was first made available to the population. By 1970 the gross reproductive rate was 1.505. The decline slackened in 1971 and in 1972 there was a rise of 0.5%. At this time the government introduced legalized abortion, legislation on sterilization, and disincentives for large families. The next three years showed a marked reduction in fertility: in 1975 the gross reproductive rate was 1.006, just below the replacement level. After a slight rise in 1976, the gross reproductive rate continued to decline and in 1983 it was only 0.766, well below the replacement level. In 1985 it was still disturbingly low at 0.780 (Fig. 1).

Fig. 1. Birth and gross reproductive rate, Singapore, 1947–85.

Source: Registrar of Births and Deaths, Singapore.
The decline in fertility was most marked among the Chinese and least among the Malays, although even here the gross reproductive rate has dropped below the replacement level. The current trend gives cause for concern, since the survival of Singapore has depended primarily on human resources.

The main factors that have contributed to the rapid decline in fertility are:

- family planning policies and the services provided by the National Family Planning and Population Board;
- legalized induced abortion;
- promotion of voluntary sterilization;
- incentive and disincentive measures affecting income tax, public housing, choice of schools, work permits, accouchement fees, and maternity leave.

Other factors are:

- rise in family income;
- increasing participation of women in the labour force;
- scarcity of domestic help, particularly for child care;
- break-up of the extended family system;
- rise in educational attainment;
- changing attitudes towards marriage and childbearing;
- increased age at first marriage.

The fertility rate in Singapore today is one of the lowest in the world. One wonders, in fact, whether the programme has been too successful and whether some of the measures have been too severe and inflexible. If the current trend continues there will be zero population growth well before the targeted date, 2030, and thereafter the population will decline. There will also be a large proportion of old people and a lack of workers to sustain the economic growth of the country and support the elderly. Furthermore, it should be noted that the drop in fertility has occurred most markedly among the higher socioeconomic strata.

**Maternal and child health**

The decline in fertility, the decrease in family size, the later birth of first children, and the spacing of children through family planning have contributed significantly to a reduction in mortality rates among mothers and children and to an improvement in maternal and infant health.

**Fig. 2. Singapore: crude birth rate, infant mortality rate and perinatal mortality rate, 1965–85, and GNP per capita, 1973–85.**

In 1957 the perinatal mortality rate was 28.2 per thousand total births. It fell to 25.5 per 1000 by 1965 and had decreased to 10.6 per 1000 by 1985. Infant mortality rates in the respective years were 41.4, 26.3 and 9.3 per 1000 live births (Fig. 2).

Maternal mortality rates fell from 40 per 100,000 live births in 1965 to 10 per 100,000 in 1985 (Fig. 3). There was a progressive fall in abortion-related deaths from 15 in 1968–70 to 9 in 1974–76, and an increase in the number of legal abortions over the same period. No abortion-related deaths occurred between 1980 and 1985.

Women using contraception are more successful than others in spacing births and preventing unwanted babies. The number of women accepting contraception and planning to have more children increased from 67% in 1976 to 88% in 1985. This trend was most marked among women of parity 0 or 1, whose use of contraception increased from 43% to 81%.

Between 1966 and 1985 there was a decline of 59.3% in births occurring among women aged 15-19 years; for women over the age of 35 years the decline was 41.6%. In 1985 the prime childbearing age range was 25-29 years, in which 42.0% of all births occurred; 89.1% of all live births corresponded to women in the age group 20-34 years.

The number of fourth and later babies fell by almost 90% between 1966 and 1985, while that of first and second babies increased. This helped to improve the health of mothers, neonates and older children.

The decline in maternal, perinatal and infant mortality and the improvement in the overall health of women and children have also been helped by a general rise in maternal educational status and in the socioeconomic circumstances of families. The gross national product per capita increased from about US$ 1900 in 1973 to $ 6400 in 1985. More than 70% of the population live in apartments with modern sanitation, and the people have become increasingly health conscious.

The use of incentives and disincentives raises certain ethical issues. The main objections to incentive programmes are that they diminish the freedom of choice of parents and may be unjust. Yet incentives can be seen to enlarge options rather than reduce them and may therefore serve both freedom and justice: the individual is presented with a choice that she lacks in the absence of the incentive. In disincentive programmes, the main problem is the possible effect on children born despite the discouragement given to the mother, e.g., not obtaining admission to the school of choice. In addition, there may be psychological effects resulting from family reactions to children associated with extra costs. Such possibilities should be guarded against.
Despite the use of incentives and disincentives, some couples have continued to have more than two children. Indeed, it is not uncommon for a mother to be admitted to hospital for a fifth birth. It is important to realize, however, that while the couples concerned do not enjoy publicly supported facilities and tax benefits, they are not penalized in any other way.

* * *

It is perhaps time to review and control measures in order to permit fertility to move back to the replacement level in the not too distant future, with a view to having a stable population in the twenty-first century. The government has already taken steps to encourage people in all social strata to have more children. Other measures, including selective liberalization of immigration laws so as to allow entry to people who can contribute to economic and social development, will probably be necessary.

---

**Family support for the elderly**

*The informal support system, most often the family, remains central to the care of the elderly. The primary function of formal care is to help the informal system maintain older individuals in the community whenever feasible.*

- Special emphasis should be given to programmes that assist the family in its traditional role of supporting the elderly.

- Frail elderly persons without family support will often require more formal support systems to permit them to remain in the community.

- Where traditions of respect for elders are under threat owing to cultural change, effort should be made to reinforce and foster them, especially among the young.

---