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Population Policies in Asia

THE ASIAN POPULATION AND DEVELOPMENT ASSOCIATION(APDA)

Foreword

This report entitled "Population Policies in Asia" is a compilation of population policies that are implemented in 7 Asian countries. National-level population policies assert large influence in solving population problems. Since the principle and method of population policies are deeply related to the political, economic, cultural and religious background of each country, they vary from country to country. Furthermore, it is difficult to study such policies from abroad owing to the nature of their content, making sufficient and detailed information hard to obtain. Therefore, information was obtained directly from the ministries and agencies of respective governments that are in charge of population policy through the network of Asian Forum of Parliamentarians on Population and Development (AFPPD), which is an organization of the parliamentarians in the Asian region for acting on the issue of population and development, and was compiled into reports in this study.

To realize this, APDA requested the representatives of parliamentarians from the 12 Asian countries that participated in the 13th Asian Parliamentarians' Meeting on Population and Development, which was organized by APDA on March 17 and 18, 1997 in Kobe, Japan (Australia, China, Fiji, India, Indonesia, Malaysia, Nepal, New Zealand, the Philippines, Singapore, Thailand and Viet Nam), to cooperate in this study and requested the ministries and agencies that are in charge of population policy to present information on population policy in their country.

As mentioned earlier, population policy differs widely from country to country and therefore cannot be generalized under single criteria. In requesting information to ministries and agencies, however, the items to be analyzed with regard to population policy were determined under the guidance of Dr. Toshio Kuroda, Director Emeritus of Nihon University Population Research Institute and Director of APDA, and were presented as the framework for preparing the report (see Appendix). For this reason, reports from respective countries have been prepared in accordance with this framework.

Among the 12 countries that participated in this study, the ministries and agencies of 7 countries in charge of population policy (Australia, China, Indonesia, Malaysia, Singapore, Thailand and Viet Nam) submitted their country report. India and Nepal submitted

materials and publications on population policy but did not present their country report. The materials received will be utilized in future study and research as valuable information.

There are some studies on world population policy conducted by the United Nations such as "*Global Population Policy DATA BASE*", "*World Population Policies Volume I - III*", and "*World Population Monitoring*". However, APDA's study comprises the first study on population policies of selected Asian countries that has been systematically compiled in descriptive form. Moreover, it is extremely valuable in grasping the trends of population policies at respective countries since information has been presented from the relevant ministries and agencies as the latest administrative information.

In conclusion, we would like to express out heartfelt gratitude to Hon. Colin Hollis, MP (Australia), Hon. Dr. Hao Yichun, MP (China), Hon. Dr. Urmilaben Patel, MP (India), Hon. Taheri Noor, MP (Indonesia), Hon. Senator Ibrahim Ali (Malaysia), Hon. Dilip Kumar Sahi, MP (Nepal), Hon. Chew Heng Ching, MP (Singapore), Hon. Senator Prasop Ratanakorn (Thailand), Hon. Nguyen Thi Than, MP (Viet Nam) and the officers in charge at relevant ministries and agencies for their cooperation and hope that this report will be utilized extensively towards solution of population issues in respective countries.

The Asian Population and Development Association

Contents

Page

Foreword 1

General Remarks 5

Country Reports:

Australia 17

China 29

Indonesia 41

Malaysia 49

Singapore 55

Thailand 63

Viet Nam 71

Appendix 77

GENERAL REMARKS

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I. Introduction

This report is the result of first attempt of Study on Population Policy in Asia, which has been prepared by each government through parliamentarians who attended the 13th Asian Parliamentarians' Meeting on Population and Development held on March 17-18, 1997 in Kobe, Japan, and kindly accepted our request of population policy study project to provide information of each country. Format of report indicating main topics which should be mentioned in the report was prepared and given to parliamentarians (See Appendix). Format is of course standard, and is likely to be subject to change depending on particular situation of each country.

The Asian Population and Development Association (APDA) is greatly concerned with interrelationship between population change and economic-social development in Asia, and responsible to assist Asian Forum of Parliamentarians on Population and Development (AFPPD) by making intensive and extensive survey and also international comparative study, by collecting information and data to be useful for policy, by organizing seminars, symposia and meetings, and so on.

We recognize that central issue for AFPPD is population policy and programs, because majority of AFPPD members' countries with a very few exception are seriously affected by rapid population growth. Population policy and programs are most urgent tasks for parliamentarians representing people who should assist and guide their governments.

However, underlying factors of diversified economic, social and cultural development are directly and indirectly interrelated with population change. Consequently, population policy and programs should be fully specified to be effective in achieving targets of each country. At the same time, successful experiences in neighboring countries

might be potentially useful examples. We have some evidence that geographical proximity and cultural affinity could bring about successful demographic transition among countries and territories. In this sense, information exchange about population policy and programs will be very important for policy makers and politicians.

II. Profile of Demographic Situation of Countries Surveyed

Several countries provided us useful information about demographic situation and population policy, including 9 countries of Australia, China, India, Indonesia, Malaysia, Nepal, Singapore, Thailand and Viet Nam. However, India and Nepal sent us copies of documents on population.

Before going to introduce population policy in each country, general demographic indicators which are basic factors motivating to work out population policy and programs.

Table 1. Selected Demographic Indicators in the Countries Surveyed

	Population (million) 1997	CBR 1990-95	CDR 1990-95	NIR 1990-95	TFR 1990-95	IMR 1990-95	L.E. 1990-95	Dependency Ratio (1995)		
								Child (0-14)	Elderly (65+)	D.R.
Australia	18	14.9	7.4	7.5	1.89	7	77.6	21.5	11.7	49.7
China	1244	18.3	7.2	11.1	1.92	44	68.5	39.0	9.0	48.0
India	960	27.5	9.8	17.7	3.39	78	60.5	57.8	7.6	65.5
Indonesia	204	24.6	8.4	16.2	2.90	58	62.7	52.5	6.9	59.4
Malaysia	21	28.8	5.1	23.7	3.62	13	70.8	65.3	6.7	72.0
Nepal	23	39.6	12.9	26.7	5.42	96	59.6	81.0	6.6	87.6
Singapore	3	18.2	4.9	13.3	1.79	5	76.3	31.4	8.8	40.3
Thailand	59	18.1	6.1	12.0	1.94	32	69.0	41.5	7.5	49.0
Viet Nam	77	28.9	7.9	21.0	3.40	42	65.2	63.5	8.5	72.0

Source: Population size in 1997 derived from UNFPA: The State of World Population 1997. Other figures are from United Nations: World Population Prospects: The 1996 Revision Annex II & III: Demographic Indicators by major area, region and country, with exception of Dependency Ratio derived from World Population Prospects: The 1996 Revision Annex I: Demographic indicators.

Remarks: CBR = Crude Birth Rate per 1000 population, CDR = Crude Death Rate per 1000 Population, NIR = Natural Increase Rate, TFR = Total Fertility Rate per woman, IMR = Infant Mortality Rate per 1000 births, L.E. = Life Expectancy at Birth for both sexes combined, D.R. = Dependency Ratio per 100

Table 1 shows population size, main indexes of fertility and mortality including life expectancy at birth, and also dependency ratio (ratio of the young and the elderly to the working age population).

It is extremely interesting to see that there are quite remarkable variation of variables among 9 countries. Firstly, population size ranges widely from 3 million of Singapore to 1244 million of China. Secondly, population density per square kilometer is also remarkably unequal, only 2 persons per km2 in Australia, but Singapore terribly congested, showing 26,730 persons (See Table 2).

Table 2. GNP per head in Countries Surveyed in Asia, 1995 (US$)

Australia	18,720	Nepal	200
China	620	Singapore	26,730
Malaysia	3,890	Thailand	2,740
India	340	Viet Nam	240

Source: World Bank: 1997 World Atlas
(from PRB 1997 Sekai Jinko Data Sheet - Japanese version)

Thirdly, GNP per capita indicating stage of economic development is extremely high in Singapore and Australia, US$26,730 in the former and US$18,720 in the latter. However, lowest level is found in Nepal, US$200, and Viet Nam, US$240 (population density and GNP per capita are shown in Table 2).

Quite important findings are recognized. Theoretically noteworthy change is that conventional category of more developed and less developed defined by the United Nations is losing efficiency. For example, GNP per capita of Singapore is now exceeding that of Australia, who is a member of more developed group. Not only in terms of economic development level, but also fertility transition supports changing borderline between "more developed" and "less developed". Total fertility rate in the more developed countries is below replacement level without exception. Now, not only Singapore, but also China and Thailand have achieved below replacement level of fertility (See Table 1). In order to maintain statistical comparativity and consistency, United Nations data on demographic indicators were used here.

Cases of China and Thailand that have been rapidly industrializing, but still much lower level in terms of GNP per head than more developed countries, demonstrate that de-

mographic transition, in particular fertility transition, could be achieved even before mature economy. On the other hand, rapid decline in fertility facilitates reduction of mortality, and contributes to the elevation of human quality which could be effective in the promotion of economic development.

Some countries among less developed countries are retiring from their group, and practically joining in the more developed category in terms of demographic transition stage or/and economic development level. However, remarkable gap of mortality still remains, higher mortality among new potential more developed countries with the exception of Singapore. For example, in Thailand and China where total fertility rate has already went down to below replacement level which is universally recognized in the more developed countries, infant mortality rate is much higher, 32 per thousand births in Thailand and 44 in China compared with 7 in Australia. Life expectancy at birth which is more sophisticated in expressing general mortality situation, is much shorter in Thailand, 69.0 years, and China, 68.5 years compared with 77.6 years of Australia.

On the other hand, Nepal is typically less developed, characterized by very high fertility, high mortality and resulting high population increase rate. Remarkably, contrasting case is represented by Singapore which demographically and economically is equivalent to more developed countries. In between Nepal and Singapore, two groups are clearly distinguished in terms of demographic transition stage. One is represented by China and Thailand characterized by below replacement level of fertility. Another is countries who are in initial stage of demographic transition, characterized by still high fertility. They are India, Viet Nam
and Indonesia. Malaysia's situation is complicated. In terms of fertility transition, Malaysia is similar to those of Viet Nam and India, but more advanced in mortality improvement, approaching to Singapore level.

Number of countries responded by each government is only 9. But extremely interesting is remarkable diversity in terms of demographic indicators, reflecting interrelationship between socio-economic factors and demographic behavior which are changing under specific, individual conditions of each country. By looking into in detail, we can identify different stages of demographic transition. Policy makers would be able to find out development stage of their own countries, and to gain some suggestion of what policy programs are needed.

III. Summary of Country Reports

Australia

Australia is only one country belonging to the more developed group among surveyed countries. Australia is gigantic country in terms of size of land with a very small population. From the standpoint of population issue, their concern lies in immigration policy of labor force in order to promote economic development, but not in population control to slow down high fertility in all other countries surveyed.

There was net overseas migration gain of 979,000 people, accounting for approximately 43% of the total population growth over the period 1985-1995. The aging of population is another serious concern for the government. The proportion of the population aged over 65 is 11.2% in 1991, which is much higher than those of countries concerned, compared with lowest of 2.4% of Thailand and highest of 6.8% of Singapore. It is projected to be over 19% in around 2030 in Singapore. However, the level and pace of aging of population in Australia is lower and slower than most of European countries.

China

China is the most populous country in the world. China's mainland population reached 1.224 billion in 1996. This enormous population is about 21 percent of the world's population but only 7 % of the world's arable land. Crucial issue for Chinese government has been how to maintain balance between rapidly increasing population due to huge size of national population and food production to be able to support them adequately. Population control has been top priority of government policy. In particular, the government finally decided to embark on new policy of "One Child per One Couple" in 1979 which was never experienced in the history of humankind.

It is remarkably interesting to point out that China adopted new economic reform shifting to market economy just one year before the new population policy (1978). Surprisingly very rapid decline in fertility and population growth rate and rapid economic growth occurred almost simultaneously in parallel with each other. The total fertility rate

went down from 5.81 to the replacement level during the period, 1970 to 1996. The population increase rate also dropped from 2.58 percent to 1.04 percent in the same period.

On the other hand, China has been enjoying very high economic growth rate of around 10 percent per year. Higher level of living accelerates fertility reduction which is strongly supported and encouraged by the government.

Rapid industrialization brings about heavy migration, pulling tremendous people from rural to urban areas. According to the result of "380 Thousand Population Survey", there was 94.9 million migrants in 1992. It is estimated that 70-80 percent of them are from rural to urban areas, and 20-30 percent between provinces. The flow of migration in large numbers creates quite complicate problems, positive and negative. This is also another issue of population policy in China.

Finally, Chinese government has been aware of seriousness of population aging in near future which is probably expected to be more rapid than that of Japan.

Indonesia

Indonesia is also a country which has successfully achieved population control among Asian countries, with particularly specifically designed official integrated institution of family planning policy and programs (National Family Planning Coordinating Board, BKKBN). Indonesia is the largest country with population of 200 million among members of ASEAN, and ranks fourth among the most populous countries in the world.

The average annual growth rate was 2.34 percent between 1970 and 1980, but declined to 1.60 percent in 1997.

Basic reason of decline in fertility and population growth rate is effective family planning policy and programs based on community-centered principle and coordinated leadership of BKKBN established in 1970. In the early 1980s, the government launched the so-called "self-sufficient family planning" programs and also the enactment of the Law No. 10, 1992 on population development and the development of prosperous family greatly intensified the prevalence of family planning practice in terms of the number of clients and quality of practice.

Second issue of population policy in Indonesia is extremely unbalanced distribution of population, so-called transmigration policy to disperse population in Java island

where too many people concentrated, to outer islands such as Sulawesi, Kalimantan, Irian Jaya, and Sumatera. Indonesian transmigration program is given high priority among population policy in terms of national development strategy.

Malaysia

Population policy in Malaysia should be distinguished from other countries concerned here in terms of drastic change of policy. The global recession of the early 1980s and the vulnerability of Malaysia's small domestic market, coupled with the emerging labor shortage in certain sectors led the Government to shift to a new population policy in 1984. It is reflected in the advocation of a population target of 70 million by year 2100. Another one is the change of the name of the National Family Planning Board to the National Population and Family Development Board (NPFDB). More emphasis on family development, higher quality of life in terms of health and education, along with family planning project.

This new population policy seems to give pronatalist nuance by implication. It is argued that the target of 70 million to be achieved in 115 years (1985-2100) with an average growth rate of 2.4 percent is not pronatalist stand and also actually annual growth rate will decline faster than expected, and population is projected to plateau at 49 million by the year 2070, and then up down gradually because of continuing fertility decline.

Mortality decline is remarkable. Crude death rate in Malaysia declined from 5.3 per thousand population in 1981 to 4.6 in 1994, and infant mortality rate from 23.9 per thousand live births in 1980 to 11.1 in 1994. Maternal mortality rate declined from 0.6 per 1000 live births in 1980 to 0.2 in 1994. Naturally, life expectancy at birth extended from 68 years in 1980 to 70 years in 1994 for male, and from 72 years to 76 years for female in the same period.

Migration is also an important area of population policy in Malaysia. Internal migration dominated by young people has contributed to urbanization and industrialization. International migration, in particular massive workers from Indonesia and the Philippines has played remarkable contribution to economic development in Malaysia, but on the other hand there is emerging issues regarding social and economic treatment.

Singapore

Singapore is a city state. Population size is only 3.5 million, but highly developed. Population policy constitutes basic issue and consequently an integral component of Singapore's socio-economic development plan. Initially total fertility was very high at 4.5 births per woman, and provoked the government to implement population control. In 1972, the message "Stop at Two" policy was introduced, and social incentives and disincentives were introduced to reinforce the small family norm.

The TFR fell rapidly from 3.0 in 1972 to replacement level of 2.1 in 1975 and subsequently down to 1.8 in 1980. Singapore Government was seriously impressed with a rapid population aging and potential population decline resulting from rapidly declining fertility, decided to shift from population control to the New Population Policy (NPP), "Have Three, and More If You Can Afford It". A package of incentive measures to support this was introduced on March 1987.

Along with drastic change of population policy toward pronatalist direction, the Government appointed two high level committees on the Problems of the Aged in 1982 and Advisory Council on the Aged in 1988 to review the problem arising from population aging. Furthermore, in 1989, the National Advisory Council on the Family and the Aged (NACFA) was set up to advise the Government on issues relating to these groups.

Migration is closely connected with the size and growth of population. In the early pre-war years, net in-migration played an important role of rapid growth of population in Singapore. However, after the World War II, fertility become the principal factor of population growth, but unfortunately it went down to very little level. In recent years, however, there has been a steady increase in net migration surplus to Singapore. An average of about 22,000 permanent residents were accepted into Singapore yearly. Singapore will continue to attract qualified foreigners from all countries.

Thailand

Thailand is also one of the countries in Asia which has achieved successful fertility control and low population growth rate. Total fertility rate is already below replacement level of 1.98 per woman. Natural increase rate decreased to 1.1 percent.

However, Thailand maintained an essentially pronatalist population policy through the 1960s. The year 1970 was very important in terms of drastic change of population policy, because the government recognizing the serious impact of high population growth rate on economic and social development, proclaimed the national population policy to support voluntary family planning practice. Fertility decline gained momentum, bringing the TFR down to 3.5 per woman in 1984 and to 1.98 at present.

Migratory movement of population in Thailand is closely related with economic development. Bangkok is an example of overpopulation caused by tremendous immigrants from rural areas in Thailand.

There are no legal or administrative restrictions to geographical mobility of people. However, indirect policies aimed to affect the location and development of economic activities. For example, policies designed to promote economic growth outside of Bangkok, to discourage the expansion of industry within Bangkok, and to decentralize government services.

In the past, rural resettlement schemes played an important role of migration between rural and rural, but is now no longer a significant factor.

Government is now facing a turning point in the area of fertility control, more concern to family development including specific services in MCH/FP and improving family planning services.

Environment issue is also grave. Rapid economic growth associated with urbanization and industrialization has had serious implications for people's quality of life, natural resources and urban environmental situations.

Viet Nam

Viet Nam is a large country with population of 76 million in 1997. High population growth rate and its economic and social implications was perceived by the government of the North Viet Nam. So since 1960, fertility control along with MCH protection, education and woman's status was adopted.

After reunification of Viet Nam (1975), these policies, particularly family planning policy was expanded and strengthened. So called "Three late" slogan was emphasized. Late marriage, late first birth and late second birth (spacing) were encouraged.

In the decade of eighties, the government policy was strengthened in order to reduce fertility effectively. In particular, in 1984 the National Committee for Population and Family Planning was established as a ministerial organizations. Government aims to achieve replacement fertility rate of 2.1 children per woman in the next decade.

Family planning practice increased from 53% in 1989 to 64.9% in 1994. However, it is reported that abortion rate is very high.

Another important issue in Viet Nam is migratory movement of population within the country. From 1954 up to the present, Viet Nam maintained the policy to motivate people to migrate from some urban and rural areas which have high population density to some new economic zones in the north mountainous and Tay Nguyen. During the last 4-5 years, around 400,000-500,000 people migrated to Tay Nguyen areas. Another pattern of migrations is tremendous concentration of people in Ho Chi Minh city. About 600,000 people migrated from rural to live in Ho Chi Minh city.

Viet Nam is successfully achieving rapid economic development, and making efforts to deal with emerging issues between population and development.

COUNTRY REPORTS

AUSTRALIA

I. The Outline of Popn Problems of Australia

* A Profile of the Australian Population

The following profile of the population draws heavily on the Australian Bureau of Statistics publications: *1966 Census of Population and Housing : Selected Social and Housing Characteristics (2015.0), Australian Demographic Trends 1997 (3102.0) and The Australian Institute of Health and Welfare's publication 'Aged Care Services in Australia's States and Territories' (1996) by Sushama Mathur.*

General

The 1996 Census counted 17,892,423 people in Australia on census night. Of this total, 50.5% of people were female and 49.5% were male. The median age of the population was 34 years of age with 21.6% of the population aged between 0 and 14 years, 14.5% aged between 15 and 24 years, 30.8% aged between 25 and 44 years, 21% were aged 45 to 64 years and 12.1 were aged over 65. The highest median age was in South Australia (35 years) whilst the lowest median age was 29 years in the Northern Territory.

Home Ownership rates varied significantly across Australia in 1996 with 43.7% of Victorians owning their own home. Other high figures in this category included 42.5% in New South Wales and 42.4% in Tasmania. The Jurisdiction with the lowest rate of home ownership was the Northern Territory recording a rate of 17.8%. With respect to the Proportion of people in the process of purchasing their own dwelling both the ACT and Western Australia recorded the highest rates with rates of 34.5% and 29.8% respectively.

The median rent paid per week in 1996 was $123 per week and again there were significant variations in this category across Australia with the ACT ($150) and NSW ($140) being the highest and Tasmania ($90) and South Australia ($90) being the lowest. The median monthly housing loan repayment for Australia as a whole was $780 with the ACT recording the highest repayment ($923) and Tasmania ($585) the lowest.

In terms of income, the median personal weekly income for Australia was $292 with the highest equivalent figures being recorded in the ACT ($430) and the Northern Territory ($358) and the lowest in Tasmania ($257) and South Australia ($267).

The vast majority of the population (73.9%) were born in Australia and of those born overseas, 36.2% were born in the United Kingdom, Ireland and New Zealand. A total of 352,970 people identified themselves as being of indigenous origin, with 55.8% of those people living in New South Wales and Queensland. The importance of immigration to the development and growth of Australia's population is illustrated by the fact that over the period 1985-1995 there was net overseas migration gain of 979,000 people, accounting for approximately 43% of the total population growth over that time. (*Australia's Population Trends and Prospects 1996 : Department of Immigration and Multicultural Affairs p xv*).

The Aged Population

The usual measure of just how aged a population is (the proportion of the population aged over 65 years of gae) varied significantly across the eight political jurisdictions. Whilst the proportion of aged over 65 years was 12.1% for Australia as a whole the equivalent figure for each of the States and Territories was as follows : New South Wales 12.7%, Victoria 12.0%, Queensland 12.0%, South Australia 13.8%, Western Australia 10.5%, Tasmania 12.3%, Northern Territory 4.9% and the Australian Capital Territory 7.1%.

For a more detailed breakdown of the aged population it is necessary to analyse figures released by the Australian Bureau of Statistics in 1994. The following Table (from *Aged Care Services in Australia's States and Territories - Sushma Mathur : Australian Institute of Health ad Welfare 1996 p.3*) shows in detail the proportions of aged people in various age categories above 65 years. In 1994 there was a total of 2,109,047 persons in Australia aged over 65 years of age.

Table 1. Aged Persons, Proportion of the Total Population by Age, 1994 (per cent)

	65-69	70-79	80+	Total Aged
New South Wales	4.0	5.8	2.6	12.4
Victoria	4.0	5.5	2.6	12.1
Queensland	3.7	5.2	2.	11.3
West Australia	3.4	4.6	2.2	10.2
South Australia	4.3	6.3	2.9	13.6
Tasmania	4.0	5.9	2.6	12.4
A.C.T.	2.5	3.2	1.2	6.9
Northern Territory	1.3	1.3	0.4	3.0
Australia	3.9	5.5	2.5	11.8

Table 1 clearly shows that the two Territories had by far the smallest proportion of their populations in the aged categories, whilst of the States, South Australia had the highest. For policy makers the age group of particular relevance is the 80+ group as it is from this cohort that the most demand for services and assistance comes. As the Table shows only 2.5% of the population were in this latter category in 1994.

— Quoted from Greg McIntosh, "Ageing and Population in Australia", Information and Research Services, Department of Parliamentary Library, pp5-7, September 1997.

II. Specific Issues of Population Policy of Australia

1) Fertility and Related Issues

a) Any specific population policies (growth or control)

Australia does not have any specific population reproductive control or growth policies.

b) Family planning

The Family Planning Program provides direct Commonwealth funding to selected

non-government organisations, including Family Planning Organisations in each State and Territory, to provide a comprehensive range of information, community education, professional training, counselling and clinical services in sexual and reproductive health to the Australian community. Family Planning services are available at low or not cost to all Australians. The majority of clients are women. The average fertility rate in Australia and the decline in the numbers of women having abortions indicates Australian women and men have good access to family planning options.

c) Any specific policies on marriage or related issues

Australia does not have any specific policies aimed at controlling the rates of marriage, however it does have laws concerning who can get married.

2) Mortality

a) Infant Mortality

In Australia we do not have any major policies addressing maternal of infant mortality, however we do have services that ensure that women who are pregnant have a high level of services and that these services are also provided for the new-born child.

Infant mortality for the general population is approximately 8 deaths per 1,000. Although low by world standards, this rate is almost twice that of the world leader, Japan. Major causes of infant death are related to low birth weight and prematurely, sudden infant death syndrome and non accidental injury. Efforts to reduce low birth weight and premature delivery are directed at high quality and accessible antenatal care, education on the effects of tobacco, alcohol and other drugs on pregnancy outcome, and a reduction in the number of infants born to young mother through the availability of education and access to contraceptive advice.

The Aboriginal and Torres Strait Islander infant mortality rate is two to four times higher than the rate for the total Australian population. The major causes of death are similar to the general population of infants but are exaggerated by poor social circumstances and a greater number of infants born to very young mothers.

b) Maternal Mortality

On crude mortality data, bearing a child in Australia is not hazardous. Maternal mortality, as a direct result of pregnancy, for the triennium 1988-90 was 4.9/100,000 pregnancies. Australia enjoys a very high standard of obstetric services, and prenatal outcomes rank amongst the best in the world, although there are some groups in the community which fare substantially less well than the majority. Those with poorest outcomes include some migrant groups, Aboriginal and Torres Strait Islander women and women of low socio-economic status.

Efforts to reduce indigenous maternal mortality and morbidity have included the establishment of culturally appropriate birthing centres (which also provide prenatal care), the training of indigenous health workers and the funding of a network of community-controlled primary health care services at a local level.

c) Infectious Diseases, HIV/Aids

Australia has a number of mechanisms in place to address communicable diseases. Central to these is the Communicable Diseases Network Australia-New Zealand (CDNANZ). This body was convened in 1990 to improve the control of communicable diseases at the national level. Membership of the network comprises representatives from all States and Territories, the Commonwealth, several other government and non-government organizations and expert epidemiologists.

The CDNANZ meets fortnightly by teleconference to discuss communicable diseases activity throughout Australia. During outbreaks of national significance more urgent matters are dealt with by special teleconference. Other activities of the CDNANZ include the enhancement and coordination of several national surveillance systems, in particular the National Notifiable Diseases Surveillance Scheme, and the co-publication with the Department of Health and Family Services of *Communicable Diseases Intelligence*, A fortnightly surveillance bulletin which provides a mechanism for the dissemination of information pertaining to the surveillance and control of communicable diseases.

The National Communicable Diseases Surveillance Strategy (NCDSS) was recently developed to enhance the national capacity for a strategic approach to public health threats posed by communicable diseases. The Strategy emphasises the need for the planning and prioritisation of interventions, the optimal use of laboratory science in communicable disease management and the availability of an effective response capacity

for outbreaks of national significance.

The NCDSS has now entered the implementation phase. One of the initial tasks of the NCDSS Implementation Group was the establishment of the first national Vaccine Preventable Diseases Research and Surveillance Centre. The Centre will facilitate improvements in the research and surveillance of vaccine-preventable diseases in Australia and provide policy advice to the Department of Health and Family Services.

Australia's response to HIV/AIDS, often characterized by its enlightened pragmatism, is widely acknowledged as one of the best in the world. This success has been built upon three elements that have been vital parts of Australia's first two National HIV/AIDS Strategies.

The first element is that although HIV/AIDS has always been regarded as primarily a public health and medical problem and has been responded to as such, its social policy dimension and impacts, however, have also been accorded high priority in public policy. Australia's response to the epidemic has been guided by the best available medical and scientific information and enlightened pragmatism. Public policy and public health measures have had as central components innovative approaches such as harm minimization and community-based responses to effective education, treatment and care.

The second element has been to ensure that policies are based on developing, fostering valuing and strengthening partnerships throughout Australia. The principal partnership has been between governments, community-based organizations, affected communities, health professionals and researchers, all working together and learning from each other in developing appropriate policies. But other partnerships - between governments at all levels, between governments and various community organizations, between medical and non-medical groups, between a multiplicity of voluntary and community-based organizations, between educational authorities and the media, and so on - have also been crucial to our national effort and success. The role of people directly affected by the virus, especially HIV-positive people, their carers and organizations, has also been recognized and valued.

The third element is that non-partisan political support has been given to our efforts, and consensus has underpinned the development of appropriate public policies. This has allowed those policies to display national leadership and to be innovative, often daring, in their scope.

The third National HIV/AIDS Strategy 1996-97 to 1998-99 (Partnerships in Prac-

tice) maintains and reinforces the vital elements of the previous National Strategies and adopts the principal recommendations put forward in the evaluation of the second National Strategy - Valuing the Past...*Investing in the Future: evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96* (known as the Feachem report). The third National HIV/AIDS Strategy 1996-97 to 1998-99 extends the successful approach to HIV to other diseases which are spread through similar risk behaviours and affect similar target groups. Other sexually transmissible or blood-borne diseases such as hepatitis C are markers of the prevalence of risk behaviours in the community. HIV/AIDS remains the prime focus of the response in the third National Strategy and provides direction for the approach to the related diseases.

The implementation of the third National Strategy will continue to rely on strong cooperation between the State, Territory and Commonwealth Governments. It will allow the flexibility required for the different States and Territories to respond to the specific shape of the epidemics which they face. At the same time, the third National Strategy provides a framework to ensure consistent national standard are reached. The Commonwealth will continue to take a strong leadership role in the response to HIV/AIDS in Australia.

3) Population Structure

a) Progress of ageing of population in Australia

Population ageing raises important considerations for Government policy, particularly in the area of health and welfare outlays. We need to plan carefully now to implement economically sustainable systems for the future. We need to put in place systems which assist self-provision and allow older people to maximise their participation in the community.

However, this issue must be put in context. In the last twenty years, from 1971 to 1991, Australia experienced a 79% increase in its aged population: after Japan, the most rapid rate of increase in the developed world. It did so at a time when Government services were rapidly expanding, without causing major social or economic dislocation. In Australia, the rate of growth in the aged population is now falling, with a projected increase of 48% between 1991 and 2021.

Background Information on Population Ageing

The total population of Australia is projected to grow from around 17.3 million in 1991 to just under 23.9 million in 2031, an increase of around 38%. Over the same period, the proportion of the population aged over sixty-five is projected to grow from 11.2% in 1991 to over 19% - from under two million Australians aged over sixty-five in 1991, to over five million in around 2030. However, this is lower than the growth in the aged population experienced in the last 20 years, which was a massive 79% between 1971 and 1991.

Of more immediate concern for health and aged care spending is the rising proportion of very old people, or those over eighty. This group is expected to increase by 49% between 1991 and 2001, after which its growth rate also tapers off. However, the absolute numbers of people in this group are small, rising from 384,000 in 1991 to a projected 572,000 in 2001.

The growth in Australia's aged population is from a younger age profile than most developed economies, which already have much higher proportions of people aged over sixty-five and particularly of people over eighty. The next several decades will see Australia's age profile catch up with that of most other developed nations.

The dependency ratio is often used by economists to measure the proportion of children and old people compared to the proportion of people of workforce age. A more useful measure is the proportion of people aged over sixty-five to people who are working, including those over sixty-five. This measure omits children and also allows for the effect of changes in workforce participation, for instance by married women. This "age/workforce" dependency ratio is projected to remain steady from 0.28 in 1994-95 to around 2006, before rising steadily to 0.42 in 2024-25.

b) Responses to population ageing and growth in health and welfare outlays

The Government has implemented a comprehensive range of policies to ensure that growth in health and welfare outlays is sustainable and that Australians will be able to maintain or improve their current living standards through the decades of population ageing ahead. Some of these policies are outlined below.

Retirement Incomes Policy

Australia provides a flat-rate non-contributory age pension for Australian residents, payable to men over 65 and women over 61 (women's pension age is being progressively

raised to 65 in 2013). It is income and assets tested. Pensioners also receive additional assistance with pharmaceuticals and other concessions, and rent assistance if renting privately. Age pension is indexed to movements in the Consumer Price Index and Male Total Average Weekly Earnings. The Government has recently introduced legislation to ensure that age pension does not fall below 25% of Male Total Average Weekly Earnings.

In addition to the publicly provided age pension, Australia has a compulsory superannuation system which ensures that those in the workforce accumulate private savings for retirement. In 1995, 86% of men and 89% of women in full-time employment were covered, as were 49% of men and 66% of women in part-time employment. As a result of these superannuation arrangements, most Australian workers will receive a significantly higher income in retirement than the age pension alone could provide.

A number of initiatives have been introduced to improve the level of choice and competition in superannuation. The total value of superannuation assets in the Australian economy has increased from around $40 billion in 1983 to around $270 billion by the end of 1996.

Health Care and Healthy Ageing

Recent reforms to the Australian health care system have focused on improving the sustainability and efficiency of the acute care sector, for instance through casemix funding and improved incentives for private health insurance. All Australians are covered by the public health insurance scheme, Medicare, for medical and public hospital treatment, and compulsory community rating for private health insurance ensures that such insurance is affordable for many older people.

There is a strong focus on public and preventative health, and a number of Government initiatives to promote healthy ageing. Under the Commonwealth Government's Healthy Seniors Initiative, a range of projects will be funded which encourage good health and well-being for older Australians. The Healthy Ageing Taskforce, established by Health and Community Services Ministers in October 1996 and comprising members of the Commonwealth and each State and Territory, is developing the strategic framework for healthy ageing in Australia. State Governments, the Public Health Association (Australia) and the Australian Coalition 99, an Alliance of advocacy groups and aged care providers, have also developed initiatives in this areas, and healthy and positive ageing will be the centrepiece for public action in the forthcoming International Year of Older Persons.

Long Term Care

The Australian Government announced in its 1996-97 Budget a major package of structural reforms to long term care which will put the system on a sustainable footing through the decades of population ageing ahead.

These reforms build on the needs-based planning framework which has operated in Australia since 1985, which has implemented a ratio of residential care provision of forty nursing home places, fifty hostel places and ten care-managed Community Aged Care Packages per thousand people aged seventy or over.

The needs-based planning framework has ensured that the proportion of GDP spent on aged care has grown less in the last ten years than the rate of growth in the target population (people over seventy). This expenditure control has not been at the expense of quality or access to care. Outcome standards have ensured improvements in the quality of residential care, while a massive expansion of hostel and community services has allowed a greater proportion of people aged over seventy to access aged care services.

The Government is maintaining a 6% real rate of growth in community care funded through the Home and Community Care Programme. To guarantee the sustainability of the Programme into the future and to assist with the expansion of services, the Government is working to implement a nationally consistent and equitable user charges policy.

Better targeting, with gatekeeping and referral by Government-funded multi-disciplinary Aged Care Assessment Teams, has ensured that people only stay in residential care for as long as they need it, so that the proportion of people over seventy entering nursing homes has increased despite strict control of bed numbers.

Government funding arrangements are based on degree of dependency, providing strong incentives to care for those with higher needs.

However, the Government recognises that the program has to be sustainable both in terms of the quality of care it provides and the level of taxpayer support it receives, in the context of population ageing. The Government's package of structural reforms for residential aged care will ensure that older people in nursing homes and hostels, like everyone else in the community, make a fair and reasonable contribution to their accommodation and other living costs in line with their capacity to pay.

From 1 July 1997, the nursing home and hostel systems will be merged into a single residential aged care programme, with a single and much simpler funding system and regulatory framework. User charging arrangements in nursing homes and hostels will be

aligned, with the extension of the hostel entry contribution system (refundable capital deposits on entry) to nursing homes and the introduction of income-testing for all residential care subsidies.

It is, however, vital to protect the financially disadvantaged and those who cannot pay. Under the new user charging arrangements, older people will not have to pay more than they can afford. For instance, people receiving income-tested Government pensions who have little other income will pay only the basic resident contribution and will not have to pay additional income-tested charges. Access to care is protected for people who cannot pay entry contributions to residential facilities, with facilities being required to take a set proportion of such residents and receiving a higher Government subsidy for them.

Carers

In Australia, we recognise that the great majority of care is provided by family carers. The Government has been working with carers to improve assistance including through the income-tested Carers Pension and the Domiciliary Nursing Home Benefit, which provides assistance for people caring at home for those with nursing home level care needs. We have established a National Respite for Carers Program, with Carer Resource Centres across Australia, providing more assistance to carers and better co-ordination and improved funding for respite care.

CHINA

I. The Outline of Population Problems of China

1) The Current Demographic Situation

China is the most populous country in the world. By the end of 1996, the population on China's mainland had reached 1.224 billion. As a developing country with a large population but a fairly poor economic foundation and relatively inadequate natural resources, China has to support 21 percent of the world's population on only 7 percent of the world's arable land.

The basic features of the population are its enormous size, large growth and uneven regional distribution. During the 47 years from the end of 1949 to the end of 1996, the population on China's mainland more than doubled. According to the data of the Fourth Population Census of 1990, people aged 0-14 made up 27.70 percent, those aged 15-59 made up 63.71 percent and those aged 60 and over made up 8.59 percent of the total population, and 27.10 percent of which were women of childbearing age. The median age of China's population is 25.25 years. This age structure indicates that China's population will continue to grow into the next century.

China's population is very unevenly distributed: 94 percent of the population live in the south-east part of the country, which represents only 46 percent of China's territory. About 73 percent of the population live in rural areas. The population density in 1990 was 118 people per square kilometer.

Coupled with sustained economic growth in the past 15 years or so, China has seen a steady fall in her population's natural increase rate. This has greatly reduced China's population pressure upon its socio-economic development and gained experience in keeping the population growth balanced with socio-economic development. With this achievement, China has, to some extent, made her due contribution to the stabilization of the world population.

Nevertheless, China is still confronted with a grave population situation. With an ever-widening base figure of the population, China sees about 21 million births annually,

with an annual net increase of more than 13 million people. It is estimated that the total population on China's mainland will reach 1.3 billion by the year of 2000 and will reach 1.5 billion around the year 2030.

2) Population and Family Planning Policies of China

With a view to promoting the economic and social development and to ensuring the people's right to a better life, the Chinese Government has adopted the promotion of family planning to control the population quantity and improve its quality in terms of health and education as one of its basic national policies since 1979. The Constitution of the People's Republic of China stipulates, inter alia, that the State promotes the practice of family planning so that the population growth may be in balance with socio-economic development (Article 25), and that both husband and wife have the obligation to practice family planning (Article 49). Moreover, the Law on Protection of Rights and Interests of Women of the People's Republic of China also stipulates that women have the right to child-bearing and have also the freedom to have no children.

China's current policy on family planning includes the following main points: (1) to promote late marriage and later, fewer and healthier births; (2) to encourage each couple to have one child; (3) to persuade rural couples who have difficulties in having only one child and wish for a second child to have proper spacing; (4) to let the governments of various provinces or autonomous regions adopt, in line with local condition, their own specific rules on and approaches to family planning in areas of ethnic minorities under their respective jurisdiction.

China's population programme aims at keeping annual population growth rate below 1.25 percent in the 1990-2000 period, maintaining fertility rate at the replacement level (TFR2.1) and limiting its total population within 1.3 billion by the year 2000.

In the implementation of the national family planning programme, the principle of combining Government's guidance with people's voluntariness has been adhered to, and any form of coercion is opposed. Family planning goals and objectives are formulated and set by the State and provinces through legislative procedures and are then explained through extensive publicity and education to the people. In this way the people have adequate information on which to base their own decisions. To advocate "one couple one

child" does not mean that all couples should have only one child under all circumstance. There exist in China great differences in economic, cultural and educational backgrounds, and the concept of childbearing among different groups varies. When setting their goals and policies, the Central and lower level governments take into consideration both the requirements of the national socio-economic development plan and the degree of people's willingness and acceptance. Generally speaking, the policy is more flexible in rural areas than in urban areas, and for ethnic minority groups than among the Hans. Couples in rural areas usually have two children. In urban areas, it is easier for couples to respond to the call of the Government and enjoy more social welfare benefits. Moreover, in urban areas, it costs more money to raise and educate a child. High employment and better social security plans also contribute to the high proportion of one-child families in urban areas. In rural areas, however, the family planning programme encounters more difficulties. A number of factors contribute to farmers' desire for more children: labour-intensive farming methods, low agricultural productivity, lack of old age support, traditional ideas about childbearing, comparatively high infant mortality, and low levels of education. Nevertheless, at present, the family planning policy does enjoy the understanding and wide support of the people because it coincides with their basic interests and has taken into account their wishes and levels of acceptance.

3) A Brief History of Population Policy and Its Characteristics

The Chinese Government has gone through a long process in the understanding of the issues of population and development. In 1949, when the people's Republic of China was founded, China had a population of 540 million. This total grew rapidly because of the pro-natalist population policy which resulted in a high birth rate and because of the decline in death rate resulting from the rise of the standard of living, improvement of medical and health services, increased production and social stability. Starting from mid-1950 and in the 1960s, problems associated with rapid population growth and development began to appear. The Government began to call upon people to practice family planning and promote the use of birth control measures. Abortion was legalized around the same time. However, the seriousness of the population problem was under-estimated and no clear-cut population policy or systematic family planning programme was formulated. Further-

more, by 1969, China's total population reached 800 million and the total fertility rate was 5.7. In the early 1970, the Government began to learn that rapid population growth had exerted an negative impact on social and economic development and started to initiate a family planning publicity campaign throughout the country providing free contraceptives and birth control technical services to all the people. It also began to incorporate the programme of population development into the national programme of economic and social development. During the 1970s, China formulated a family planning policy of promoting delayed marriage, longer birth spacing and fewer number of births, and its total fertility rate fell from 5.7 to 2.7. However, projections showed that with a young population structure, a birth peak would come in the middle of the 1980s. China's population would still grow at a rapid speed and would total 1.3 billion before the year 2000. This realization resulted in the tightening of the population policy in 1979. In the early 1980s, the Government has further established that the practice of family planning, the control of population growth and the improvement of population quality in terms of health and education to be one of the basic national policies and which was written into the Constitution of the People's Republic of China.

II. Specific Issues of Population Policy of China

1) Fertility and Related Issues

In the past more than two decades, the Chinese Government has made unremitting efforts to push ahead efficiently with the implementation of its population and development programme. During the period from 1970 to 1996, the total fertility rate went down from 5.81 to the replacement level, with a drop in birth rate from 33.43 to 16.98 per thousand and the rate of natural increase from 2.58 to 1.04 percent.

The major measures to promote family planning are summarized as follows:

— *Strong commitment from Governments at various levels;*

The government officials are required to play a key role in the promotion of family planning. The governments at various levels incorporate population programme into their overall plans for socio-economic developments. All government officials,

especially those in leading positions, are required to take the lead in practicing family planning.

— *Information, education and communication (IEC) as the first priority of the family planning.*

An extensive information, education and communication programme has been carried out to enhance the people's awareness of the importance and skills of practicing family planning. At present, the IEC programme is focused on interpersonal communication and counseling.

— *Safe, effective and easy-to-use contraceptives and family planning services provided for people of childbearing ages.*

Most of these service are free of charge to users.

— *Integrated approach for family planning programme.*

The Government's integrated approach combines the family planning activities with the development of rural economy, eradication of peasants' poverty and realization of their family happiness through providing better services in production, family life and childbearing.

— *Improvement of women's status.*

Women have played a major role in the implementation of family planning programme. The experience from the developed east coastal areas shows that it is essential to eliminate all practices of discrimination against women and help women to be economically independent through education, skill development and employment. This is the key to the final success of the family planning programme. Since the promulgation and implementation of the Mother and Infant Health Care Law, the Government has further stressed that abortion of female foetuses by use of technologies to determine foetal sex must be strictly banned in accordance with the law.

An important task for China family planning programme at present is to stabilize the low fertility level already reached. This is actually much more difficult than bringing down the fertility level in the past. The difficulties exist mainly in rural areas, especially in those poor rural areas, where the traditional believe on childbearing is still strong, and the phenomenon of early marriage and early childbearing still exists. In some areas, there is still such a phenomenon as a vicious circle of " the poorer the more births, and the more births the much poorer". There is still a certain gap between the rural people's desire for

more children and the nation's long-term interests and the government's policy requirement.

2) Mortality

The programme of mortality reduction has achieved notable success. The crude death rate has been dropped from about 20 per thousand in 1949 to 6.56 per thousand in 1996, maternal mortality declined from 1,000 per 100,000 in 1949 to 67.3 per 100,000 in 1993, infant mortality dropped from 200 per thousand in 1949 to 31.4 per thousand in 1995. The life expectancy at birth increased from 35 years in 1949 to 70 years in 1995.

The major strategies of the programme are as follows:

— Establishment of the primary health care system throughout the country to meet the basic needs of the people in medical and health care;

— Implementation of the planned immunization programme to improve the health care for children.

— Improvement of the people's living standards and especially their patterns of food consumption to decrease morbidity and mortality caused by malnutrition.

— Strengthening of preventive health services and of public health management to control endemic and infectious diseases as they are threatening the people's lives.

It is particularly necessary to point out that as China is still a developing country, primary health care, including reproductive health care has not yet been popularized in vast rural areas. There are still many women who fail to get adequate maternal and child health care and family planning services. Some women with reproductive tract infection can hardly receive treatment in time due to limited medical conditions. In the poor areas of China's Midwest, there are still about 58 million people living under the poverty line, most of whom are women and children.

The prevention and treatment of STD/HIV/AIDS is an important aspect of reproductive health. Since 1987 a National Programme on HIV/AIDS Prevention and Control has been implemented. A new national strategic plan was formulated for 1995-2000 to serve as a guide for developing, implementing and evaluating workplans for management and prevention of STDs and HIV/AIDS.

The STDs incidence has increased in the past 10 years. HIV infection and AIDS

have also spread to a certain extent in some areas. Therefore, extensive public education has been conducted through television and other mass media to increase awareness of the harmful and disastrous consequences of HIV infection and AIDS and associated fatal diseases at the individual, community and national levels. In recent years, the counseling activities for prevention of STDs, HIV infection and AIDS have been gradually carried out, with relevant services of treatment offered so as to improve sexual and reproductive health and prevent wide transmission of such diseases.

3) Migration

a) Internal migration

According to the result of "380 Thousand Population Survey", which was conducted by the State Family Planning Commission of China, there was 94.9 million migrant population in China in 1992. Some researches showed that the total number of migrant workers was about 50 million. In China, people move mainly from rural villages to cities and towns and from economically less developed areas to more developed areas, largely within the boundary of provinces. It is estimated that 70-80 percent of them are from rural areas to urban areas, and 20-30 percent between provinces. Since the 1980s, China's economic development has accelerated the process of her urbanization with a great increase of migratory population. This has had positive impacts upon socio-economic development. But, some blind and disorderly movement of such a population has also brought about certain adverse effects upon employment, public security, public health and family planning matters. The flow of migration in big numbers, especially the flow from rural to urban areas is quite a complicated problem, which remains to be solved through further investigations and studies.

The Government policy on the rural labour force is to have it absorbed locally through the active development of the township enterprises as well as the non-agricultural industries. Such a development has created a basis for transforming the surplus agricultural labour force to other industries. In the meantime, efforts are being made to strengthen agricultural productions in order to create more opportunities for absorbing and utilizing the rural labour force.

b) International migration

International migration is only in very small numbers. The overseas Chinese was estimated at 22.18 million in 1986. However, since the early 1980s, emigrants from mainland China have been increasing. In recent years, emigrants from mainland China to foreign countries, Hong Kong and Macao is about 100,000 each year. Labour force emigration takes the most amount in recent years, cultural emigration takes the second. The source of emigration are mainly in the Eastern coastal provinces where economy and culture are more developed. Meanwhile, immigrants are estimated at 346,000, that is about 25,000 each year.

In accordance with the basic principles of the ICPD Programme of Action and the relevant international instruments concerning the solution to the issues of international migration, China has, in the recent two years, made great efforts to further improve her laws and regulations relating to international migration. It is worth mentioning in particular that all the exit and entry formalities were simplified last year, making things more convenient for people going abroad and coming back to the country for the sake of study, employment and tourism. This is conducive to international exchanges and also helpful to economic construction in the country. While encouraging the students abroad to return to serve their motherland, the government has also further improved the policy of "freedom of coming and going". In this way, with respect for the individuals' rational efforts to seek new opportunities in life, it can bring their efforts as such into line with international laws, making international migration an orderly process with positive consequences for development.

International migration concerns the sovereignty of the relevant countries and the migrants vital interests. Therefore, Chinese Government believes that in dealing with issues of this area, there should be full respect for the sovereignty of countries of destination, including the right to control the migrants' entry into their countries. Besides, it is essential to respect the basic human rights of migrants, including undocumented migrants, ensuring protection for them against racism, ethnocentrism and xenophobia. It is particularly neçessary to take care to ensure the personal safety of undocumented migrants under special circumstance, so as to avoid any possible tragedies.

4) Population Structure

The age structure of the total population in China has been changed fundamentally since the early 1950s, due to the rapid decline in fertility, and reinforced by continued decline in mortality. The population ageing has become a crucial problem for China.

In 1994, the elderly population aged 60 and over was about 103 millions and their proportion was 8.8 percent. This proportion will be over 10 percent of the total population and the elderly population will be around 150 millions by the year 2000. China is the first country to have its aged population exceeding 100 million, the largest number of the aged people compared with those in all other countries of the world.

The Chinese Government has promulgated laws and regulation for the protection of the legal rights and interests of the elderly people and thus pursuing such goals that "the elderly are financially supported, medically looked after, meaningfully occupied, culturally updated, and recreationally amused".

— At present, organizations on senior citizen affairs have been established in the majority of the provinces and countries. A service network linking together academic institutions and civic organizations for the aged people has been set up.

— Retirement pension systems are being established in cities. After retirement, retirees from the government and the enterprises are entitled to a pension, and the bulk of the their medical expenses are defrayed by their original departments or enterprises.

— Family member are asked to fulfill their obligations to continue looking after their elderly folks. Mutual help and mutual supports amongst relatives and neighbours of the elderly people are encouraged. In rural areas, a system of "five guarantees" that is, the guarantee of provision of food, clothing, lodging, medical care and funeral expenses, is practiced to assist those childless elderly who lost working ability and who have no source of income.

— Rural social security systems are being set up or improved. Rural insurance system for the elderly is being experimented in economically more developed areas, and to date about 1000 counties in the country have established such a system. In addition, the Chinese People's Insurance Corporation has established long-term life-insurance and other old age insurance schemes in rural areas as supplementary measures to the old age social insurance scheme.

It is stipulated by China's Constitution that grown-up sons and daughters are obliged to support their parents. Up to now, the governments of provinces, autonomous regions and municipalities have formulated their regulations and rules to protect the legal rights of the aged.

Facing the enormous size and large growth of the elderly population, and appearance of the aged society with a fairly poor economic foundation, the increasing demand of social support for the aged population will become a big problem to the society.

To deal with this problem, a comprehensive proposal is being raised by the Government department concerned, and of which the main points are as follows: to make full use of the "Golden Period of the present low dependency ratio and earnestly accelerate economic development; to improve and strengthen a comprehensive population programme; to set up a social security system for the aged; to continuously advocate the support for the aged by family and grown-up sons and daughters; and to give full play to the positive role for the elderly people after their retirement.

III. Future Strategies

China has made notable achievements in its population programme, yet it is still confronted with many knotty problems caused by the present population situation. In the light of the Programme of Action adopted at the International Conference on Population and Development (ICPD) held in Cairo in 1994, China is determined to make tremendous efforts in various ways to reorient its population and family planning programme.

At the end of 1995 the SFPC officially announced that China's family planning programme is to undertake two major changes, namely, a change from focusing on family planning alone to an integrated approach that combines FP with socio-economic development; and a gradual change from the mechanism of social restriction to a service-oriented mechanism based on publicity and education, scientific management and delivery of multiple services coupled with social interaction.

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INDONESIA

Indonesia's Vision on Population Development

With an estimated total population of 200 million today, Indonesia ranks fourth among the most populated countries on this planet. The average annual growth rate between 1970 and 1980 was 2.34 percent, the growth rate between 1980 and 1990 declined to 1.97 percent, and in 1997 the growth rate is estimated to decline further to 1.60 percent. These achievements were resulted from the considerable success through multiple stage of development in population and family planning programs which have paved the way for a different direction for the future.

The Government of Indonesia is very concerned with the broader aspects of population development. Family planning and family development have been developed as part of its total development program. Such a focus has produced a major change of orientation not only for the government, but also for communities and for the families themselves. The institution of the family, its development, its improvement, its future is now the core elements of the government's emphasis, the government's plans, and strategies as signified by the enactment of the Law No.10, 1992 on Population Development and the Development of Prosperous Family.

The population growth rate is expected to decline, even further, although there will still be the tendency of the total population to increase. But, the population growth and improvement of its quality are very strategic outcomes since the Indonesian people must become reliable and dependable human resources for the national development. With the high level of capability, the large young population will become a valuable asset for the nation building. Indonesia no longer perceive the family as the institution that receives all of benefits from the society. The family, in this new locus, to become agent of development. The family is viewed as the recipient as well as the doers of the development. The program is not solely for the benefits that recipients receive, such as contraceptives and small family size, but also for the development of ways of providing other benefits to families such as family income. Empowerment of the family is, of course, one of prominent elements of Indonesian Population and Family Planning Policy.

Indonesia pursues the quality of the family through three types of intervention : re-

productive health, family resilience and economy of the family. The family is required to develop cooperation in partnership with other families, business groups, banks and other private sectors to have an access to funds. The modern way of life which has been encouraged is a transfer of modern urban ways of life to the village (Bangga Suka Desa) will include economic activities associated with agribusiness and agroindustries.

I. The Outline of Population Problems of Indonesia

1) The Current Demographic Situation

In view of its significant achievements in dealing with population issues within the past twenty five years, almost all of insurmountable problems were reversed, and a major transition has occurred. Despite the fact that Indonesia is primarily facing some major population issues.

The first issue is a continuing high rate of population growth. Indonesia is still facing a challenge of large and diverse population with a growth rate of 2.8 and the total fertility rate of 5.6. In addition, the working age population will continue to increase rapidly that leads to an increase of the labor force. An increasing life expectancy of the people results a significant increase of aged population. In 1997 Demographic and Health Survey, the total aging is about 4.6 percent of the total population.

The second issue is uneven distribution of the population among the regions. The population is still concentrated on urban areas with an estimate that 31 percent of the total population. Redistribution of the population is considerably implemented through transmigration and regional development programs.

The third issue is relatively low quality of the population. This will undoubtedly determine the productivity and the capability of the people in improving the quality of life.

2) The Basic Concept of Population Policy

Large population, high growth rate, and an uneven distribution of the population are some distinct characteristics of Indonesia's demographic features. The main Indonesian population policy is to control the size and the growth of the population, to enhance the quality of the people through mutual help, within a spirit of national unity, and to direct the population mobility. The population development is directed towards improving the standard of life, capabilities, knowledge, and a variety of support programs. The family becomes both the object and subject of development efforts, and therefore all action programs dealing with population are based upon the existence and the well-being of the families.

The population growth is expected to decline through the family planning program as well as to decrease the death rate, especially the death rate of the children under-five through integrated health and family planning services. Population distribution and its mobility must be relevant to the environment capacity through transmigration program, infrastructures to support economic growth at the target areas, providing the labor incentive infrastructure and promoting job training so that new job seekers can take advantage of the newly created employment opportunities.

3) A Brief History of Population Policy

The government's population policy changed dramatically. Indonesia had adopted a pronatalist policy for about two decades after independence, and then declared an anti-natalist policy. Despite the fact that Indonesian Planned Parenthood Association, a private organization, has silently promoted family planning in the country since its establishment in 1957. The National Family Planning Coordinating Board (BKKBN) that was established in 1970 has been responsible for the implementation of family planning programs in Indonesia and reports its activities directly to the president. BKKBN began to promote family planning activities from that date. The use of contraceptives through the national family planning programs has been increasing rapidly, indicating that the decline in marital fertility has been related to the increased practice of modern contraceptives.

In the early 1980s, in line with improvement of living standards due to significant

socio-economic development in general, and particularly to educate people to be self-reliant, the government launched the so-called "self-sufficient family planning" programs. These programs aimed at encouraging people to fulfill their contraceptive needs through private sectors, especially to those who can afford it. Thus, although family planning providers through public services are still available for everybody, these services are primarily meant for the underprivilege segments of population.

The enactment of the Law No.10, 1992 on the Development of the Population and the Development of Prosperous Family indicates that the Government of Indonesia has taken a clear and strong policy on population development. The focus of population programs in Indonesia is no longer on conventional family planning, with or without the beyond family planning, but rather on the Indonesian family as an institution. The family in this new construct would be the planner, the promoter, the participant, and the decision-maker in development. This family centered development has become a major focus for a successful population and development program.

II. Specific Issues of Population Policy of Indonesia

1) Fertility and Related Issues

In line with the stipulation of Law No.10 of 1992 on Population Development and the Development Prosperous Family, Indonesia is developing the family approach to improve the quality of the people.

One of the issues is that postponing age of the first marriage. Young people are encouraged to get married at least 20 years old for female and 25 for male. Another issue is birth spacing. For young spouse is encouraged to postpone the first pregnancy, and to make birth interval for 2-4 years. The third issue is improving the quality of the family. The government has been launching prosperous family programs to improve the quality of the people. These programs are being conducted through Prosperous Family Savings (Takesra) and Prosperous Family Loans (Kukesra) as well as Prosperous Family Income Generating Program (UPPKS).

The fourth issue is family resilience. This approach is dealing with eight family

functions through Family Guidance Programs, Program for Child under Five Development, Program for Family with Youth, Program for Adult Family, and Program for Elderly.

2) Mortality

To cope with infant mortality and maternal mortality, several programs and activities have been developed. The first feature is safe-motherhood. Several phases of the programs have been undertaken such as the improvement of women education and skill, the improvement of knowledge of family members in taking care of pregnancy and mother who is giving birth, and the enhancement of community awareness to pregnant mothers.

The second feature is integrated health and family planning services (Posyandu). This program is regularly taken place at rural level to serve five activities including baby weighing for children under five, reporting and recording, nutrition program, counseling, family planning, immunization program and other health programs.

The third feature is child under five development program. This program enhances the awareness, the knowledge, the skills and the attitude of parents and other family members in growing and rearing children under five by preparing the physical, mental, spiritual, social, emotional and moral aspects. The fourth feature is HIV/AIDS prevention with the enhancement of awareness through IEC campaign and family resilience.

3) Migration

One distinct component of this specific issue is transmigration. By this, the population is given the opportunity to improve their lives through transmigration programs. There have been deliberate efforts by the government through transmigration programs to redistribute population from densely populated islands (Java, Bali) to outer islands such as Sulawesi, Kalimantan, Irian Jaya, and Sumatera. Nearly two million families have relocated voluntarily under Indonesia's transmigration program easing overcrowding and poverty on the islands of Java, Madura and Bali. New employment opportunities have resulted in higher standards of living for transmigration families, resettled areas have gained

from the introduction of new food and tree crops. Indonesia's transmigration program has provided a significant benefit to long term national development by spreading settlement and spurring growth throughout the country as well as alleviating environmental and economic strains.

4) Population Structure

Age structure of Indonesian population indicates that the young group is relatively large. In 1961 population census, the number of population between the age of 0-1 years was 17 million, in 1971 population census was 19 million, in 1980 population census increased to 21 million. Whereas in 1990 population census it declined to 20 million.

In 1961, the population who classified as economically productive (15-65 years old) was 53.2 million, and those who economically dependent (0-14 years old and 65 years above) was 42.9 in number. It is apparent that 80.7% of population are considered economically non-productive. Whereas in 1971, 1980 and the end of 1990 those who economically non-productive was 86.8%, 79.3% and 70.2% respectively.

III. The Indonesian Role in South-South Cooperation

Since the inception of South-South Cooperation, Indonesia has played active role in promoting sharing of successful programs in the area of population and development.

Beginning at the G-15 Meeting in Malaysia in 1990, followed by the 1992 Meeting of Heads of State of the Non-Aligned Movement and the establishment of Partners in Population and Development: A South-South Initiative whose Secretary General is Prof. Dr. Haryono Suyono - the State Minister for Population /Chairman of National Family Planning Coordinating Board-, up to the International Conference on Population and Development in 1994, Indonesia has consistently articulated the south to south cooperation and collaboration in this field. Therefore, it is well recognized that the UNFPA finally identify Indonesia as one of four 'center of excellence' countries that have taken a lead in sharing experiences in Family Planning/Reproductive Health with others.

Within this framework, Indonesia offers not less than thirteen modalities or means

of cooperation of which six - Observation-Study Tour, Technical Assistance, Internships, High-level visits, Contraceptive supplies and Training - have been effectively done with 86 countries.

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MALAYSIA

I. The Outline of Population Problem of Malaysia

1) The Current Demographic Situation

Malaysia has been able to monitor the population growth rates in line with the pace of socio-economic development. However, with the changing population structure, the country now faced the challenges of catering to the needs of the young and the elderly population.

The gradual increase in the proportion of the elderly population has led to an increase for the demand of care and services, and with the emergence of nucleic family formation, the social support of extended family system has eroded. This subsequently resulted in serious difficulties to support and care for the elderly.

The high proportion of young population has also given rise to a number of social problems. The main problems associated with youth are unemployment, provision of social services, urban housing and delinquency. Considering the high rate of female participation in labour force, childcare also pose a serious problem. There is a need to strike a balance to facilitate women to play their multi-faceted roles as wife, nurturer and career person.

2) The Basic Concept of Population Policy

The rationale for setting an optimum population target of 70 million in the year 2100 is clearly stated in the mid-term review of the Fourth Malaysia Plan, as such:

> "The formulation of a new population policy will be necessary as the current target for population growth is up to 1985. Malaysia's population is relatively small and the nation has the capacity to generate the wealth that will support a much larger population..... Recognizing that a larger population constitutes an important human resource to create a larger consumer base with increasing purchasing power to generate and support industrial growth through productive ex-

ploitation of national resources, Malaysia could, therefore, plan for a larger population which could ultimately reach 70 million. The experience of some countries of similar size to Malaysian has shown that a large population is not necessarily a liability if the population is provided with skills that can be effectively and productively utilized for national development. It needs, therefore, to be stressed that raising the level of productivity of the population and being more diligent will be critical for further improving the standard of living of an anticipated larger population."

Mid-Term Review the Forth Malaysian Plan,
(1981-85) Page 21-22, 1984.

The target of 70 million to be achieved in 115 years (1985-2100) with an average growth rate of 2.4 percent is not a pro-natalist stand. However, studies have shown that the target may not be achieved due to the fact that the annual growth rate will decline faster that expected. The population is projected to plateau at 49 million by the year 2070 then tip down gradually, an obvious effect of fertility decline.

3) A Brief History of Population Policy

Population factors were not included in the Malaysian development plans prior to the 1960's due to the lack of awareness among the planners. However, the attitude of government has changed by mid-1960s due to the awareness of the social, economic and health implication of high rates of population growth. The Government subsequently decided to adopt family planning as a policy. In June 1966, the Family Planning Act was passed in Parliament, followed by the establishment of the National Family Planning Board (NFPB) as an inter-ministerial organisation with statutory powers and a certain degree of autonomy. The establishment of the NFPB enabled detailed population plans, objectives, programme strategies and activities to be developed and executed.

By the 1980's, the concept and implementation of family planning contraceptive delivery have been remoulded to encompass the whole field of population and family development. Hence, the Family Planning Act was reviewed and revised, subsequently leading to the change in the name and directions of the organisation to the National Population and Family Development Board in 1984.

II. Specific Issues of Population Policy of Malaysia

1) Fertility and Related Issues

The population of Malaysia is expected to increase from 20.7 millions in 1995 to 23.3 millions in the year 2000. This estimate is based on the rates of natural increase of 2.3 per annum. The total fertility rate (TFR) is expected to continually decline to a level below 3.0 by the year 2000. The estimate is based on the rate of decline of the TFR from 3.9 in 1980 to 3.3 in 1994.

The mean age at first marriage for women are expected to increase particularly with the improved status of women as seen in their school enrolment and participation in the labour force. The mean age at first marriage has increased from 23.5 year in 1980 to 24.7 in 1991.

Studies have shown that the proportion of nuclear family type has increased from 55 percent in 1980 to 60 percent in 1991 and 68 percent in 1994.

With the emergence of nuclear families and decline in fertility rates, the average family size has gradually decrease from declined for 5.0 per household in 1980 to 4.8 in 1991.

2) Mortality

Statistics show that the crude death rates in Malaysia has declined from 5.3 per thousand population in 1980 to 4.6 per thousand in 1994, and is expected to decline further. Other mortality rates have also shown impressive improvement; infant mortality rates has declined from 23.9 per thousand live-births in 1980 to 11.1 in 1994 while the maternal mortality rate declined from 0.6 per 1000 live-births in 1980 to 0.2 in 1994.

Improved quality of life has led to the extension of the life expectancy of the population. In 15 years, the male population has gained 2 years, extending their life expectancy from 68 years in 1980 to 70 years in 1994. The female portion of the population gained 4 years, from 72 years to 76 years during the same period.

3) Migration

The internal migration pattern in Malaysia tend to be selective. Majority of the migrants are young males and females and the receiving areas tend to be economically developed and urban in nature. However, rural-rural migration do persist particularly in relation to the land development schemes that provide rural population with occupational opportunities in another rural set-up.

International migration is an important factor contributing to the population growth of Malaysia in the 1980's and 1990's. Studies show that immigration has contributed 0.4 percentile point per annum to the population growth rate during the period 1980-1991. The increase in the employment of contract labours during 1991-95 further increase the impact of immigration on the growth rates. By the end of 1995, it was estimated that almost 650,000 work permits were granted to foreign workers to be employed in the various sectors of the economy.

The impetus of both migration trends led to social problems such as shortage of physical facilities as well as social problems.

4) Population Structure

The structure of the population experienced changes due to the declining fertility and mortality rates and to an extent, migration pattern of the country. The proportion of the young population aged 15 years and below is expected to increase from 7.3 million (35.4 percent) in 1995 to 7.7 million (33.3 percent) in the year 2000. Albeit the decline in percentages, the increase in absolute numbers lead a greater needs for social, health and economic supports for the young. The proportion of elderly population aged 60 and above will be on the increase, from 1.2 million (5.8 percent) in 1995 to 1.4 million (6.3 percent) in 2000.

The dependency ratio has declined from 69 percent in 1991 to 64 percent in 1995, and is expected to further decline to 59 percent in the year 2000.

5) Others

a) Female Labour Force Participation

The improved status of women in Malaysia could be demonstrated by their high enrolment rates in primary as well as secondary and tertiary levels. The education policy that provide free education, prohibits marriage of students while in school, and equal educational access to all has facilitated female staying in school longer.

Education has also provided women knowledge and skill to enter the job market. The female labour force participation rate is expected to increase from 47 percent tin 1995 to 52 percent in the year 2000.

b) Urbanization

The development process with the shift from agricultural to modern sector and mobility of the population have contributed greatly to the urban definition and structure of the nation. The urbanization rate has increased from 24.2 percent in 1980 to 54.7 percent in 1995, and is expected to further increased to 58.8 percent in the year 2000.

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SINGAPORE

I. The Outline of Population Problems in Singapore

1) History of Population Planning

Population planning has constituted an integral component of Singapore's socio-economic development plan. Family planning activities were first started in 1949 by a voluntary organisation, the Singapore Family Planning Association (SFPA). Owing to the high fertility prevailing and its national implications, the SFPA in 1963 recommended that Government take over the responsibility for population planning. Government formulated population planning on a national scale in 1966 with the setting up of the Singapore Family Planning and Population Board (SFPPB).

The SFPPB had 5 units, namely Clinical Services, the Information, Education and Communications Unit, Research and Evaluation Unit, the Cytological Unit and the Training Unit. Family planning services were provided to the population through the network of maternal and child health clinics, which was servicing the target population.

At the time in 1966, the Total Fertility Rate (TFR) was high at 4.5 births per woman. The nation-wide population policy, contained in the message "Stop At Two", was introduced in 1972. Social incentives and disincentives were introduced to reinforce the small family norm. These included rising fees for delivery with increasing birth orders, waiver of delivery fees upon sterilisation, low priority for choice of primary school for children of forth and higher birth orders, and priority for choice of primary school for the first and second child, upon sterilisation of either parent.

The TFR fell rapidly from 3.0 in 1972 to replacement level of 2.1 in 1975 and subsequently down to 1.8 in 1980. Following the 1980 Census, the SFPPB carried out population projections. At a Population Colloquium held in 1983 involving major Government ministries and organisations, the implications of a rapidly ageing population after Year 2000, resulting from the declining fertility and improved life expectancy, was first publicly highlighted.

2) Current Population Programme

As population control was known to require inter-sectorial efforts to be successful, the SFPPB was dissolved in 1984 and an Inter-Ministerial Population Committee (IMPC) set up. In 1986, the TFR hit a low of 1.4. This was also the 10th year of below replacement fertility for Singapore.

In response to the prospect of rapid population aging and potential population decline, the Singapore Government reversed its population control policy. Government's effort to redress the declining fertility and its consequences, was encapsulated in the New Population Policy (NPP), "Have Three, And More If You Can Afford it". A package of incentive measures to support this was introduced on 1 Mar 87. The objective of the NPP was to reverse the declining fertility trend, and to maintain overall fertility at replacement level in the long term. The NPP aimed to increase the number of births (especially 3rd order births) and the average family size as a whole.

3) Basic Concept of Singapore's Population Planning Programme

The implementation of the new population policy measures has been through a multidisciplinary approach, involving various Ministries and relevant Organisations. The Population Planning Unit (now Population Planning Section), which was set up in 1986, serves as the research arm for this Inter-Ministerial effort and evaluates the effectiveness of the new policy. The PPS undertakes research to provide the basis for policy formulation, monitors policy changes introduced and evaluates the population programme as a whole.

II. Specific Issues of Population Policy in Singapore

Policy measures include tax incentives for parents, tax deductible delivery fees, child care centre subsidies, abortion and sterilisation counselling, special child care leave schemes for working mothers with young children and a special housing scheme. Other important related measures include the setting up of several organisations responsible for

providing social activities for young adults, and a large-scale public family life education programme.

1) Fertility and Related Issues

Current policy measures to encourage couples to marry earlier and have more children, if they can afford it, are attached in Annex A.

2) Mortality

Rising standards of living, better education, improved environmental health conditions and sanitation, and improved medical services with the active promotion of preventive medicine especially in the last 2 decades, have all helped to significantly boost the health of Singaporeans. These improvements have led to changes in the distribution of deaths by the various causes. Infant mortality rate has fallen to about 4 per 1000 live births, while maternal mortality is less than 1 per 1000 live births. Cancers and heart diseases are the main killers today in Singapore, together they account for 51% of all deaths.

3) Migration

Migration has played a dominant role in determining the nature and changes of Singapore's population profile and structure. While the high surplus of net migration had enabled the population to grow rapidly in the early pre-war years, fertility replaced migration as the principal factor in population growth after the World War II. In recent years, however, there has been a steady increase in net migrational surplus to Singapore. An average of about 22,000 permanent residents were accepted into Singapore yearly. This was due to the adoption of an open-door policy in 1989 to attract qualified foreigners from all countries to take up permanent residence in Singapore. Singapore will continue to attract talent from abroad.

4) Population Structure and Aging

The aging of the population is expected to pose a major challenge to Singapore's socio-economic progress in the next century. With 7% of the population over 65 years of age today, Singapore's population is still a youthful one. By the year 2030, however, the proportion of elderly is projected to increase to 18.4% of the population.

In Singapore, the appointment of two high level committees - Committee on the Problems of the Aged in 1982 and Advisory Council on the Aged in 1988 - to review the problems arising from population aging reflected the recognition of the seriousness of population aging. The recommendations of the two committees, as well as other initiatives, provided the basis for the formulation of a national policy on aging in Singapore. In 1989, the National Advisory Council on the Family and the Aged (NACFA) was set up to advise the Government on issues relating to these groups. Today, a number of recommendations concerning the elderly have been implemented, including:

— ***Employment***

Raising of retirement age from 55 to 60 and subsequently to 67 by the year 2003.

— ***CPF Minimum Sum Scheme***

Members who reach the age of 55 will be required to set aside greater amounts of their CPF money in the Retirement Account.

— ***Tax Relieves***

Children's contributions to their parents' CPF accounts are tax exempt.

— ***Health Services***

Training of more doctors in geriatric medicine, providing more day care and rehabilitative programmes, building more nursing home for the aged sick etc.

— ***Community-Based Services***

To reduce the burden of care on the family, services such as home visiting, day care and respite care have been introduced.

— ***Family Cohesiveness***

Various public housing schemes have been implemented to encourage families of different generations to stay together.

— Financial Assistance

Under a new funding scheme in 1992, voluntary welfare organisations that provide institutional care facilities for the elderly are eligible for government financial assistance.

— Moral Education

The Government has initiated changes in the school curriculum to strengthen traditional values and inculcate filial piety and respect for the elderly.

— Legislation

A law has been passed to impose on children the obligation to care for their elderly parents.

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Annex A

CURRENT POPULATION POLICY MEASURES

— ***Medisave for Third Child***

The Medisave scheme can be used in both government and private hospitals for the delivery and hospital charges incurred for the first, second and third child.

— ***Childcare Subsidy***

A childcare subsidy of $150 and $75 for a full day care and a half day care respectively is given for the first four children, under the age of 6, of a working mother.

— ***Tax Rebates***

Parents with third and fourth born after 1 an 87 and 1 Jan 88 respectively are eligible to claim a $20,000 Special Tax Rebate. A gradated tax rebate is granted for a newborn second child born on or after 1 Jan 90. Further tax rebates claimable against the mother's earned income are given in lieu of maternity leave of the third and fourth child.

— ***Priority Hosing Allocation***

Priority to families with their third child born after 1 Jan 87, to upgrade to bigger flats.

— ***Special Childcare Leave Provision***

Special childcare leave schemes - No pay leave for childcare up to 4 years for each childbirth, part-time employment up to 3 years regardless of age of child, and full pay unrecorded leave of 5 days to look after sick child aged 6 and below up to a maximum of 3 children - were introduced for married female officers in the Civil Service and Statutory Boards.

— ***Sterilisation Counselling***

Pre-sterilisation counselling given to women with less than 3 children.

— ***Abortion Counselling***

Pre-abortion counselling is mandatory for married women who have at least secondary education and less than three living children. These women are thought to be able to have 3 or more children, in line with the NPP.

Post-abortion counselling is mandatory for all women who have undergone abortion.

— ***Activities for Singles***

The Social Development Unit and Social Development Section were formed to organise social activities and promote social interaction among singles.

THAILAND

I. The Outline of Population Problems of Thailand

1) The Current Demographic Situation

According to the office of the Central Registration, at 31 December 1996, the country's population size is 60.1 million. The natural growth rate decreased to 1.1 per cent and the total fertility rate is 1.98 per women. Although fertility falls bellow replacement level, Thailand's population will inevitably continue to grow for some time. This is because of the momentum built into the population structure as a result of earlier, high levels of fertility.

During Thailand's recent years of rapid economic growth, the economic structure has become increasingly oriented towards the modern industrial and services sectors. At the same time, traditional rural agricultural society has steadily been moving towards an urban industrial orientation. As a result of these and other forces, environment quality has deteriorated, with increasingly serious pollution problems.

Rapid economic growth associated with urbanization and industrialization has had serious implications for natural resources and urban environment situations. In rural areas, rapid forest depletion and related soil degradation, mainly because of unsustainable agricultural practices and commercial logging, are placing these natural resources in jeopardy. Water supply and distribution for rural and urban use is becoming a major problem.

Migration of population from areas of lesser to greater economic opportunity has long been occurring. If regional income disparities continue to widen, such migration is likely to increase. As the population urbanization and urban environmental issues become more acute, new health problems could very well arise, in addition to AIDS which is already causing great concern.

2) The Basic Concept of population policy

For more than 20 years now, Thailand's population policy has emphasized reducing fertility and mortality rates as essential ingredients for national development. As a result, Thailand stands at a significant turning point with respect to its population development situation. The policy framework must now turn to other aspects of population and development, including regional-specific concerns in MCH/FP, improving family planning services, combating the HIV/AIDS threat, with its implications for both mortality and fertility, planning of rapid urbanization, and seriously addressing women's and environmental issues.

3) A Brief History of Population Policy

Population problems have been developmental issues since the country began its First National Economic Development Plan (1961-1966). Historically, Thailand maintained an essentially pronatalist population policy through the 1960s. The possibility that population growth might indeed have an impact on economic development was first mentioned in 1959 by A World Bank Economic Mission, which suggested that the rate of growth at that time was excessively high and was adversely affecting economic development. The Thai government created a number of committees to study the problem but little else transpired until 1963 when the first of a series of national population seminars was held in which a number of Thai intellectuals in the fields of medicine, the social sciences and economics discussed their concerns about the high rates of population growth.

Recognizing that rapid population growth is a major obstacle to economic growth, a committee under the lead of National Economic Development Board was established in 1969 to prepare a policy statement for submission to the Cabinet. The government proclaimed in March 1970 the national population policy to support voluntary family planning. The policy stated that: The Thai Government has the policy support voluntary family planning in order to resolve various problems concerned with the very high rate of population growth which constitutes an important obstacle to the economic and social development of the nation.

Voluntary family planning was used as a means of containing the growth of the pop-

ulation to a rate which was commensurate with the employment potential of the country and which would allow the Government to develop adequate education, health, and other services.

Consequently, in 1974, when a new constitution was drafted, an article was included which raised the population policy to the level of a constitutional objective. The provision, section 86, reads as follows: "The State is to formulate a population policy to suit the natural resources of the nation, social and economic conditions and technical progress for the interest of the economic and social development and security of the State".

II. Specific Issued of population policy of Thailand

1) Fertility and related issues

The onset of fertility decline in Thailand probably occurred around the mid-1960s. For the family planning services, the Thai Government announced a policy of supporting voluntary family planning in 1970. The mandate was given to the Ministry of Public Health to be responsible for a National Family Planning Program (NFPP). As a result, fertility decline gained momentum, bringing the TFR down to 3.5 children in 1984 and to 1.98 at present. This TFR decline was a large extent made possible by a rapid spread of family planning practices.

Contraceptive prevalence surveys and reports, moreover, have shown that the rate of contraceptive use has risen sharply from 15 per cent to 75 per cent of married women of reproductive age (MWRA) from 1970 to 1992. All seven modern contraceptive methods such as male and female sterilization, oral pill, IUDs, injectables, Norplant and condom are accessible in both rural and urban areas throughout the country.

The NFPP has also organized mass media programs to regulate the fertility pattern of couples bearing their first child at age 20 and over, birth spacing of not less than three years between children, and limiting the number of children in each family to two only.

The official projection for Thailand during 1990-2020 based on the medium fertility assumption, which is thought to be the most likely phenomenon, is that the population,

which numbers around 56 million in 1990 will increase to 62 million by the year 2000.

2) Mortality

Mortality levels are quite low due to vast improvements in public health and education. A decrease in the mortality rate was reflected in an increase in life expectancy. The current crude death rate is 5.0 per thousand population and the life expectancy at birth for males and females are 66.6 years and 71.7 years respectively.

Based on direct and indirect measures of infant mortality, the estimated rate in 1992 was 35.5 per thousand live births. A declining trend in maternal deaths can also be observed even though the number of maternal deaths is believed to be under-reported and miscategorized. It is estimated that the maternal mortality rate was less than 30 per 100,000 live births in 1989. The most common causes of death were hemorrhage, infection and eclamsia. Today, the MCH program aims to reduce IMR and MMR by half the current rate by the year 2000 by improving MCH services quality, promoting breast feeding, and strengthening nutrition programs.

During the present decade, non-infectious diseases and accidents are increasingly important causes of death, and they have become one of the nation's most unsolved health problems. Infectious diseases, namely, pneumonia, diarrhea, diseases of the digestive system and viral diseases, remain as major health problems among the under one and the under five year old population groups. A new factor in mortality patterns is the growth in the AIDS epidemic. It is estimated that if current sexual behaviors do not change by 1993, two to four million Thais will become infected by the year 2000. During that period, 650,000 AIDS cases and 560,000 AIDS-related deaths are projected to occur.

To solve such public health problems and improve the health status of the Thai population, health development, policies have been included in all the National Five-Year Development Plans. Recent Cabinet resolutions have also institutionalized the National AIDS Prevention and Control Plan as the national policy guidance instrument. The AIDS Policy and Planning Coordination Bureau was established in 1992 to implement. AIDS related activities in the Office of the Permanent Secretary under the Office of the Prime Minister.

Condom use increase - STD incidence decrease. The Ministry of Public Health

has reported drastic increased in condom use over the past few years. Condom distribution by the MOPH itself has increased from 5-10 million pieces annually in the past several years to 60 million pieces in 1993 and another 50-60 million condoms sold through commercial channels. Simultaneously, the incidence of sexual-transmitted diseases has decreased. HIV prevalence among intravenous drug users and females commercial sex workers has stabilized or even declines in some provinces. With 100% condom use programs implemented in all provinces, the government expects that these trends will continue to increase this year reinforcing a belief that condom use behavior among Thai males may be changing.

Efforts must continue in order to improve attitudes and motivation to change behaviors in ways that will significantly slow the epidemic and facilitate a comfortable life for those people infected with HIV.

3) Migration

The role that internal migration plays in undesirable patterns of population distribution is fully recognized by the government. Total internal migration will continue at the rather high rates of the recent past, but the rural to urban movement will increase for economic reasons. However, no policies are applied which directly intervene in the migration decisions of individuals. There are no legal or administrative restrictions to geographical mobility. Instead, indirect policies, primarily aimed at affecting the location and development of economic activities, have been instituted with the aim of affecting internal migration. All Five-Year National Economic and Social Development Plans since the Fourth Plan (1977-1981) have included policies designed to promote economic growth outside of Bangkok, to discourage the expansion of industry within Bangkok, and to decentralize government services.

One area in which government policy has a major impact on internal migration is through rural resettlement schemes. In the past, the opening up by the government of new areas for agricultural production was an important contributor to the high levels of rural to rural migration that has been observed in Thailand. While the expansion of agricultural frontiers is no longer a significant factor in migration patterns.

International migration from Thailand is not regulated and hence data concerning

the international movement of Thai is difficult to obtain. A major concern of the government has been the large numbers of illegal immigrants residing in Thailand. Disparities in levels of economic development between Thailand and the neighboring countries has resulted in increasing flows of illegal migrants into the country. Thailand is also used as a staging area for illegal immigrants moving on to other countries. An active policy of enforcement of immigration laws is followed, with illegal immigrants being apprehended and deported. Problems resulting from large numbers of refugees have been eased with the successful repatriation of Cambodian refugees during 1993 although there still exist refugee groups from Myanmar and Laos.

4) Population Structure

Mortality and fertility declines during the past few decades caused substantial shifts in the population age structure. After 1970, the level of fertility declined and the Thai population grew progressively older. This is indicated by a rapid drop in the proportion of the population below age 15, from about 45 per cent in 1970 to 29.2 per cent in 1990. At the same time, the proportion within the age group 15-59 and the age over 60 years grew from 50 per cent and 5 per cent respectively in 1970 to 63.4 per cent and 7.4 per cent in 1990.

It is estimated by the year 2000, young and old age groups will account for about 27 and 8 per cent of total population respectively. Thailand is now experiencing unusually fast growth of the elderly population, however, in comparison to other less developed countries. Thus the Thai population will become noticeable older in the next few decades provided fertility remains low and mortality continues to improve.

In Thailand, Government services for the elderly are quite limited although effort is being made to expand free medical care. Only a few token institutional residences have been established for elderly who are unable or unwilling to live with their families or on their own. Given the rapid increase in the absolute size of the elderly population that is certain to occur in the coming decades, any meaningful shift of responsibility for their welfare from the family to the state will require massive outlays of government funds. Undoubtedly in recognition of this, the Seventh Five-Year Plan (1992-1996) of the Thai government and the latest official declaration on Long-Term Policies and Plans for the Elderly (covering 1992-2011) appear to rely on and emphasize the responsibility of the family for

providing welfare for elderly members. While social security schemes to provide old age financial assistance are scheduled to be implemented by the end of the decade, details of such schemes are still in discussion.

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VIET NAM

I. The Outline of Population Problems of Viet Nam

1) The Current Demographic Situation

Viet Nam is developing country in Southeast Asia with population of about 76 million (1997). By latest data (5/1997), fertility rate and mortality rate is about 22.8 and 6.0 per thousand respectively, so the population growth rate will be around 16.7 per thousand. The fertility declined in the urban and some rural areas, but it is still very high in some mountainous and remote regions. Due to effect of modernization and industrialization, there are more and more people migrate from rural to urban regions as well as from The North Mountainous region to Central Highland (Tay Nguyen). The data of migration is not yet ready because now Viet Nam Government start to carry out a national survey of domestic migration.

In the decade of eighty and first half of decade of ninety (1990) population explosion were big concern of our government and people. Based on national budget and UNFPA support, The Family planning program in Viet Nam were more and more strengthened. CPR was increased from 53% (in 1989) to 64.9% in 1994 among that IUD using is sharing 50%. Abortion rate is also very high, during reproductive age, each women get two time abortions.

Our overall objective is reach replacement fertility rate (2.1 children per women) in the next decade (at present is around 2.9). The biggest of concerns on population in Viet Nam is high population growth rate in mountainous and Tay Nguyen, island regions as well as high abortion rate that have strong negative effects to women health.

2) The Basic Concept of Population Policy

Population policy is law, ordinance, Government and some ministerial regulation as well as statements made by the national leaders concerning to population.

Viet Nam country have policy to reduce population growth rate but it must be based on a voluntary principle. All people have right to choice family size, birth spacing and contraceptive methods. It presents in the Constitution (1982 and 1992) as well as The Law on Health protection (1989). All contraceptive methods were given free to people who wanted. Viet Nam have policy to motivate each family should have 1 or 2 children and women give the first birth after 20 years old and birth spacing is 3-5 years.

3) A Brief History of Population Policy

Since from 1960, the government of the North of Viet Nam were aware of high population growth rate that affected on quality of life particularly on mother and child health care so government promulgated some social policies on birth control, healthcare, mother and child protection, education and women's status.

After reunification of Viet Nam (1975), these policies expanded to apply including the South. Official statements of birth control policy are to encourage late marriage, late first birth and late second birth known as "Three late" and recommend that each family should have not more than 3 children. At that time IUD were most popular (70%) contraceptive method which were inserted and follow up by health staffs. But due to long time of war as well as "baby boom" after war, the birth control policy was not success so birth rate almost was stable at high level in the decade of 1970s.

In the decade of eighties, the political commitment strengthened step by step, some laws, regulations and official statements of leaders supported and antinatalist policy, for instance The Law on Marriage and Family (1987), Law on Health Protection (1989). Government paid attention more on family planning program and allocated more national budget for birth control program.

In 1984 the National Committee for Population and Family Planning was established (as a consultative organization) and this committee worked as a ministerial organization with branches in each commune from 1993. The rate of the national budget for population and family planning program was increase ten time during period of 1989-1995. At that time, some incentive and disincentive policies (on land and housing, healthcare service, urban migration..) related to family size also were passed. Government also encourage people to migrate to new economic areas. In the decade of eighties,

although fertility rate has been declined but it still is at high level, total fertility rate (TFR) was 4.1 and contraceptive prevalent rate (CPR) was 53%. However fertility rate were different by region, in some urban areas the family planning program have had success with TFR was around 2.1 but in all mountainous and remote areas, TFR was around 5 or 6. There are still big gap of socio-economic conditions between region, for instance gap of income, educational level, ethic and cultural, religious conditions while population policy are same for all region, that may be main reasons for different fertility rate.

II. Specific Issues of Population Policy of Viet Nam

1) Fertility and Related Issues

The overall of our goals of population policy is reduction of population growth rate and improving quality of life and we have plan to reach replacement fertility rate in the next decade. All population policy must be carried out by voluntary motivation of people to use contraception. At present 65% of married couple in reproductive age is using contraception, among that 50% is IUD but 40% is traditional method (Rhythm, Ogino-Knaus..). The contraceptive are distributed free of charge to all people those who want to use it. In some province in the period of 1980-1990, if some one had use IUD they have got some incentive such as rice or small cash. Users can get contraceptive methods at Commune health centers (IUD, injection), at shop (condom, pill) or at hospital (for sterilization).

The Ministry of Health is in charge for all family planning service supply while The National committee for Population and Family planning is in charge for making budget plan, for information and education (IEC) program.

In 1986, The Law on Family and Marriage was approved by the Parliament. By the Law, polygamy is illegal and family planning is voluntarily, the legal age at first marriage is defined at 18 and 20 years old for female and male respectively.

The government have policy to encourage people have birth spacing from 3-5 years and each family should have only one or two children. Mother should give first birth after 19 (for rural) and 22 (for urban).

2) Mortality

Mortality is most efficiency policy in Viet Nam during post war time (1954-1960). In that time mortality was reduced from more than 15 to less than 10 per thousand. Main reason for the success is public health policy and other social welfare policy. The network of health care system was spread to whole country. Each commune have a health center with 3-6 health staffs including assistant doctors, midwife, nurse and medical doctor (in some commune only). They are paid by local authority.

The first of top ten disease is diarrhea and digestive infection (365/100,000). The main reasons are lack of sage water and sanitation. Only half of population and 16% use safe water and sanitary toilet respectively. So the IMR rate is about 43/1000 live birth. Main reasons of the infant mortality is infectious disease such as diarrhea, bronchitis, pneumonia. Although Viet Nam have some good conditions such as high literacy rate (93%) and some national programs such as anti malnutrition, prevent Iodine deficiency, supplement Vitamin A, Expanded immunization program...but IMR still is 43/1000.

There are more than 5000 positive HIV and among that some hundred AIDS patient and some of them were died. The drug abuse (injection) is sharing 70% of reasons of positive HIV.

3) Migration

In general the international migration is not available, but the trend as follows:

During the last time (1975-1988), there were some Viet Namese refugee in neighbor Asian country like Thailand, Hongkong, Malaysia... From 1990 up to now, there are nobody try to illegally migrate to other country.

Domestic migration: At present Viet Nam carrying out a national migration survey, so the data for domestic migration is also not yet available, but the trend as follows:

From 1954 up to now, Viet Nam have policy to motivate people migrate from some urban and rural areas which have high population density to some new economic zone in the North mountainous and Tay Nguyen. There were a lot of people who migrated to new economic region and have good life, but some of them still are poor and suffered from health problem such as malaria, malnutrition... Now government try to create good infra-

structure conditions in new economic zone before people move to. In general encourage people to migrate to new economic zone is good policy and success but some thing in the policy it must be adjusted.

During ten year ago and until now, due to effect of socio-economic development, a lot of people migrate from rural to urban areas looking for the jobs and income because farmers in rural they have a lot of spare time after harvest. Also some new factories and companies are established and created many jobs for people not only in urban and also in rural areas. An unofficial estimation in Ho Chi Minh city now there are about 600,000 people who migrated from rural to live in Ho Chi Minh city now.

Other trend of domestic migration is rural-rural migration. A lot of people migrate from North mountainous areas to Central highland (Tay Nguyen), almost all of them are belonging to minority group. They cultivated rice, cava by "slash and burn technique" so when forest is clear they also have to move other place and will cut down a lot of forest. It becomes a serious problems for environment. During last 4-5 years, around 400-500,000 people migrated to Tay Nguyen areas. Now Viet Nam government have pay attention more to deal with it.

4) Population Structure

As data from population census that was taken in 1989, population in age group 60 + is about 7.70%. At that time the fertility was about 29/1000, now when fertility are going down 22.5/1000 in May 1997, the population structure must be changed. As our survey in some communes with success of family planning, the age group 60 + is about more than 10%. We hope that ten years from 1990 to 2000 the fertility rate will decline as same trend in Japan after the second world war or in China (1979-1989).

Viet Nam government have some social policy to take care elderly such as: Health insurance, social insurance and material supports for some elderly. The association of elderly also is established in all level. In Ha Noi, Gerontological hospital was established from 1980'. By the Law on Health protection, give priority for elderly patient during check up and treatment in the hospital. There are a lot of fresh air club for physical training and cultural clubs for entertainment for elderly in urban and rural areas.

Concerning to health insurance, it covers only for retired people and who have

great contribution during the war time. All of them get free health care. For other elderly they must pay by themselves, or family members, but if they are too poor they also get health care free.

For social insurance, it is applied for retired persons, so the rate of elderly who enjoyed pension is around 8-10%. For person who have great contribution during the war time they get monthly supports from government.

In general in each commune or village there is a fund for elderly that is organized by association of elderly. Elderly pay one time and then when they get sick or died they will get big support from the fund.

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Appendix

REQUESTED INFORMATION

I. The outline of population problems of your country (1,000 words)

1) Please specify the current situation regarding population problems and their characteristics (or features) in your country (300 words).
2) Please specify the basic concept of population policy in your country (300 words).
3) Please specify a brief history of population policy and its characteristics (or features) of your country (400 words).

II. Specific issues of population policy of your country (1,000 words)

Please specify the basic concept and the present situation for each issues of population policy in your country as follows.

1) Fertility and related issues (200 words):
   - For example, Does your country apply any specific population policy (growth or control)? How is family planning carried out in your country? Does your country have any specific policy on marriage or related issues?
2) Mortality (200 words):
   - What is the major policy and how does your country cope with; infant mortality, maternal mortality, infectious disease, AIDS/HIV infections, etc.
3) Migration and distribution (200 words):
   - What is the situation of internal and international migration to your country? Does your country apply any specific countermeasures such as a distribution policy?
4) Population structure (200 words):
   - How is the aging of population progressing in your country? Does your country have any measure to deal with this issue?
5) Others:
   - Please specify the other issues regarding population policy in your country which are not covered in above 4 items.

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