Comparative Study of Population Policies in Asia

—Focus on Eight Asian Countries—

The Asian Population and Development Association
(APDA)

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Foreword

Since its foundation in 1982, the Asian Population and Development Association has conducted numerous studies and researches on population and development from various viewpoints with the aim of contributing to social and economic development in Asia. This year, we conducted Comparative Study of Population Policies in Asia by receiving the Fiscal 1997 Health Sciences Research Grants from Ministry of Health and Welfare of Japan. The study was led by Dr. Toshio Kuroda, Director Emeritus of Nihon University Population Research Institute, who has also been offering guidance for our study and research projects over the years as one of directors of the APDA. This report is a compilation of the results from this study and research.

As the world population reaches 5.8 billion, the question about the Earth's carrying capacity, i.e. whether the planet can support humanity on a sustainable basis, is being asked. It is said that demographic trends in Asia, having 60% of the world population, will determine the demographic trends of the world as well as its future. It is also said that national level population policies have enormous impact in solving the problems of population. Asian countries have been actively engaged in population policies in particular after the Second World War by stressing the need for population control at United Nations meetings and recognizing the importance of family planning. On the other hand, some of the developed countries have started adopting policies for recovering fertility in the recent years because of their concern over the impact lowering fertility will have in the future, and some of the Asian countries are following suit. Therefore, the purpose of this research is to study the history and condition of population policy in the Asian countries at the present moment which may well be the turning point when the problem of population is seen as a global problem and to set out short- and long-term outlook on these matters.

Direction and method of population policy which is adopted as the basic policy of a country are deeply related to the political and economic background as well as cultural and religious background of that country and therefore differ from country to country. In this research, joint research was conducted on 8 countries in the Asian region (China, Korea, Indonesia, Malaysia, the Philippines, Singapore, Thailand and Vietnam) with cooperation from the experts of population issues at respective countries, carrying out comparative research after obtaining country information directly.

Since population policy have considerable impact not only at home but also abroad, we believe that adoption of more effective population policy by respective countries in the future would facilitate the solution of population problems on a global scale.

Lastly, we would like to express our sincere gratitude to: Dr. Kuroda; Prof. Tian Xueyuan, Director, Institute of Population Studies, Chinese Academy of Social Sciences (China); Dr. Jung Duk Lim, Dean, Office of planning and Research and International Relations, Pusan National University (Korea); Dr. Prijono Tjiptoherijanto, Assistant to the State Minister for Population and Mr. Eddy N

Hasmi, National Family Planning Coordinating Board (Indonesia); Dr. Tan Poo Chang, Assoc. Professor, Faculty of Economics and Administration, University of Malaya (Malaysia); Dr. Mercedes B. Concepcion, Professor Emeritus, University of the Philippines (the Philippines); Dr. Paul Cheung, Chief Statistician, Department of Statistics (Singapore); Dr. Jawalaksana Rachapaetayakom, Senior Expert in Decentralization of Development, National Economic and Social Development Board (Thailand) for their cooperation, and hope that this report would be utilized extensively towards solving the population problems in Asia and in the world.

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General Remarks
- Top Priority in the Strategy for Human Survival -

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I. A Divide in the History of Humanity: The Advent of Population Explosion

The Second World War marked an important divide for the history of mankind as it signified an entry into the era having characteristics that could be distinguished from those in the history of humanity prior to that. One economist has stated that the 20th Century is a century in which the civilization that started 5,000 to 10,000 years ago entered a major turning point towards post-civilization society (K. E. Bouldings: The Meaning of the Twentieth Century, 1964). On the other hand, a historian saw the Second World War as a divide that separated history into two periods and characterized it as the arrival of Asian era in which China played a central role (Owen and Eleanor Lattimore: China, A Short History, 1947). The war also triggered an explosive increase in the world population. The history of humanity, which had been constantly exposed to the risk of destruction due to war, civil strife, epidemic and famine, had finally entered a period of steady low growth after the agricultural revolution and industrial revolution. However, it entered a period of sharp increase called population explosion after the Second World War. The world population increased at an annual rate of only 0.8% in the first half of the 20th Century and 0.5% in the 19th Century. After the Second World War, however, it reached an abnormal increase rate of 2.0% a year in the 20-year period from 1955 to 1975. It was an exceptionally high rate that was 2.5 times higher than the rate of growth in the first half of the 20th Century and 4 times higher than that in the 19th Century.

It was after the Second World War that the question of whether Homo sapiens is a species that could survive on the finite planet Earth was first publicly criticized. The question of whether quantitative increase is possible within the framework of the Earth never existed in the long history of humanity. In this sense, the Second World War was a divide that created a new history for the human race.

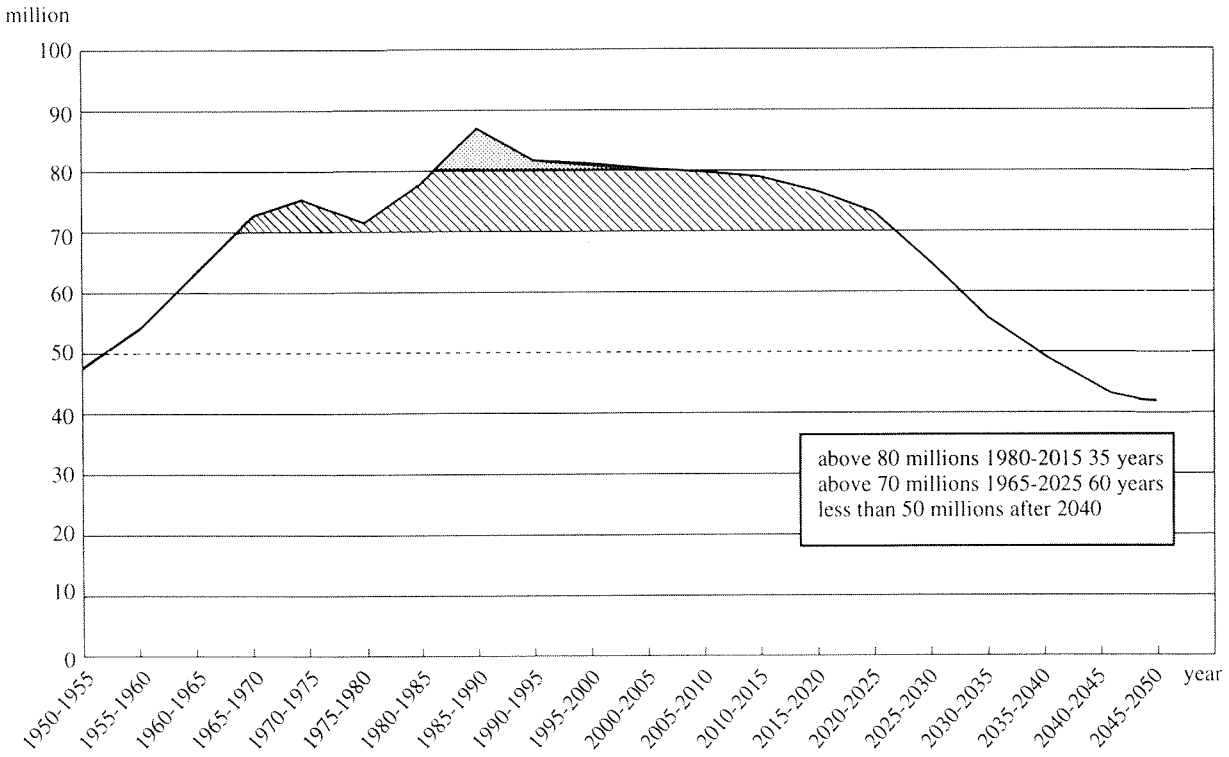
II. Short-Term Viewpoint and Long-Term Viewpoint: Annual Increase of 80 Million and World Population of 10 Billion

Family planning policies for controlling population increase have been implemented on a global scale to alleviate the increase of world population. On the other hand, population increase rate (natural

increase rate) has been remarkably reduced despite the improvement in mortality rate. Annual increase rate of 2% that had continued from the latter half of the '50s to the first half of the '70s has recently been decreased to 1.48% (1990-1995). While the fact that the increase rate has been revised downward from 1.57% in the 1994 projection to 1.48% in the 1996 projection must be welcomed, an undesirable factor among the causes of this downward trend must be noted. It is an increase in mortality rate-increase of mortality rate in Eastern Europe and Africa have contributed to the lowering of natural increase rate.

Another point that must be considered along with the issue of increase rate is the issue of annual increase rate and the scale of global population as a whole. It is an issue of population increase of more than 80 million a year continuing for 35 years in the short-term (see Figure 1) and the projection that the world population will reach 10 billion in the long-term. We must not rest assured that annual population increase rate has gone down. Furthermore, we must remember that population momentum created by baby boomers of the past reaching their marriage and childbearing age and by the ever-increasing total population will inevitably have their impact on the future.

Figure 1 : Annual Growth of World Population (Five year's average), U.N. 1996



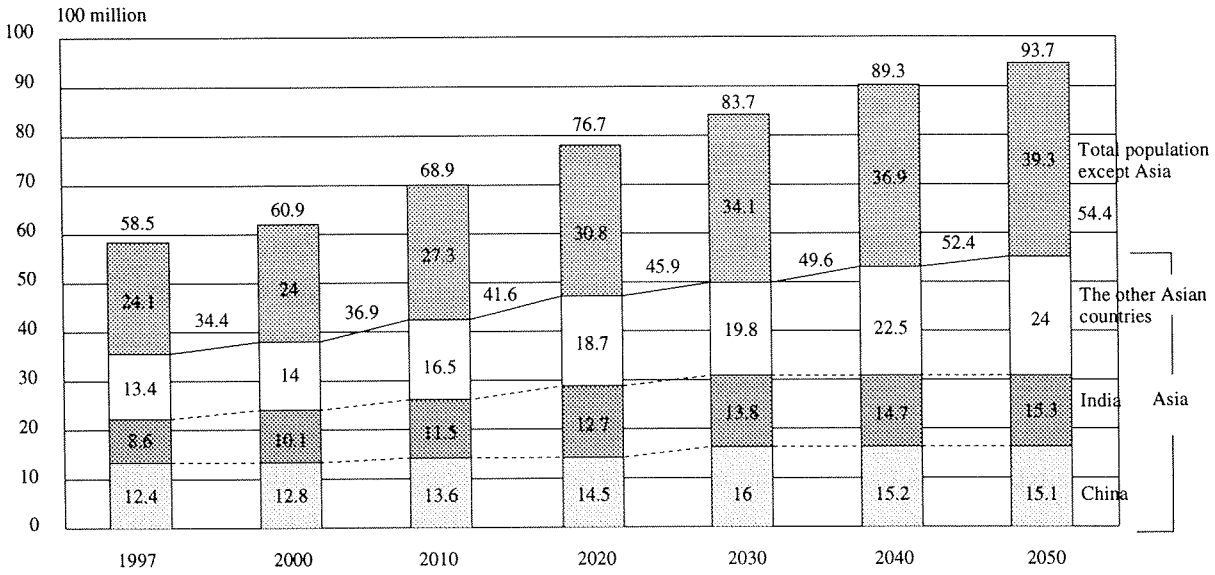
Most experts are pessimistic when it comes to the issue of whether it is possible to provide food, housing and medical care to the population that continues to increase at the rate of more than 80 million a year. The projection of world population in 2050 was revised downward to 9,367 million in the 1996 Revision, a decrease of 466 million from the projection made 2 years earlier. However, IIASA, which

assumes that diffusion of family planning will prove to be unsuccessful among African and Islam population, has projected that the global population will reach 9,900 million by 2050 (IIASA, 1996). At any rate, it appears that we must prepare ourselves to having a population close to 10 billion on this planet in the long-term. Can the finite earth tolerate having 10 billion Homo sapiens inhabiting the planet?

III. The Enormous Population of Asia and the Pioneer of Population Policy

At 3,438 million in 1995, Asian population accounts for 60.5% of the entire population of the world. In addition, Asian population accounts for 76.1% of the total population of the developing countries in the world, which amounts to 7,940 million. These facts indicate that Asia plays a crucial role in solving the global population problem. The population of Asia in 2050 is predicted to reach 5,440 million and will be comprised of 1,510 million in China, 1,530 million in India and 2,400 million in other Asian countries. China and India will have a combined population of 3,040 million and will account for 56% of total Asian population. For this reason, attention must be given to the population policies of these two countries (see Figure 2).

Figure 2: Population of Asia, China, India and World Population 1997-2050



This mega-region has an extremely complex multi-layered structure and is characterized by the disorderly coexistence of countries with extremely different population scale; of different religions, ethnic groups and cultures; and of rich and poor countries at varying levels of economic development.

These complex and diverse characteristics of society, economy, culture and history are clearly

various causes of demographic phenomena. To avoid the complexity of making comparison based on a country basis, the characteristics of population for the 4 sub-regions of Asia; East Asia, South-central Asia, South-eastern Asia and Western Asia, can be shown by using several indices as shown in Table 1.

Table 1: Characteristics of Population in the 4 Sub-Regions of Asia

Asian sub-regions	Population (million) 1997	Birth rate (‰)	Death rate (‰)	TFR (per woman)	Average life expectancy (both sexes combined)	Urban population (%)	GNP (US$) per person
Eastern Asia	1,457	16	7	1.8	71	36	4,400
South-central Asia	1,417	30	10	3.8	59.5	27	370
South-eastern Asia	501	26	8	3.2	64	30	1,410
Western Asia	176	29	7	3.5	63	35	3,380
Total	3,552	24	8	2.9	65.5	33	2,360

Source: Japanese version of Population Reference Bureau's 1997 World Population Data Sheet

A notable trend can be observed if Asia, having a huge population of 3.5 billion, is seen in terms of its 4 sub-regions. In other words, dividing Asia into 4 sub-regions cancels the distinct characteristics of individual countries and gives rise to characteristics that are intrinsic to Asia. For instance, demographic phenomena such as birth rate, TFR (total fertility rate) and average life expectancy are at similar levels except in East Asia. In addition, regional differences in death rate and urbanization rate are small. The most significant regional difference exists in GNP per capita with that of East Asia standing out above other sub-regions at US$4,400.

The characteristics of Asia as seen from these 4 sub-regions can be summarized into the following 3 points.

Firstly, mortality rate is low throughout the region. Secondly, East Asia is demonstrating remarkable levels of advancement compared to other 3 sub-regions in terms of fertility, average life expectancy and GNP. The fact that TFR in East Asia has fallen below the replacement level to 1.8, in contract to 3 and above at other 3 sub-regions, suggests that demographic transition of this region has reached the level of developed countries. The fact that GNP per capita of this sub-region is much higher at US$4,400 implies that the lowering of fertility and the economic growth accompanied by high standard of living complemented each other in accelerating the demographic transition. In this case, it must be remembered that lowering of fertility in this sub-region was the result of rigorous and efficient implementation of population policies.

Thirdly, although other 3 sub-regions are lagging behind East Asia in terms of demographic transition, difference in economic development can be observed among the 3 sub-regions. In other words, South-eastern Asia (sub-region in which ASEAN plays a central role) is ahead of other 2 sub-regions and is following in the footsteps of Eastern Asia. South-eastern Asia is ahead of other 2 sub-

regions in birth rate, TFR and average life expectancy. On the other hand, South-central Asia is most backward among the 3 sub-regions in terms of demographic transition process, having the highest fertility (Birth rate 30, TFR 3.8) and shortest average life expectancy. Its GNP per capita is also at the minimum level of at US$370 and has become a factor hindering the launching of demographic transition process.

It is true that there are sub-regions and countries in Asia that are considerably lagging behind others in demographic transition. However, the practicing rate of family planning in Asia is 59% compared to 58% in Latin America and Caribbean and extremely low rate of 18% in Africa. While the rate of contraception has increased considerably in Latin America and Caribbean countries and has come close to that of Asia in the recent years, concern in population policy and implementation of family planning have taken root much earlier in Asia and enabled the region to play the role of pioneer in lowering the fertility of developing countries in the world.

To look at the speed of decline and the level of TFR in Asia as possible indicators that reflect the effectiveness of family planning policy programs, it started to fall below 5 after 1970. This did not occur in Latin America and Caribbean countries until 5 years later in 1975. As for individual countries within the region, the fact that China, Korea and Singapore, not to mention Japan, have already fallen below the replacement level reflects the high awareness of Asian countries about population policy.

The inhibiting effect of high population growth rate on economic takeoff has already been pointed out and the need for controlling population increase through family planning has been stressed at the First U.N. Asian Population Conference in 1963. Moreover, the emphasis Asian countries unitedly placed on the need for family planning to counteract the opposition against family planning from the Communist countries and the Catholic Latin American countries at the World Population Conference at Bucharest in 1974 must not be forgotten as a historical fact.

IV. Demographic Profile of the 8 Countries

Please refer to the respective sections for the results of population policy study by experts from a total of 8 countries consisting of 2 countries from Eastern Asia, namely China and Korea, and 6 countries from South-eastern Asia including Indonesia, Malaysia, the Philippines, Singapore, Thailand and Vietnam. In this section, a comparative analysis will be performed first according to various indices of population in these 8 countries. The fundamental background of population policy will have to be clarified in understanding the population policy of each country (see Table 2).

Table 2: Demographic Indices of the 8 Countries

Country	Population (million)	Crude birth rate (‰)	Crude death rate (‰)	Total fertility rate	Infant mortality rate (per 1000 births)
China	1,237	17	7	1.8	31
Indonesia	204	25	8	2.9	66
Korea	46	15	6	1.7	11
Malaysia	21	27	5	3.3	11
Philippines	73	30	7	4.1	34
Singapore	3.5	16	5	1.7	4.0
Thailand	60	18	7	1.9	32
Vietnam	75	23	7	3.1	38

Country	Contraceptive prevalence (%)	Knowledge of family planning (%)	Illiteracy rate (>15 years)		Average life expectancy at birth (both sexes combined) (years)
			Male (%)	Female(%)	
China	79	-	1	3	70
Indonesia	55	95	10	22	62
Korea	79	100	-	-	73
Malaysia	48	99	11	22	72
Philippines	40	97	5	6	66.5
Singapore	65	98	4	14	76.5
Thailand	66	100	4	8	69
Vietnam	65	95	4	9	67

Source: UNFPA: The State of World Population 1997 for the percentage of those with "Knowledge of family planning" and "Illiteracy rate among those aged 15 years and above." The Japanese version of Population Reference Bureau's 1997 World Population Data Sheet (May 1997) for all other indices.

As mentioned earlier, Eastern Asia is a sub-region that has made remarkable progress in demographic transition process and achieved high economic growth compared to other sub-regions of Asia. South-eastern Asia is a sub-region that has demonstrated the degree of demographic transition and economic development second to East Asia. However, a comparison of 8 countries listed here shows considerably different stages of economic development. Needless to say, the most conspicuous among them all is Singapore. Singapore's birth rate has already fallen significantly below the replacement level. In addition, her infant mortality rate, for instance, has reached a level comparable to that of Japan which is one of the lowest in the world. The country's GNP per capita is at a high level similar to that of Europe and, although small in terms of land area, virtually ranks among the group of developed countries. On the other hand, however, there are countries like Malaysia and Vietnam where total fertility rate exceeds 3 and the Philippines where the same rate exceeds 4.

Another point worthy of special mention is the fact that there are 4 countries, including Singapore, that have reached the level of total fertility rate below the replacement level of 2. Attention must be given to the fact that these 4 countries with total fertility rate below the replacement level of 2, i.e. Singapore, China, Korea and Thailand, have a combined population of 1,346 million, which corresponds to almost 80% (78.3%) of the total population of the 8 countries which is 1,719 million.

Prevalence rate of family planning has also reached 60 to 80% in these countries except for the Philippines where the rate is 40%. Nearly 100% of the people have knowledge about family planning. Illiteracy rate (among those aged 15 years and above) is below 5% in most countries except Indonesia and Malaysia where the rates are 10% and 11% for male, respectively. Illiteracy rate is higher among women than among men but does not exceed 10% in most countries with highest of 14% in Singapore, with the exception of Indonesia and Malaysia where the rates are both 22%. Such sociocultural conditions as well as remarkable demographic transition and economic growth of neighboring countries are expected to play the role of accelerating population policies in the later developing countries.

V. Regime of Fertility Transition in the 8 countries

In the early years following the Second World War, fertility was at the level of developing countries in all of the 8 countries and total fertility rate ranged between 5 and 6 (see Table 3). A trend of rapid decline started in the first half of the '70s. With the exception of Singapore, the majority of countries had high total fertility rates in the neighborhood of 5. The rate of decline from 1960-65 period to 1970-75 period, the rate of decline from 1970-75 period to 1990-95 period, and the rate of decline from 1960-65 period to 1990-95 period are as shown in Table 4.

Table 3: Comparison of Declining Fertility in the 8 Countries

Country	1960-65	1965-70	1970-75	1975-80	1980-85	1985-90	1990-95
China	5.72	6.06	4.86	3.32	2.55	2.46	1.92
Indonesia	5.42	5.57	5.10	4.68	4.06	3.31	2.90
Korea	5.63	4.71	4.28	2.92	2.50	1.80	1.65
Malaysia	6.72	5.94	5.15	4.16	4.24	4.00	3.62
Philippines	6.61	6.04	5.50	4.96	4.74	4.30	4.00
Singapore	4.93	3.46	2.62	1.87	1.69	1.71	1.79
Thailand	6.39	6.11	4.99	4.25	2.96	2.57	1.94
Vietnam	6.05	5.94	5.85	5.59	4.69	4.22	3.40

Source: United Nations: World Population Prospects, The 1996 Revision, Annex I, Demographic Indicators (24 October, 1996)

Table 4: Decline of Total Fertility Rate by Period (%)

Country	From 1960-65 to1970-75	From 1970-75 to1990-95	From 1960-65 to1990-95
China	15.0	60.5	66.4
Indonesia	5.9	43.1	46.5
Korea	24.0	61.4	70.7
Malaysia	23.4	29.7	46.1
Philippines	16.8	27.3	39.5
Singapore	46.9	31.7	63.7
Thailand	21.9	63.1	69.6
Vietnam	1.8	41.9	43.8

Source: Calculated from Table 3

If we look at the period from 1960-65 to 1970-75 as the former period and the period from 1970-75 to 1990-95 as the latter period, Singapore is the only country where fertility decline was greater in the former period than in the latter period. The majority of fertility declines have taken place over a short period of time in almost all countries.

These facts suggest that fertility control measures with emphasis on family planning had already been started in the former period and that their effect was rapidly materialized after the '70s as the measures were intensified.

VI. Population Policy

Population policy is a policy science in the form of strategy for survival that was created by humanity in the latter half of the 20th Century. Only human beings have the wisdom to control their reproductive capacity when their sustainable survival is endangered because of the balance with their environment. For the first time in human history, we are faced with the challenge of globalization in which we have to seek for the possibility of our own survival in the context of Planet Earth.

Controlling and managing the reproduction of population, i.e. fertility of population, represent extremely complex phenomena and a task that is difficult to carry out. After the Second World War, family planning was taken up by the developing countries that have lost their hope for development due to unprecedented high birth rate and population increase. In particular, family planning was implemented as a powerful government policy in poverty-afflicted Asia, which had 60% of the world's population.

In developed countries, fertility control had been implemented since before the war and had shown success in reducing fertility. However, an important point is that fertility was lowered under voluntary will of individuals. Governments even tried to stop the diffusion of family planning.

In the case of developing countries, government plays the central role in implementing fertility control measures-an experience developed countries have never had. In a sense, family planning is a population policy that can be regarded as a new social engineering method.

Demographic transition realized in developed countries of low fertility and low mortality has now entered a new phase of reproduction rate (total fertility rate: TFR) below the replacement level. Almost all developed countries are faced with extremely low fertility. Total fertility rate in countries such as Italy, Spain and Germany is at abnormally low level of 1.2 to 1.3.

As for the 8 countries that were included in our study, below-replacement level low fertility has been attained in Korea, China, Singapore and Thailand. In particular, fertility in Singapore has dropped as low as 1.44 in 1986, which falls within the range of developed countries.

That some of these Asian countries that fall within the category of developing countries already have achieved decline in fertility comparable to that of developed countries has extremely high significance both in terms of theory and practicality. The question must be asked whether fertility should be recovered by means of national policy as in the case of Sweden, whether such policies will prove effective, and what kind of understanding is needed on a global scale.

Singapore has made a turnaround to the New Population Policy of increasing fertility, as exemplified by slogan "Have three, or more if you can afford it." Korea has also started to give serious consideration to the matter. Malaysia is also shifting its focus on the qualitative aspects of population such as health and education under her version of New Population Policy.

The purpose of our study is to set forth short- and long-term outlook from a global perspective in view of the present situation of population policies adopted by the Asian countries. Such effort will contribute to the study of population policy that Japan, as a developed country and a member of Asia, must follow. At the same time, measures that are taken by Japan against aging society with emphasis on

lowering fertility are expected to offer a precedent for other Asian countries.

VII. Population Policy of Selected Countries

China

Although China has the largest population in the world, the percentage of Chinese population in Asia has dropped from 38.7% in 1970 to 35.9% in 1990 and is projected to go down to 30.1% by 2030 as a result of population control policies that has been put in place since 1973. If such population control policies were not adopted in China, the Chinese population would have reached 1,617 million in 1996, a figure exceeding the actual population by 392 million. In reality, crude birth rate and population increase rate were as low as 16.98 and 1.04%, respectively, in 1996.

However, the absolute numbers of annual births of 21 million and natural increase of 13 million still need to be controlled, making implementation of family planning a major challenge for China.
The issue of quality is given importance in addition to quantity in China's population policy. Quality in this case signifies health and education, and remarkable improvements are being made in these areas as well.

Rapid decline in fertility naturally brings about aging of population. The percentage of children in the population has already dropped to 26.7% and the elderly population of aged 65 and above accounts for 6.7% of total. This translates to 83 million in actual number of elderly population and security for elderly has become one of the vital issues for the government.

While China's population policy includes various aspects of quantity, quality and structure of population, family planning is the central element in her population policy as means of controlling population. Late marriage, late childbirth, small number of children and one-child family are encouraged while giving birth to second child after an interval of several years is allowed in rural areas. Minorities are also allowed to have second child, and how to implement is determined by local governments.

A remarkable change in population control through family planning occurred in September 1979 when "One Child Per Couple" was addressed in the open letter of the Central Committee of the Chinese Communist Party. As for the period of duration of this unprecedented policy in human history, the open letter suggested "next 20 to 30 years." Professor Tien Xueyuan, the author of section on China in this report, argues that this period corresponds to single generation and that it is equal to population control who are expected to be parents of next generation.

The slogan of "perfect policy" that makes it possible to adjust the policy to all different people was introduced in the mid-'80s. To achieve the flexibility of policy that would make it possible to respond the policy to various issues in reality, for example bearing the second child was permitted when the only child in a rural village was a girl.

New changes that have taken place in the '90s were the integration of family planning into social and economic development amidst the reform towards market-oriented socialist economy that was taking

place in China and the switchover in the nature of family planning itself from control-oriented policy to livelihood-improvement and family welfare-oriented policy. Attention must be given to these changes, as they were attempts for important shift in China's population policy.

The results of family planning in China are clearly shown in birth rate and natural increase rate. Crude birth rate has been cut by nearly half from 33.4 in 1970 to 17.1 in 1995 while natural increase rate dropped to less than half from 2.58% in 1978 to 1.06% in 1995. The number of natural increase also went down from 21.14 million in 1970 to 12.71 million in 1995, a reduction of 8.43 million.

Migration is a main subject that is usually considered in a population policy. Migration consists of internal migration and international migration. Rapid development of modern economy that followed the switchover to the market economy system is triggering large-scale migration in all over the country. According to a population sample survey conducted in 1995, 32.37 million people migrated. The majority of migration was to the southeastern coastal regions-these people were referred to as "Peacocks Flying to the Southeast"

The third feature of China lies in the rapidly advancing aging of the population. People aged 65 years and above will account for 7% of the entire population by the end of this century and will increase to18.3% by 2040. Aging of population in China is predicted to advance at higher speed than any other developing country. The main problem of aging in China lies in the fact that aging will advance rapidly before economic development is achieved, as opposed to aging in developed countries which is taking place amidst high level of economic development.

Indonesia

During the Sukarno era, which is referred to as the "old order," the population policy of Indonesia was to increase population. Therefore, population control policy in Indonesia did not start until 1966 when Suharto took over the administration and introduced the "new order." Particularly from 1970 onward, population planning was considered to play a central role in the development plan. For this reason, National Family Planning Coordinating Board (BKKBN), which played a coordinating role with relevant ministries, was established to implement family planning for controlling population increase.

BKKBN's activities were truly remarkable and the results of its community-based family planning activities are rated highly throughout the world. In addition, the Ministry of Population became independent from the Ministry of Population and Information and is placed in charge of policies and administration of population-related affairs. The point that is worthy of note is the fact that Dr. Haryono Suyono is serving as the Chairman of BKKBN in addition to holding the post of Minister of Population.

As of 1997, Indonesia has a population exceeding 200 million, which is the largest among ASEAN countries. Crude birth rate has dropped from 40.6 in 1971 to 22.9 in 1997 while total fertility rate has declined to less than half during the same period from 5.61 to 2.58. Meanwhile, crude death rate has been improved from 19.1 in 1971 to 7.54 in 1997, which is less than half, and average life expectancy for men and women combined has been extended by nearly 19 years from 45.7 years to 64.3

years during the same period.

Striking characteristics of population in Indonesia lies in the extremely unbalanced regional distribution of population. For instance, Java accounts for mere 6.9% of national land but has 58.9% of national population (as of 1995). In contrast, Kalimantan accounts for 28.1% of national land but has only 5.4% of national population. A subject of particular interest to the government, in addition to migration from rural to urban areas, is transmigration from Java, which is an island with high concentration of population, to other islands such as Kalimantan and Sumatra.

The content of population policies currently implemented by Indonesia is as follows:

(1) Improvement of quality of population
(2) Control of population scale
(3) Guiding of migration
(4) Improvement of demographic information system
(5) Development of facility supply system for aging society
(6) Development of family self-help effort and improvement of quality of family
(7) Increase of information about family planning movement and strengthening of education structure
(8) Strengthening of international cooperation

Examples of success in community-based activities in the area of family planning has earned the country's position as the leader of the so-called "south-south cooperation."

Korea

Korea is characterized as a country that has succeeded in controlling fertility mainly by means of family planning over an extremely short period of time. After reaching the peak of 3% around 1960, Korea's annual population increase rate fell below the 2% mark in 1975 and the 1.5% in 1980. By 1995, it dropped further and reached 0.5%. The country's population reached 44.6 million in 1995, resulting in population density of 449 persons per square kilometer which corresponds to one of the highest levels in the world.

Realizing that population increase and overpopulation are serious obstacles against economic development, the government implemented a thorough policy for controlling population increase.
Fertility as seen from total fertility rate was extremely high at 6.0 in 1960 but dropped by nearly half to 3.2 after 15 years in 1975 and reached the replacement level of 2.1 in 1985. Since then, it has fallen far below the replacement level and has been realizing a level comparable to developed countries of 1.6 in 1990, 1.8 in 1992 and 1.7 in 1995.

Such rapid decline in fertility was realized through strong promotion of family planning movement by the government, socioeconomic incentives and administrative measures. All kinds of administrative measures including assigned number of sterilization operation to local governments and health stations were utilized. Please refer to Table 4 in the report by the author, Dr. Jung Duk Lim, for details on implementation of family planning and tax reduction and others offered to encouraging small family.

Decline of total fertility rate to below the replacement level since 1985 gave rise to serious self-questioning about the family planning policy implemented by the Korean government. In a sense, it was a complete turnaround in population policy. The rapid decline of fertility to below the replacement level since 1985 made the Korean government reluctant about implementing family planning, resulting in abolition of all incentives and non-incentives related to family planning in the '90s.

Korea found herself in the same situation as developed countries of having to decide the country's course after having reached the final stage of demographic transition and having fallen below the replacement level in terms of total fertility rate. In Korea, there are two different views regarding such fertility transition. The first view holds that social support for the present family planning policy of encouraging the norm of small family having up to 2 children has already been established. On the other hand, numerous problems associated with population structure such as aging and lack of sex ratio balance suggests the need for reconsideration of the population policy.

The other view holds that fertility control is still important. It argues that traditional fertility pattern can always be recovered because decline of fertility in Korea is not the byproduct of sociocultural changes that were seen in the Western society but was realized over a short period of time through strong government policy.

The next important aspect of demographic phenomena in Korea after fertility is the drastic change of regional distribution of population resulting from migration. First, there is concentration of population in cities. The percentage of urban population has increased from 36.6% in 1966 to 74.4% in 1990 which is a level comparable to developed industrialized countries. Second, there is concentration of population in the Seoul Metropolitan Area. The percentage of Seoul Metropolitan population soared from a mere 20.8% in 1960 to 45.3% in 1995. The percentage of the population of Seoul city only increased from 9.8% in 1960 to 24.4% in 1990 but went back to the level of 35 years ago of 9.0% in 1995 five years later. This is attributable to large-scale out-migration from within the city limits of Seoul, as well as from other parts of the country, to the suburbs of Seoul.

The Korean Government naturally adopted a diffusion policy to alleviate the rapid concentration of population in certain industrial areas such as the Seoul Metropolitan Area and other large cities. In particular, the First National Land Development Program (1971) and the Second National Land Development Program (1982-1991) checked excessive concentration of population in large cities and sought adequate redistribution of population among 15 key cities for balanced development of national land.

It is clear from the experience of many developed countries that, as long as population and industrial locations are determined by the free will of individuals and companies, sweeping redistribution will be extremely difficult to realize because government policies will naturally become indirect.

Lastly, unbalanced sex ratio, which is the uniqueness of age structure in the Korean population, must be discussed. The characteristic of sex ratio for the entire population is that the number of male population is slightly larger which is the direct reflection of unbalanced sex ratio at birth. When the average number of children goes down to 2 or 1 per family as a result of thorough implementation of

family planning, preference for male child that had not manifested in the past will come to surface. In Korea where the influence of Confucianism is still strong, the likelihood of induced abortion increases when it becomes known that the fetus is a girl. Sex ratio for newborn babies as a whole was below 110 until 1985 but increased rapidly thereafter to 116.6 in 1990 and fluctuated between 115 and 113 until 1995. However, sex ratio increases proportionately with the parity of children in the family. For instance, sex ratio become extremely high for the third child and has surpassed 200 in 1993 and 1994, which means that twice as many male babies were born than female babies. This trend becomes even more conspicuous with the fourth child, surpassing 200 since 1989 and reaching an unusually high level of 247 in 1993.

It can be said that the population policy of Korea is a noteworthy example of having succeeded over an extremely short period of time but at the same time faces a new policy issue.

Malaysia

The point that distinguishes Malaysia from other countries included in this study is that fact that it is a multi-ethnical country. Distinct features can also be seen in the area of population variables and also considerable regional difference exists between Malaysia Peninsula (11 provinces) and East Malaysia (Sabah and Sawarak, Borneo).

The country mainly consists of three ethnic groups. According to the 1991 census, Bumiputera (comprised of Malay and aborigines) accounts for 61.7% of the total population while those of Chinese and Indian origin account for 27% and 7.7%, respectively.

After its independence in 1957, the population of Malaysia doubled in a period of a little less than 30 years and reached 18.4 million in 1991. While population increase rate declined slightly over the last 30 years, it continues to grow at an annual rate of 2.4% which is noticeably high compared to other countries in the region. This is reflecting Malaysia's population policy.

The government decided to control the population increase rate in the '60s in view of the hindering effect of rapid population growth on economic and social development and incorporated family planning and population control into the government policy. The government set the target on lowering the population growth rate from 3% in 1966 to 2% by 1985, and enacted Family Planning Act in 1966 and created the National Family Planning Board (NFPB) in the Prime Minister's Office.

Thus the policy and program for family planning played the role of an important component in her 5-year development plans. In particular, the need for diffusion of small family system has been emphasized in the Third 5-Year Development Plan (1976-1980).

However, serious changes occurred after entering the '80s. Amidst the worldwide recession that occurred in the early '80s, the Malaysian government announced the New Population Policy in 1984 as a measure for counteracting the smallness of her domestic market and emergence of labor shortage in certain industries. Through this policy, firstly the government proposed "70 million population by the year 2100" in view of expansion of market transition and secondly renamed the National Family Planning Board (FFPB) to National Population and Family Development Board (NPFDB).

The characteristic of NPFDB lies in the emphasis it placed on the improvement of human quality such as health of the entire population and family development while continuing to offer the same family planning services as before.

In other words, the focus had shifted from demographic aspects to manpower and human resource development in the midst of remarkable socioeconomic development process. The undercurrent of family planning in Malaysia is making a transition from merely limiting the number of population to development of human resources, i.e. improving welfare for family members, particularly for women, as well as quality of life.

Amid such changes in government policy, difference in fertility is being observed among different ethic groups. In total fertility rate, Malays had a lower figure of 6 compared to 7.3 of Chinese and 8.0 of Indians in 1957. However, this trend changed thereafter as total fertility rate of the Chinese and Indian population dropped to 2.6 and 2.8, respectively, compared to 4.1 of the Malays and demonstrated that the decline in fertility has slowed down among the Malays compared to the rapid decline among the people of Chinese and Indian descent. Fertility in Malaysia as a whole remains at a high level compared to other ASEAN countries with the exception of the Philippines.

The Philippines

The Philippines is a great power in ASEAN having a population of nearly 70 million. It has the characteristic of being a country made up of innumerable islands with different languages and cultures and of being the only Catholic country in Asia. Population has continued to increase at more than 2% a year in the recent years and total fertility rate remains as high as 3.6.

In the Philippines, the Commission on Population, abbreviated as POPCOM, was founded in 1970 to implement population policies with emphasis on fertility control and family planning. The goal of this commission was "to implement national family planning for the people with respect for individual religious beliefs to counter act enormous social and economic challenges brought about by high population increase rate." The first half of the'70s was referred to as "the period of population policy" as the programs were carried out under the strong support of President Marcos.

Owing to political instability that continued after the People's Revolution in 1986, the activities of population programs stagnated with serious slowdown of the economy. In addition, Catholic influence always emerged to a greater or lesser degree in connection with the family planning policy of the government.

The current president, President Fidel V. Ramos, who is the first Protestant president to take office in the predominantly Catholic Philippines, sought activation of POPCOM. The present program has two new characteristics. One is transition from "population control" to "population management." It is an approach to improve the livelihood of the Filipino people through human resource development in balance with available resources and through marriageable population level, which, in turn, will promote sustainable development. The other is the fact that it incorporates family planning into the framework of population, resources and development.

However, reorganization of organizations that are implementing family planning and fertility control policies in the Philippines, political background and opposition from Catholic Church appear to be delaying the diffusion of effective family planning. For this reason, it is said that a compromise that is acceptable to the Catholic Church is indispensable for achieving population policies in the Philippines.

The second most important aspect of population policy in the Philippines is that of migration. Large-scale migration from rural villages and backward frontiers to developing cities and metropolitan areas occurred in the '60s, resulting in nearly five-fold increase of urban population from 5.7 million to 26.6 million between the period from 1950 to 1990. The government announced the need to decelerate migration into cities as early as 1976. However, concentrated migration into cities still continues up to now for 20 years.

The government is taking measures to promote balanced distribution of population among regions. Noteworthy among them is a migration registration system implemented at villages. It must also be remembered that imigration abroad of the Filipinos is an important task for the Philippines in terms of population policy.

Singapore

Singapore offers the most typical example of success in the population policy of fertility control. The need for controlling population increase has resulted in continued involvement of the government, and fertility dropped at an unprecedented rate as the program succeeded in winning the consent of the people. When the government founded the Singapore Family Planning and Population Board (SFPPB) in 1966, total fertility rate at the time of 4.5 saw a dramatic decline to the replacement level over a period of 10 years or so. What was even more surprising was the fact that this replacement level fertility continued to decline in 10 years to 1.44 in 1986 which is an extremely level that is seldom found even among developed countries.

Singapore is an island country with population of 3 million and a city-state as well. Its area is less than one-third of Tokyo Metropolis. Her population is less than one-fourth of Tokyo Metropolis but her population density is 4,833 per square kilometer as of 1995 and is comparable to 5,383 of Tokyo. Strong recognition that "rapid population increase in this small country would be a hindering factor for social and economic development" gave rise to an achievement of exceptional control over population increase. However, Singapore decided to turn around her population policy after being confronted with shortage of labor and at the same time starting to experience long- and short-term elements of instability brought about by unusually low fertility such as aging of population and labor force, rising expenditure on welfare for the elderly and lowering of economic dynamism. It was materialized in the form of New Population Policy which was announced in March 1987 and signified a renunciation of the previous policy for reducing population through population control. A decision was made to prevent the trend of lowering fertility and a series of measures were taken to promote increase of fertility.

Labor shortage continued into the '90s and the country became increasingly confident that her ongoing economic development could support a larger population. From the viewpoint that there will be

increasing demand for skilled foreign workers, Singapore considerably eased her restrictions on immigrants in 1997. Foreigners account for about 10% of Singapore's population (1990 census) and total population increase rate reached as high as 4.2% in 1996.

The decline of fertility has been halted since Singapore 's new population policy was implemented in 1987. Total fertility rate of 1.4 in 1986 went up to 1.9 in 1990 but has shown a slow decline since then to 1.7 in 1996.

However, the Singapore Government is not anticipating that fertility will exceed the replacement level and expects it to remain between 1.8 and 2.1 with the country's population starting to decrease around the year 2020 after reaching the peak of 3.2 to 3.4 million.

Singapore's new population policy is to encourage marriage and childbearing, as expressed in the slogan "Have three, or more if you can afford it," and offers numerous incentives for having many children. An important pillar of this new population policy aside from increasing fertility is the continuous acceptance of foreigners.

Thailand

Thailand is worthy of attention among ASEAN countries for having achieved remarkable demographic transition. The country's total fertility rate went down from a very high level of 6.3 in the 1964-65 period to 2.6 in the 1985-90 period. This corresponds to a sharp decline of nearly 60%. Furthermore, the rate continued to decline to 2.2 in 1991 and finally fell below the replacement level at 1.98 in 1997. Crude birth rate and crude death rate for the same year was 15.6 and 5.0, respectively, which means that natural increase rate has dropped to 10.6, i.e. to nearly 1%.

Thailand's population increase rate based on population census during the period after the Second World War from 1947 to 1960 was 3.2%, which meant that she belonged to a group of countries with one of the highest increase rates in the world. Having realized the hindering effect of this exceptionally high population increase on economic and social development, the Thai Government finally decided in March 1970 to implement a policy for supporting family planning. On and around 1970 was a period when major countries of Asia decided to adopt population control policies.

The main point was the recognition that policies for controlling population increase are inseparable from social and economic development programs. The fact that target increase rates from the Third National Development Program (1972-76) to the Seventh National Development Program (1992-1996) were all realized demonstrates the miraculous success attained by family planning policies and programs.

Such dramatic success of controlling fertility and population increase in Thailand is directly linked to the extremely high rate (75%) of contraceptive use. Only 5% do not have access to contraceptives despite their desire to use them. The Reproductive Revolution that Thailand boasts is an example of one of the greatest successes in the world. Pills are the most common method, followed by sterilization of women.

Thailand is also making striking improvement in mortality rate, with non-infectious diseases and

accidents replacing infectious disease as the main cause of death. Noteworthy among causes of death in Thailand is AIDS. As of January 1997, there are 55,443 AIDS patients in Thailand and the disease is becoming a new cause of death that requires measures.

The second most important population policy in Thailand concerns migration and distribution. There are two types of migration-domestic migration and international migration-and both are important policy tasks for Thailand. Domestic migration consists of migration from rural to urban areas, which is commonly observed in any country. In Thailand, such migration is concentrated in the capital city of Bangkok, resulting in the population of this primate city being far greater than any other city in the country. For instance, Bangkok is a mega-city whose population is 22 times larger than the second largest city of Nonthaburi. Compulsory migration is usually not observed in migration policies. Therefore, measures for alleviating migration or indirectly promoting migration to certain regions or cities are taken. In Thailand, policies for promoting the construction of growth pole cities and satellite cities and for regional and rural development are adopted to alleviate concentration of migration to Bangkok. However, sufficient results have not been obtained in terms of filling the gap between Bangkok and other regions.

A large-scale international migration is taking place between Thailand and East Asia and between Thailand and neighboring countries. In addition to legal migration, there are many that are illegal. The government is carrying out numerous measures for promotion of migration and protection of the migrants. It is worthy of note that Thailand is signing bilateral agreements with receiving countries for effective utilization of Thai labor force.

Vietnam

With a population of 75 million as of 1997, Vietnam has the second largest population in Southeast Asia after Indonesia (204 million as of 1997). After the Second World War, the country followed a tragic fate and experienced decades of military and political confusion. The population of 75 million is facing the new era and is about to achieve revolutionary change and progress in areas such as economy, social development and population.

According to recent data, Vietnam's crude birth rate and crude death rate have gone down considerably to 23 and 7, respectively. Remarkable progress has also been made in terms of natural increase rate (1.6%) and total fertility rate (3.1). (Data from PRB, 1997 World Population Data Sheet.)

The turning point in Vietnam's history of development was the Doi Moi policy of 1986, which became the driving force behind the revolutionary development in the area of population as well as politics and economy.

Family planning, the method for addressing rapid population increase, had been implemented since the North Vietnam era. However, it was after the unification of North and South in 1975 that family planning was practiced widely among the people. In particular, implementation of systematically powerful program did not take place until 1984 when the National Committee on Population and Family Planning was founded.

Starting in 1983, number of children in the family was limited to 2 and the target of lowering total fertility rate to 3.1 by 2000 and to 2.1 by 2010.

However, the point that must be noted is the rapid increase in number of induced abortion. The number of abortion per 1,000 population of women in reproductive age has gone up from 58.5 in 1987 to 71.3 in 1988 and 70.0 in 1989.

Migration and population distribution are another important population policies implemented by Vietnam. Migration occurs in 3 different patterns. The first pattern is the traditional migration from rural to urban areas. A typical example of this is migration from rural areas to Ho Chi Minh City, which is estimated to have reached 600 thousand. The second pattern is migration from rural to rural areas. For instance, 400 to 500 thousand people have migrated from the mountainous regions in the north to the central highlands (Tay Nguyen) in the last 4 to 5 years. The third pattern consists of migration from the northern part of the country to the southern part of the country. Migration of this type was encouraged by the government after the reunification of the country in 1975.

International migration, including the boat people, became a serious problem between 1975 and 1988. However, there are no longer international migration in terms of refugees today.

Chapter II

China's Population Policies and Population Studies

China's Population Policies and Population Studies

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I. Introduction

The 'population train' accelerated after World War II has been slowing down since the 1970s. This is true, in particular, for Asia, where the population decreased from 66.2% of 1970 to 60.3% of 1990 as a world's percentage, and is projected to decrease further to 59.4% by 2030. As the most populous country in both Asia and the world, China is critical either to the growth decline or to the percentage fall. In 1970, China's population accounted for 38.7% of the Asia's total, but it declined to 35.9% in 1990, and is estimated to decrease further to 30.1% by 2030[1]. In China, although there is no doubt that the population slow-down has been coupled with rapid economic growth and substantial improvement in living standard as well as educational attainment for recent 20 years, it is generally argued that the major reason for the slow-down should be attributed to the implemented population control policy since 1973. Due to its emphasis not only on fertility control but also on improvement in population quality and its concern about population aging, the policy has increasingly been demonstrating its impact on social and economic development especially on sustainable development in China. At the turn of this century, reviewing the history of China's population policies and coping with their problems are relevant not only to China's population and development but also to either Asia's or world's population change.

II. A Macro-perspective in China's Population Problems

1. China's Population Problems and Their Characteristics

Due to the population policies implemented for more than 20 years, population problems have been resolved to some degree, and population pressures have been alleviated too. At the meantime, the quantity, quality and structure of population have changed significantly. On the other hand, the problems will by no means be solved in one day due to their accumulation in a long time. So, the problems have a characteristic of transition.

(1) Given the huge size, there is a sharp contradict between low growth rate and great increment. In 1949, China's population was only 542 million, and it grew to 1224 million by 1996, increased by 682

[1] Source : United Nations: World Population Prospects, The 1994 Revision, New York, 1995; China Statistics Yearbook 1996, China Statistical Press. 1996

million for a period of 47 years. Taking 21.1% of world's 5804 million population and 34.8% of Asia's 3513 million population, China boasts the largest country in the world in terms of population size[2]. Nevertheless, if the population policies had not been carried out by China, its population should have increased to 1617 million by 1996 in terms of a birth rate of 33.4 ‰ and a growth rate of 2.6% in 1970, which is 392 million more than the otherwise. So, it is easy to see the effects of population policies. However, it is still a significant event that the population actually grew by 1.26 times, which has led to a sharper contradict between population's low growth rate and large increment. In 1996, China's birth rate was 16.98 ‰, and growth rate was 1.04%. Both of them are much lower than those of the developing countries and even of the world average, and decreased by a half compared with those in the 1950s in China. Even though, births are still as many as 21 million and net growth as many as 13 million each year, and both of them are higher than the average of the 1950s. To reduce population growth, both birth rate and growth rate must go down further, which is the challenge for China's future family planning practices.

(2) In spite of a great progress, population quality in general is still low. Here, population quality includes physical and educational aspects. Physical quality refers to the measurements of height, weight, muscle, chest, and the health condition of body. From a demographic view of point, those measurements will be reflected in death rate and people's longevity. In terms of infant mortality and life expectancy at birth, two of the most important indicators, physical quality of China's population increased rapidly. The infant mortality reduced from 200 ‰ of the 1940s to 32.9‰ of 1990 and further to 30 ‰ a present. The life expectancy at birth risen from 35 years in rural areas and less than 40 years in urban areas in the 1940s to 68.6 years of 1990, and has reached 70 years by far[3]. In 1996, the infant mortality was 57‰ for the world as a whole, and 9‰ and 63‰ for developed countries and developing countries respectively while the life expectancy at birth was 65 years for the world as whole, 75 years for the developed countries, and 63 years for the developing countries[4]. In terms of death rate, incidence of diseases, and daily intake and composition of nutrition, the physical quality of China's population is significantly better compared with the developing countries and even with the world's average, and is only slightly worse than compared with the developed countries.

Educational attainment of the population has also increased significantly. Using the data coming from the 1964, 1980 and 1990 censuses respectively, Table 1 has contrasted the percentage change of the population with different educational levels5.

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[2] Source: China Statistical Yearbook 1996, it is number of population in 30 continental provinces, autonomous regions, and municipalities, which excludes Taiwan, Hongkong, and Macao.

[3] Source: China Statistical Yearbook 1995, Economic Management Press, 1995; People's Daily, Jan. 18, 1997.

[4] Source: Nafis Sadik: The State of World Population 1996, New York, 1996.

[5] Source: China Statistical Yearbook 1996;. China Population, Faburary 16, 1996.

Table 1: Percentage Change of the Population with Different Educational Levels (1964 - 1990) (%)

	1964	1982	1990	1995
College	0.42	0.60	1.40	2.07
Senior High School	1.32	6.63	7.95	8.28
Junior High School	4.68	17.75	23.30	27.28
Elementary School	28.33	35.40	37.17	38.44
Illiteracy and Semi-illiteracy	45.61	28.26	18.12	12.01

Note: The minimum age regarded as the illiterate or semi-illiterate was 7 years in 1964 census, 12 years in 1982 census and 1990 census, and 15 years in 1995.

Table 1 suggests that the percentage of the population with an educational level of college, senior high school, junior high school and elementary school has grown substantially for recent 30 years while that of the illiterate and semi-illiterate population has experienced a rapid decline. It is worth noting that the greatest increase occurred in the population with an educational level of college, following by the population with an educational level of junior high school and senior high school. The population with an educational level of elementary school increased only by 8.6% due largely to the relatively high prevalence of elementary school in China. The percentage of illiterate and semi-illiterate population has decreased by more than a half, and the efforts to carry out the national compulsory education has achieved a great accomplishment. However, the rate of illiteracy and semi-illiteracy, not only much higher than that of the developed countries but even higher than that of some developing countries, is still relatively high in China, and is becoming a barrier to China's modernization strive. To eliminate the remaining 145 million illiterate and semi-illiterate population, priority must be given to the popularization of the 9 year compulsory education while promoting advanced and specialized education.

(3) The potential of growth still exists in the age structure which is in the transition from the adult to the aged. According to the classification for young, adult and aged population, China's population completed its transition from the young to the adult in the mid-1980s, and is approaching a aged structure. In 1995, the juvenile population aged 0-14 years took a percentage of 26.7% and the proportion of the elderly population aged over 65 years took 6.7%. In fact, a substantial decrease in birth rate occurred in the 1970s. In terms of the percentage taking in the total population, the age group 5-9 ranked the first, 10.7% , and was followed by the age group 25-29, 10.2%, the age group 30-34, 8.8%, the age group 20-24, 8.7%, the age group 15-19, 7.4%, and the age group 0-4, 7.3%, and...respectively[6]. This indicates that the proportion of the most reproductive population has declined while the population as a whole still has some growing potential. Various estimations with similar conclusions tell that the population can not realize zero growth until 2050 when it reaches 1600 million, therefore, it is still a tough task to control population growth in this country.

[6] Source: China Statistical Yearbook 1996.

(4) With uneven urbanization, the composition of rural-urban population is backward. Originally, China was a backward agricultural country where the proportion of urban population was relatively low, only 10.6% in 1949. Due to the industrialization through implementing the heavy industry-oriented development policy of the 1950s, urban population grew quickly, and the proportion of urban population increased to 19.8% by 1960. However, as a result of the economic difficulties of early 1950s, the economic adjustment of late 1960s, and the impacts of the subsequent 'cultural revolution' lasting for 10 years, industrialization was impeded, which led the proportion of urban population to decline and then to being stagnant. It was not until 1978 that the percentage of urban population was only 17.9%. The rapid economic development and accelerated modernization process since the economic reform and open up to the outside have been greatly encouraged population mobility and migration, which has stimulated urbanization greatly. In 1995, the proportion of urban population reached a level as high as 29.4%[7]. Given it is an official statistic from governmental statistical department, the real number is likely to be higher. Any way, China's urbanization degree is falling far behind in comparison with the world's average of 43%, so, more efforts must be devoted.

(5) It is difficult to adjust the imbalance of regional population distribution by means of migration. By grouping such 6 provinces and autonomous regions as Inner Mongolia, Ningxia, Gansu, Qinghai, Xinjiang, Tibet as northwest; such 13 provinces and municipalities of Shanxi, Heilongjiang, Jilin, Shaanxi, Henan, Hubei, Hunan, Sichuan, Chongqing, Guizhou, Yunnan, Jiangxi, Anhui as central region; such 12 provinces, municipalities and autonomous regions of Beijing, Tianjin, Liaoning, Hebei, Shandong, Jiangsu, Shanghai, Zhejiang, Fujian, Guangdong, Guangxi, Hainan as coastal southeast, table 2 contrasts the areas, population size and density among those regions.

Table 2: China's Population Distribution in 1995

	A Percentage of National Areas	A Percentage of National Population	Population Density (Persons / km^2)
Northwest	52.9	6.3	15
Central Region	33.1	52.8	200
Coastal Southeast	14.0	40.9	375

From table 2, we can see the ratio of the population density of Northwest to that of Central Region and of Coastal Southeast is 1:13:15. The ratio seems too skew to be reasonable. Nevertheless, it is not a easy job to change the patterns of population distribution which are determined by geographical, historical, and ethical factors, as well as social and economic development. In China, the most populous areas are concentrated in southeast. The population pressures facing different regions are too uneven to be adjusted by means of migration.

[7] Source: China Statistical Yearbook 1996.

(6) With population aging rapidly, old age security becomes an urgent problem. Due partly to current age structure and partly to future control policy, the aging speed of China's population will be very fast. It is estimated that China's population will be near to the aged by 2000, and to seriously aged by 2040 when the proportion of the population aged over 65 years is more than 10%. It is projected that the proportion of the population aged over 65 will reach 18%, the highest in the developing world, by 2040. Given its great impacts on economy, culture and society, the accelerating population aging is likely to limit China's development in the 21st century. Therefore, to cope with the seriously aged population during 2020-2040, the establishment of a reliable security system for old age will be critical. Facing the seriously aged population, all of the developed countries have responded by setting up a social security system for old age. This is possible for the developed countries due mainly to their developed economies. But in China, a seriously aged population will come up 20 years later while its economy just begin to be better off, and thus face a "time behind" between economic development and the aged population structure. So, it seems impossible for China to simulate what the western world has done for the aged. The security system for old age in China must sufficiently take into account the contributions of social support, family support, and self-support for old age. In so doing, the support of children to their old parents must be advocated, the re-employment at old age must be organized properly in establishing the social security system for old age.

2. The basic points of China's ongoing population policies

As for population policies, several aspects such as the quantity, quality and structure of a population must be included. Given the importance of population control in China, family planning is therefore a key component of the ongoing population policies. The main points of family planning policy in China include: encouraging late marriage and late childbearing, fewer and better births; encouraging one child family; second birth is allowed for rural couples after several year interval; family planning policy is also applicable to minorities, but how to implement the policy among them can be determined by the governments of autonomous regions or local provinces. With respect to policy implementation, some differences exist between rural and urban areas, and between Han ethnic and minorities, that is, the policy implementation is more flexible in rural areas than in urban areas, more flexible for minorities than for Han ethnic. Furthermore, the local provinces (municipalities and autonomous regions) have a right to stipulate their specific regulations and to legislate their own laws according to their local realities. The basic points of above policy can be concluded as follows:

First, fewer births. What is the degree to have fewer births? Being an "urgent brake", the policy of encouraging one child family has been used to limit population growth since the 1980s because it would be impossible to slow down the rapid population growth otherwise. But the policy is significantly different between rural and urban areas. Now, one child family has basically become a norm in urban areas while it is rare to see in rural areas. For example, a sample survey conducted between October 1, 1995 and September 30, 1996 revealed that the fertility of urban women at reproductive age was 37.22 ‰ and the ratio of the first birth to the second and the third birth was 28.4:5.6:1.0 while the fertility of

rural women at reproductive age was as high as 54.51 and the ratio of the first birth to the second and the third birth was 7.1:3.2:1.0[8]. The reason responsible for this is the difficulties for rural couples have only one child as well as the second birth allowed for the family with single female child. China has 56 ethnic. In addition to Han ethnic, the other 55 minorities only account for 8% of the total population, but the minorities can enjoy a more flexible policy stipulated by the governments of autonomous regions (municipalities and provinces) according to local laws and regulations. Some places, such as Tibet, have no birth control policy at all, and the aim of family planning there is only to educate people and provide services for them.

Second, late childbearing. The Marriage Law of the People's Republic of China stipulates that the first marriage age 22 for male and 20 for female. Late marriage means 3 years later than the legal first marriage age. From a reproductive point of view, late marriage implies a decline of general fertility because it can enlarge the interval between births.

Third, better births. Deferring from eugenics, the better births defined by China's family planning policy only aim to reduce the ratio of disabled births, including congenital malformation and mongolism, and to raise the proportion of normal and healthy births. For example, the policy bans the marriage between relatives, encourages a larger marriage circle, and restricts the births by the couples who have serious genetic diseases.

In addition, China's population policies also cover such aspects as the improvement of population quality and the adjustment of population structure. The policies have put high priority to the development of health and medical facilities as well as the reduction of death rates. As a result, the crude death rate decreased to around 7 ‰ from 20 ‰ of the 1940s, and population's physical quality was improved greatly. The policies have also put emphasis on sciences, education and culture. As a consequence, population's educational level has upgraded substantially. The improvement will be much more phenomenal when the country basically completes the publicization of 9 year compulsory education and eliminates the illiterate and semi-illiterate population in 2000. At the same time, the policies also pay attention to the change of age structure associated with fertility decline and population aging. In 1991, the Sate Council issued "A Decision on Reforming Security System for Old Age in Enterprises". In this Decision, an old age security system, which consists of such three parts as basic security, supplementary security of enterprises, and savings security of individuals, was proposed. According to the security system, basic security, equivalent to 60% of a worker's salary, will jointly borne by enterprises and workers; the supplementary security, provided by the enterprises, will contribute no more than 15% of gross salary pay to worker's personal accounts; savings security, a kind of commercial security, will be solely shared by individual savings which enjoys a favorable interests rate. In the rural areas, old age security has to depend mainly on family support and the labor income of the aged. It is worth noting here that a kind of social security for elderly, consisting of farmer's savings and supplemental assistance from collectives, has developed rapidly in recent in rural areas. By 1995, more than 60 million had participated the above security system for old age. With the increase of farmer's

[8] Source: 1% National Population Sample Survey Data, 1995, China Statistical Press, 1997.

income and the development of rural economy, the coverage of such a security is likely to expand further.

3. Historical evolution of the population policies

When the People's Republic of China was founded in 1949, population transition in this country was at a stage of high birth rate, high death rate and low growth rate. Due to subsequent 3 year economic boom, death rate started to decline, and the population accelerated its transition toward high birth rate, low death rate and high growth rate. China's first baby boom appeared in 1953-1957, during which the average annual growth rate increased to 2.4% from 2.0% of 1949-1952. In 1954, some top central leaders expressed their support to birth control at a symposium. In 1956, the "Report on the Second Five-year Plan for National Economic Development" mentioned: "support for appropriately limiting fertility", "to properly publicize" (contraceptives) and "to adopt effective measures". However, the explicit policy did not take shape then. One reason is that the "support for limiting fertility" at that time mainly aimed to "protect women and children"[9] and lacked of real understanding about the nature of population problems in China. The other reason is that the monograph "On Population Again" by Mr. Ma Yinchuo as well as the arguments of limiting fertility by others were wrongly criticized, which resulted in the prevalence of "left" thought and "left" theories which ignore the population problems facing China then.

Following the Baby Bust of 1958-1961, which was mainly caused by economic depression, a kind of compensating population growth started in 1960, and it lasted for 12 years at an annual average growth rate as high as 2.6%. The discord between rapid population growth and economic development was felt soon by the then central government. At the end of 1962, the Central Committee of the Communist Party of China issued a document entitled "A Guidance to Encouraging Family Planning". In this document, the idea "gradual birth control" was strongly addressed. Besides a statement of (family planning) "is conducive to protecting the health of women and children", the Guidance also stressed that "it (family Planning) is the need for developing our planned socialist economy"[10]. Compared with the expressions of the 1950s, the viewpoint, a planned economy requiring a planned reproduction of population, expressed in the Guidance was out of question a progress, but the Guidance did not show willingness to intervene the rapid growing population. Although the State Council set up a family planning office to intensify the leadership in 1965, the practices of family planning were soon suffering from an anarchy due to the "Cultural Revolution".

In 1973, the population problem became more and more serious as national population increased to as many as 892 million. To cope with it, the State Council decided to set up a leading group at national level. Thereafter, similar governmental apparatus was set up one by one at local level. This greatly intensified the leadership to family planning. In the same year, Shanghai and Hebei province respectively proposed "late (childbearing), large (interval), and fewer (birth)" as their requirements for family planning in their Working Reports on Family Planning. Forwarded by the Central Committee of CPC, those requirements became the actual goal of family planning practices in middle 1970s. As far as those

[9] Source: China Population Yearbook 1985.
[10] Source: China Population Yearbook 1985.

requirements are concerned, "fewer" was a key, which was also called as "one, no less; two, enough". In late 1970s, policy had a big change. In early 1979, the editorial of People's Daily entitled "Put Emphasis on Family Planning" prologurized one child policy. The editorial first proposed "one (child), enough; two (children), maximum" for a couple. In the spring of 1980, several subsequent symposiums convened by the Central Committee of CPC reached consensus on one child policy respectively. In September, the Central Committee of the CPC issued an "Open Letter" to all members of the Party and the Youth League, and called for 'one couple, one child'. Regarding how long the one child policy to last? A period for 'recent 20 to 30 years' was stressed in the Open Letter. In my opinion, "recent 20 to 30 years" implies a period of one generation because fertility control in one generation, equivalent to controlling the number of being parents in next generation, is critical to future population change. Based on its deep understanding about China's population problems, the Open Letter specified the contradicts among rapid population growth, economic development, and improvement in living standards and education; and it finally reached a conclusion that the population must be taken under control.

Apart from some revision, above policy has been basically carried out since the 1980s. In middle 1980s, a slogan of "perfect policy" was proposed. The aim of the slogan was to make the policy manageable, that is, let the policy be applicable to the masses. In so doing, some practical problems were solved, for example, making the policy more flexible for the couples with practical problems. According to this revision, second birth was possible for almost every rural couple with only one female baby. Since the 1990s, the policy has put more and more emphasis on interest incentive in the course of reform toward a market-oriented socialist economy. That is, in rural areas, the implementation of the policy has been integrated into farmer's strive for better-off and happy family construction. This is the so-called 'three combinations' in family planning. In recent, two 'changes' has been proposed in the framework of family planning and its implementation. One of them is to change family planning policy as a comprehensive policy that can integrate population control into social and economic development; the other one is to change the family planning from a control-oriented policy to an interest-oriented policy. In essence, what the 'two changes" aim is to combine the family planning policy with people's self-interests better and to make the policy be a voluntary choice of the masses.

Family planning and population control are two key components of the population policies, but they are not the whole. Population policies also include such components as improvement in population quality and adjustment of population structure. Although the call for improvement in population quality and adjustment for population structure can date back to the speeches by some top leaders as well as to some documents issued by the Central Committee of the CPC, they were not formulated as an explicit component in the policies until the Fourth Session of the Fifth National Congress approved the 'Working Report of the Government' in 1981. The Report formally stated: "limiting population growth and improving population quality are our population policies". As two sides of a coin, the two components interplay each other. On the one hand, population growth control is conducive to the improvement in population quality, including population's physical and cultural qualities. On the other hand, the improvement in population quality, in particular, the increase of educational attainments, can in turn lead

to fertility decline and create a sound environment for a control policy. So, population growth control is closely related to the population structure by age and sex. As early as the 1980s, the problems of aging and skewed sex ratio was noticed. In collaboration with the State Statistical Bureau, the author chaired a project entitled "Sampling Survey for the Aged and Studies on Social Security Reform for Old Age in China" in 1987. In this project, a national sample survey among the aged population over 60 years was conducted nationwide except for Tibet and Taiwan, and a set of data on the aged population was built up . The governmental organization, such as the National Aging Commission, and the academic organization, such as China Gerontological Association, were formed respectively. As aged population is growing rapidly in terms of percentage, aging issue is also being regarded as a component of China's population policies. In his recent report presented at the 15th Congress of the Communist Party of China, Jiang Zemin has stressed that we must "limit population growth, improve population quality, and pay attention to population aging" when speaking on China's population problems and sustainable development strategy. As China's population is aging, it seems that the population policies are more and more likely to depend upon the adjustment of population structure.

III. Comments on China's Family Planning Policy

For more than 20 years, China has devoted a great deal of efforts to population control and implementation of various inherent population policies. Those efforts have already influenced China's population transition and social economic development significantly, and their effects will become more and more phenomenal. The arguments are as follows:

1. Fertility

Since the implementation of population control policy, general fertility, age-specific fertility, total fertility rate, and lifetime fertility have declined rapidly in China. Taking the total fertility rate as an example, figure 1 illustrates its change since the 1970s[11]:

From Figure 1, we can see a rapid decline of the TFR, possibly attributed to its high starting level, occurred in the 1970s. The decline slowed down in the 1980s with a slight rebound after the middle of 1980s. Although TFR continued showing a downward trend after 1990, it is apparent that its pace has slowed given it already decreased as low as 2.0. Coupled with the substantial decline in fertility, both birth rate and natural growth rate have declined . It is decline that contributes to a reduction of the number of birth and growth while the total population is still growing in terms of absolute number. See table 3[12]:

[11] Source: China Statistical Yearbook 1996.
[12] Source: China Statistical Yearbook 1996.

Figure 1. The Deline of TFR since the 1970s

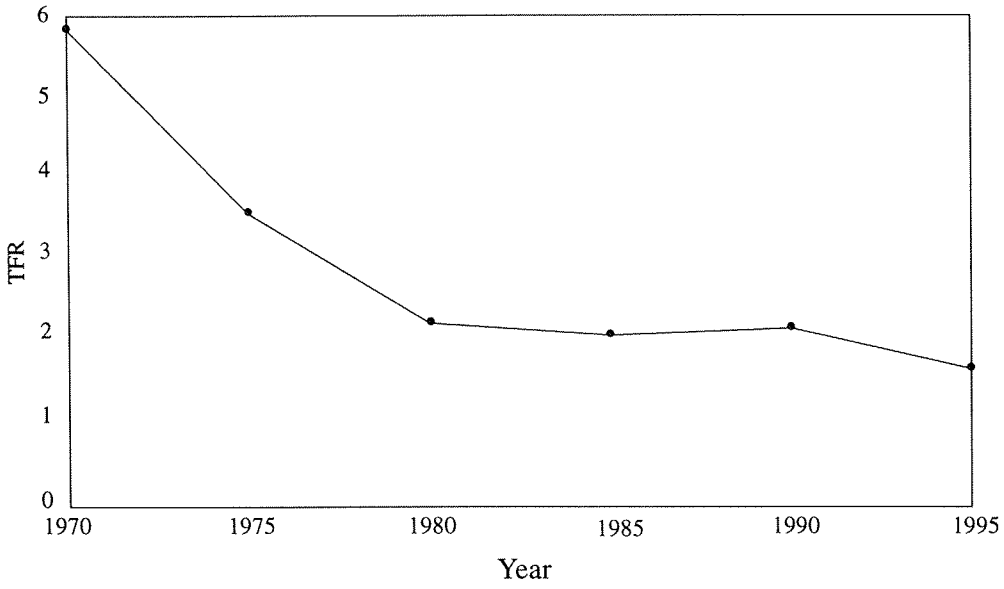


Table 3: The Change of Births and Natural Growth of the Population since the 1970s

	Number of Births (in thousands)	Birth Rate (%)	Number of Growth (in thousands)	Growth Rate (%)
1970	27360	33.43	21140	2.58
1975	21090	23.01	14380	1.57
1980	17790	18.21	11600	1.19
1985	22020	21.04	14920	1.43
1990	23190	21.06	16290	1.44
1995	20736	17.12	12710	1.06

The decline of fertility, birth rate and growth rate is directly associated with the family planning policy. Before the 1970s, the contraceptive rate of married women at reproductive age was only 13.4%; and it increased to 28.6% by 1973, further to 54.6% by 1980, 66.2% by 1985, 73.2% by 1988. For recent 10 years, it has increased continuously. Consequently, the first birth rate increased from 44.2% of 1980 to 49.5 of 1990; the second birth rate fluctuated, first increased from 28.4% to 32.1 and then decreased to 27.8%; and the third birth rate decreased from 27.5% to 19.3% and further to 9.5%[13]. In addition, the increase of age at first marriage and the delay of childbearing also played their roles in the declines. The 'Marriage Law', issued in 1950, stipulates that "the age at first marriage is 20 for male and 18 for female"; the revised 'Marriage Law', issued in 1980, states that "the age at first marriage has to be more than 22 for male and 20 for female." Due to the Marriage Law as well as late marriage and late

[13] Source: Department of Poulation and Employment, the State Statistical Bureau, ed. "Handbook of Major Population Data in China 1995".

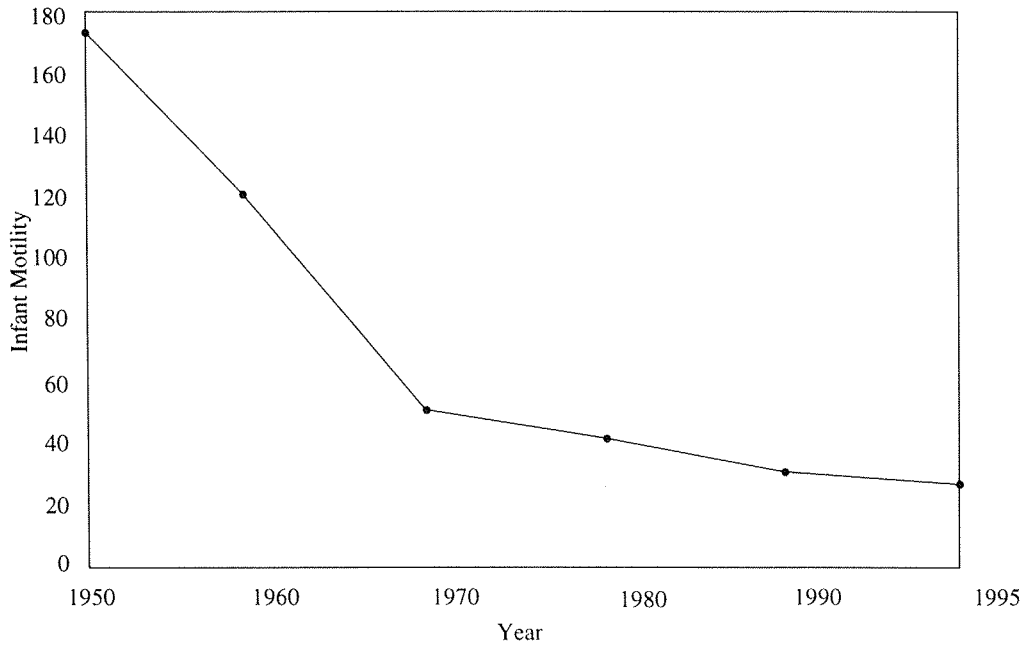
childbearing, actual age at first marriage has increased substantially. Up to now, the average age at first marriage for female has increased to as high as 23 years[14]. Certainly, late marriage can result in late childbearing, and further in fertility decline.

2. Mortality

Undoubtedly, it is the implementation of the basic national policies aiming at limiting population growth and improving population quality that has facilitated mortality decline. By statistics, the national infant mortality has declined to 30 from 74.4 of 1950. See figure 2[15]:

Crude death rate is an indicator for deaths of a population. But, it must be standardized before comparison. The death rate of 1995, which was standardized on the basis of the age structure in 1964, is included in table 4[16]:

Figure 2: The Decline of Infant Mortality (‰) in China



[14] Source: Department of Poulation and Employment, the State Statistical Bureau, ed. "Handbook of Major Population Data in China 1995".

[15] Source: China Population Yearbook 1991; The Data on 1% of the National Population Sample Survey in 1995.

[16] Source: China Population Yearbook 1991; The Data on 1% of the National Population Sample Survey in 1995.

Table 4: The Death Rate of 1995 Standardized on the Basis of the Age Structure of 1964

Age Group	Population	Death Rate (‰)	Number of Deaths
0 - 4	174535361	7.309	1275679
5 - 9	163634471	0.660	107998
10-14	150553403	0.539	81148
15-19	108282174	0.943	102110
20-24	88660572	1.441	127760
25-29	87933846	1.474	129615
30-34	81514433	1.557	126918
35-39	71703632	1.915	137313
40-44	62135073	2.651	164720
45-49	53777724	3.999	214573
50-54	46268222	6.336	293155
55-59	39364325	10.299	402657
60-64	31006976	16.779	520266
65-69	20348328	27.551	560616
70-74	12717705	45.757	581924
75-79	6661655	68.752	458002
80-84	2442420	108.370	262517
85-89	48448	133.445	6465
90+	12112	300.000	3633

After standardization on the basis of the age structure of 1964, the number of deaths in 1995 was 5,557,069 and the crude death rate was 4.59 ‰, a decrease of 1.97 ‰ compared with the actual level of 6.56 ‰ in 1995; and a reduction of 6.91 ‰ and decreased by 57% compared with the level of 1964. The rapid decline of the standardized death rate can generally be attributed to the economic development; the improvement in living conditions; the progress in health, sanitation and medical care; and the effective prevention from contagious diseases. Since better birth is an important component of the population policies, the governmental departments at various level involved in family planning have pressed great emphasis on perinatal cares and delivery, which have greatly contributed to the decrease of the perinatal mortality and the incidence of diseases and the increase of the infant survival rate. Furthermore, recent mobilization on preventing AIDs and the other sexual diseases and ban pornographic books and videos as well as prostitution have effectively curbed the spread of the AIDS and the other various sexual diseases. In comparison 1995 with 1970, the hospitals at county level and above has increased to 14,771 from 6030, growing by 145%, and the medical personnel has increased to 5,373 thousand from 1,793 thousand, growing by 200%. In 1995, the top 6 causes for deaths are all "modern": cerebral diseases, malignant tumors, respiratory diseases, hearth diseases, injure and intoxication, and diseases in digestive system in urban areas; respiratory diseases, malignant tumors, cerebral diseases, injures and intoxication,

heart diseases, diseases in digestive system in rural areas[17]. Since 1990, a series of laws have promulgated subsequently. Those laws include: the "Protective Law of the People's Republic of China on the Disabled" (1990), the "Protective Law of the People's Republic of China on Children" (1991), the "Decision on Stricter Penalties for Swindling Children and Women by the Standing Committee of the National Congress" (1991), the "Adoptive Law of the People's Republic of China" (1991), the "Protective Law of the People's Republic of China on Women's Rights" (1992), the "Protective Law of the People's Republic of China on Female Infants" (1994). Those laws have contributed to a further decrease of death rate due to their legal protection for women, children and the disabled.

3. Migration and Distribution

The discrepancy of ongoing fertility policy between urban and rural areas as well as among different regions might have played some role in regional distribution of the population. Obviously, the fertility, lower in urban areas than in rural area, lower in east than in west, is disadvantageous to urbanization in terms of natural growth. However, the regional distribution of population have not yet influence by the fertility discrepancy significantly. Thanks to migration, the urban is still growing.

Here, our attention is mainly focusing on migration rather than talking about the history of urbanization and population distribution. According to the 1.028 ‰ Sample Survey by the State Statistical Bureau in 1996, the people, who registered a permanent residence and resided in the surveyed districts took a percentage of 94.56%; the people, who lived in the surveyed districts for more than a half year but registered a permanent residence in other places, took a percentage of 4.50%; the people, who lived in the surveyed districts for less than a half year and left the place where he/she registered a permanent residence for more than a half year, took a percentage of 0.31%; the people, who have not clear resident identification, took a percentage of 0.63%. The last three types, who are classified as immigrants crossed the boundaries of townships or urban blocks, took a percentage of 5.44% in the surveyed population. Based on the 1.0266% Population Sample Survey in 1995, table 5 shows the immigrants who crossed the boundaries of counties, cities or prefectures[18]:

Table 5: Immigrants Crossed the Boundaries of Counties, Cities or Prefectures since 1990

(in thousands)

	1991	1992	1993	1994	1995
Total	4458	5623	7529	9696	8108
Cities	2743	3473	4479	5553	4395
Towns	441	556	773	1043	865
Counties	1274	1594	2277	3100	2848

Note that the derivation of above statistics is based on China's specific permanent residential registration system, that is, immigrants only include those who live in one place but have a permanent

[17] Source: China Statitical Yearbook 1996.

[18] Source: China Statistical Yearbook 1997, China Statistical Press, 1997.

residential registration in other place, but exclude those who already registered a permanent residence in his/her living place after migration. So, actual migrants will be much more than the numbers listed in the table. According to the same survey, the migrants, who have a permanent residential registration in one place but live in other place, accounted for 32,367 thousand as early as 1990, and most of them migrated into urban areas. According to table 5, the ratio of town's immigrants to county's was 2.5:1.0 in 1991, 2.3:1.0 in 1993, 1.8:1.0 in 1995; the ratio of city's immigrants in cities to town's was 6.2:1.0 in 1990, 5.8:1.0 in 1993, 5.1:1.0 in 1995. This clearly shows a migration trend from towns to cities. It is the migration toward towns and cities that contributes to the acceleration of China's urbanization. As far as destinations are concerned, migration did not occurred from high density place to low density place, but in the opposite direction. Generally speaking, the migrants usually move from Sichuan, Henan, Anhui, Heilongjiang, Guizhou, Hubei, Hunan, and Jiangxi provinces or autonomous regions to coastal areas or municipalities, such as Guangdong, Hainan, Zhejiang, Jiangsu, Beijing, Shanghai, Shandong etc.. The traditional migration patterns, such as "going for Guandong" (migration from Shandong to northeast) and "supporting the great northwest" (the migration of school graduates mainly from Beijing and Shanghai to Xinjiang and Inner Mongolia etc..) are being replaced by the pattern of "peacocks flying to southeast" (talents concentration in southeastern coastal areas). As an inevitable result of earlier economic take-off associated with China's economic reform in the southeastern coastal areas than in other areas, this can also be explained by the "push-pull" theory of migration.

The earliest massive international migration can date back to the migration to Japan led by Xufu in Qin Dynasty, and the subsequent migrants out of China were either pushed by poverty or pulled by the business opportunities outside China or due to religious and cultural exchange activities. By middle 1990s, China had deteriorated further to a semi-feudal and semi-colonized country, and the bad economy caused more and more labors migrated to overseas. By 1992, out-migrants were estimated as many as 8,000 thousand . According to 1954 census, overseas Chinese and students amounted to 11,743 thousand, and they increased to 22,180 thousand by 1986. Of all Chinese in 109 countries, those in Asia took 89.4%, as many as 19,844 thousand; those in America took 7.7%, as many as 1,700 thousand; those in Europe took 1.7%, as many as 380 thousand; and those in Australia and Africa took 1.2%, as many as 236 thousand[19]. Since the economic reform, both internal and external migration has increased, and the people who worked or studied at overseas were as many as 236 thousand by 1995. In recent, more than 100 thousand visas have annually been issued . Although the foreigners living in China were as many as 346[20] thousand in 1990, this was still a relatively low number as far as a big country with more than 1200 million population is concerned. Nevertheless, international migration is likely to increase as China becomes more and more open to the outside world.

[19] Source: See, China Population Yearbook 1997, Li Honggui, "International Migration and the State Policy".
[20] Source: 1995 1% National Population Sample Survey.

4. Population Aging

In both China and the world, population tends to be aging, but China's aging problem has some characteristics that are different from the other parts of the world.

The first characteristic is reflected in the current fast speed and a likely aging level to be realized in future. Various projections at both home and overseas have a similar result. By the end of this century, the percentage of the aged over 60 years in China is going to increase to 10%, and the aged over 65 years to about 7%. The median age of China's population is going to reach 29.9 years. By 2040, the percentage of the aged is going to reach its peak, 23.7% for the aged over 60, and 18.3% for the aged over 65, and the median age of the population will rise to 39.4 years[21]. It only takes China 40 years for the proportion of the aged over 60 years to increase from 7% to 17% , but it took the developed countries 80 years or even 100 years to do so. By 2040, China will have more than 18% aged population, and rank at the first in the developing countries although this level is lower than that in the developed countries.

The second characteristic is the geometrical growth of China's aged population. According to the same projections as above, the proportion of the aged over 65 years increases by 1 percent every 10 years in 1980-2010, by 3.1 percent every 10 years in 2010-2030, and by 4.3 percent every 10 years in 2030-2040. After 2040, the increase will slow down[22].

The third characteristic is the uneven distribution of aged population. Firstly, in urban areas, population aging comes earlier and is likely to achieve a relatively higher level. Secondly, from west to middle and to east, aged population increases progressively and forms a "contour".

It is not difficult to see there is a "time behind" between China's population aging and social and economic development. According to China's goals for social and economic development, i.e., achieving a comfortable living standard by the end of this century and becoming a developed country by the middle of the next century, China has to face a seriously aged population at a unfavorably development stage. This contrasts the developed countries in that they are able to cope with a seriously aged population with a developed economy. Therefore, in order to cope with China's premature aged population, a security system for old age must be established:

First, actively developing social support and pursuing reform. When the People's Republic of China was founded in 1949, the security for old age was nothing and it has developed rapidly especially since the economic reform and open-up to outside world. In 1978-1995, the number of the retired or retired with honor increased by 8 times, from 3,140 thousand to 30,940 thousand; the expenditure on welfare of elderly increased by 88.1 times, from ¥ 1.73 billion to ¥ 154.18 billion, of which 84% was due to the state-owned units[23]. It is estimated that the retired will double from 1995 to 2000, and redouble from 2000 to 2010, and double again from 2010 to 2020; and the old welfare system is unlikely to sustain due to a unbearable fiscal pension burden. In order to cope with the challenge, the state has formulated a plan for reforming its old age security system: the people already retired are still ensures by the original

[21] Source: See, United Nations: World Population Prospects The 1994 Revision, New York, 1995.
[22] Source: United Nations: World Population Prospects The 1994 Revision, New York, 1995.
[23] Source: China Statistical Yearbook 1997.

system; the newly retired people will follow a new system in which the pension will be raised from monthly contributions of both workers and their enterprises or working units. At the same time, the state also encourages insurance business especially among the huge rural farmers.

Second, encouraging family support and creating more community service. The eastern countries, like China and Japan, have a tradition to respect and support the elderly. China should continuously encourage its tradition of family support for the elderly. This tradition is still playing an important role in rural areas. A survey reveals that around 60% of the elderly are still living together with their children, and family is taking a major responsibility for old age support in rural areas. Nevertheless, with the development of market-oriented economy and the change of people's value, family support for old age is facing a crisis as more and more people are no longer willing to take the responsibility of supporting their aged parents, so, it is necessary to legislatively strengthen the role of family in supporting the aged. The 'Constitution' of China has stipulated that parents have the responsibility of raising their children and the children have the responsibility of supporting their aged parents. At the meantime, although the communities in China are increasingly taking the responsibility of providing the aged with various services, which involves in almost every aspect of the aged life such as food, clothing, housing, transportation and medical care etc., the experiences of our neighboring Japan are still valuable for improving and perfecting those services.

Third, encouraging the aged self-support and developing their human resource. Similar to the elderly in Japan, China's elderly also have a relatively higher labor participation rate, 15% in urban areas, and more than 30% in rural areas. In rural areas, the income from economic activities taken by the elderly an important source for old age support. Actually, the aged people, in particular, those at younger age, still have the ability to work and are therefore an important human resource that can be developed. In both Japan and China, working at an old age is not only regarded as a tradition but is also highly valued by the elderly themselves, so, properly organizing the aged re-employment will be beneficial to both the elderly themselves and the society. However, due to a surplus labor problem, China should be very careful when encouraging the aged re-employment in the sense that the aged should not compete for the limited working opportunities with the young. The employment of the elderly should put priority to the jobs with less technological components, such as, working in agriculture, being a doorkeeper, working in service sector etc..

5. Gender Issue

Women's status has a great impact on population problems and population policies. Women's status in China can be reviewed as follows:

At first, gender's equal rights has been clearly stipulated by the state. In the "Constitution", article 48 stipulates: "women and men in the People's Republic of China equally enjoy political, economical, and cultural rights in every aspect of social and family life. Based on the "Constitution", the equality between gender is mainly ensured by the "Protective Law on Women's Rights" as well as the "Marriage Law", the "Labors Law", and the "Protective Law on Mothers and Babies". It is under the

legal system that women's rights and participation have been protected. Statistical data tell that women's participation in the election of congress representatives is more than 90%. Female representatives take a percentage of 21.0% in the Eighth National Congress, 12.3% in the Standing Committee of the National Congress, and 10.5% in the vice-presidents of the National Congress. Of all the state servants, the cadres in enterprises and institutions, females take a percentage of 33%. There is one female state councilor, and there are 38 females at the levels of minister or provincial governor. Females are playing more and more important roles in this country[24].

At second, women enjoy equal rights in employment and economic activities. Women's employment rate is relatively high in China. Now, of all the employed labors, women take a percentage of 44%. In 1996, female workers in cities and towns were as many as 57,452 thousand , 38.7% of the all workers, and they scattered in almost every sector of the industries. In spite of a significant increase in female's wage, there still exists a wage disparity between male and female. As far as the educational level is concerned, the females are a little bit less educated than males, but the gap is narrowing. See table 6[25]:

Table 6: Educational Levels of the Employed by Gender (%)

	Illiteracy	Primary School	Junior High School	Senior High School	Specialized School and above
Male	8.1	33.4	42.4	12.7	3.4
Female	18.6	37.6	31.9	9.7	2.2

At last, women enjoy sufficient rights in households. A survey reveals that 74% marriage are determined by brides and bridegrooms after they take into consideration the opinions of their parents. Of all married females below 40 years, 80% of them have a self-determined marriage. In addition, females also have the freedom of divorce and re-marriage. With respect to childbearing, women's power is apparently higher than men's, see table 7[26]:

Table 7: Rights of Reproductive Determination by Gender (%)

	Wives	Husbands	Share by Wives and Husbands	Others
Urban Areas	14.1	2.5	79.9	3.5
Rural Areas	6.7	3.9	82.9	6.5

[24] Source: China Statistical Yearbook 1997.
[25] Source: China Statistical Yearbook 1997.
[26] Source: Survey Data on Contempary Women's Status (1993), Wanguo Xueshu Press, 1994.

Besides, the state has some special policy to protect women and children. For example, the "Marriage Law" stipulates: "males are not allowed to apply for divorce when women are pregnant or within one year after women's childbirth", but women are free to apply for divorce at above two cases. The "Protective Law on Women's Rights" stipulates: "women have the freedom to determine whether to have a birth or not", "the departments concerned have the responsibility of providing secure and effective contraceptives for the women who have taken some measures to control their births" etc.. Furthermore, the "Labor Law" has stipulated that women should be specially protected at "such four stages as menses, pregnancy, childbirth, and breast-feeding", which has provided legal basis for women's reproductive rights and labor rights and has significantly improved women's economic status. As early as 1950s, women's contribution to household income was less than 20%, but now it has increased to about 40% or even to above 60% in the specialized rural households. Women's economic independence has greatly promoted their power on household economy and other household affairs. Now, women have equal rights to claim inheritance and household property. Those legal protections have substantially increased women's social and household status and have laid a solid foundation for women's organization at both national and local levels. In addition, Chinese women are actively participating international women's affairs, such as the Fourth World Conference on Women held in China, and are playing their roles in international women's affairs.

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Chapter III

Demographic Transition and Policy in Korea

Demographic Transition and Policy in Korea

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I. Introduction

Like Korean economy, Korean population has changed dramatically both in size and structures within a short period. Up to early 1960s Korea was a less industrialized country heavily relying on agriculture. It had a high fertility and mortality rate and the age structure showed a typical pyramid pattern of an underdeveloped country. Urbanization was delayed and it experienced the liberation from the colonial ruling in 1945 and the Korean War shortly after that.

Along with the five-year economic development plans started from 1962 the industrial structure changed rapidly and thus the population structure changed accordingly. The central government adopted family plan policies to curve high fertility rate. The urbanization was proceeded at a high speed with industrialization. Due to the strong government policy and rising standard of living the fertility rate and mortality rate decreased at the same time and the population growth declined reaching to a stabilized level of an advanced country since early 1990s. The urbanization rate reached at 75% in 1995 and the population structure was completely changed in 40 years.

This paper discusses the demographic transit in Korea and analyzes the structural change in terms of demographic characteristics, population distribution and labor market. In addition to the analysis on changes the government policy on population and its result is discussed especially.

The analysis period starts from 1945 which is the year of liberation from Japanese colonial rule but more emphasis is put on the period after early 1960s when the Korean industrialization began by the economic development plans.

Since Korea is divided into South and North, only South Korea is included in the analysis because there is no reliable statistics on North Korean population. Therefore the country name Korea indicates South Korea in this paper.

II. Demographic Transition

1. Changing population and growth rate

Korea has experienced rapid demographic changes over the past four decades. The Population size was 16,873,000 persons in 1945 and increased to 44,608,000 in 1995, about 2.6 times as large as that of 1945.

Table 1: Demographic transition in Korea

Year	Population (In thousand)				Average annual growth rate(%)	Population density (persons per sq. Km)
		Male	Female	Sex-ratio		
1945	16,873	-	-	-	-	-
1949	20,189	10,201	9,988	102.1	4.6	205.1
1955	21,526	10,767	10,760	100.1	1.1	222.1
1960	24,989	12,544	12,445	100.8	3.0	253.9
1966	29,160	14,684	14,475	101.4	2.6	296.1
1970	31,466	15,796	15,670	100.8	1.9	320.4
1975	34,707	17,461	17,245	101.3	2.0	351.3
1980	37,436	18,767	18,669	100.5	1.5	378.2
1985	40,448	20,244	20,205	100.2	1.6	408.0
1990	43,411	21,782	21,629	100.7	1.4	437.3
1995	44,608	22,397	22,209	100.8	0.5	449.3

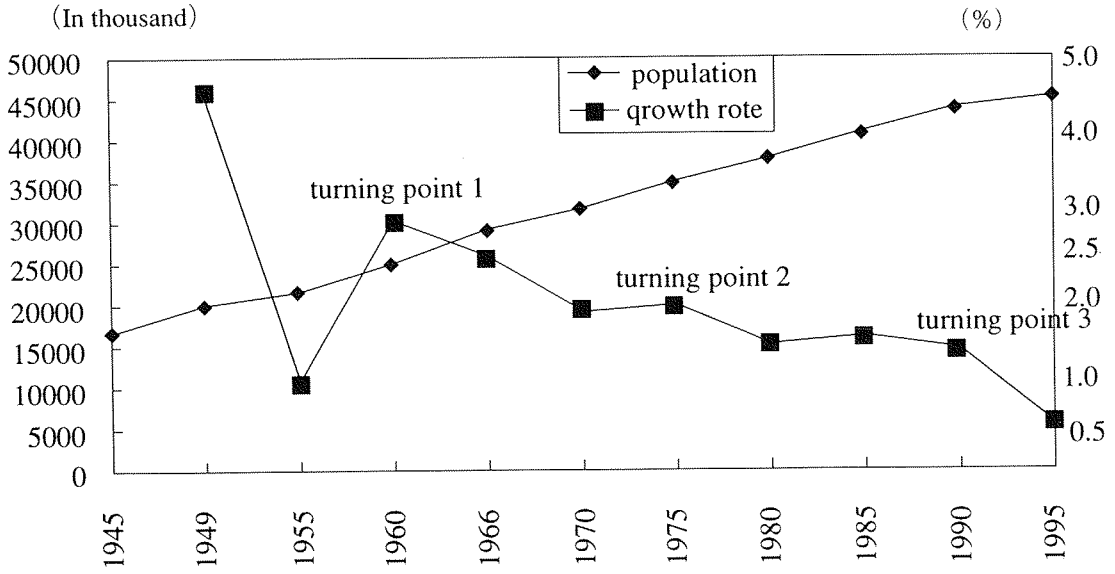
Source: Korea Statistical Yearbook, 1996, National Statistics Office.

The demographic transition is shown in Table 1 with the average annual growth rates. The average annual growth rates between 1945 and 1990 were a mountain-type pattern and during that period Korea showed a high-fertility and low-mortality in general. However the growth rate of the 1990-1995 period recorded a very low rate, 0.5% similar to the levels of advanced countries. Korea was transformed from a rapid by growing country to a stabilized country in population in only 40 years.

Analyzing the growth rates by periods in detail, the average annul growth rate of the 1945-1995 period is 2.0%. In the 1945-1949 period, the growth rate was recorded as the highest average annual growth rate at 4.0%. The growth rate in this period was mainly due to massive overseas in-migrants rather than due to natural growth rate or other factors. After Liberation of 1945 from Japanese colonial ruling, a number of people who had lived in Japan and other countries came back home. During 1950-1955, the average annual growth rate was very low at 1.1% because Korean War had occurred during 1950-1953. The growth rates of the two periods, therefore, are considered to be abnormal.

After 1955 Korea has three turning points in demographic transition as shown in Figure 1. The average annual growth rate between 1955 and 1960 was 3.0% recording the highest natural growth rate in Korean history that reflects the unusual psychological attitude after the war. It changed to 2.6% in the 1960-1966 period. The growth rates started to fall from 1960, the first turning point in Korea's demographic transition. The decline of growth rate was caused mainly by the decreasing fertility. There are many reasons for the decreasing from the early 1960's. The two most important reasons are a strong population control policy and the economic development plan initiated by the military government from 1962.

Figure 1: Population change and average annual growth rate in Korea



The second turning point is 1975 where the population growth rate went down below 1.5% for the first time, and since then the growth rates remained around 1.5% until 1990. Even though the growth rates between 1975 and 1990 are higher than those of the advanced countries, the growth rates were relatively lower compared to the previous periods.

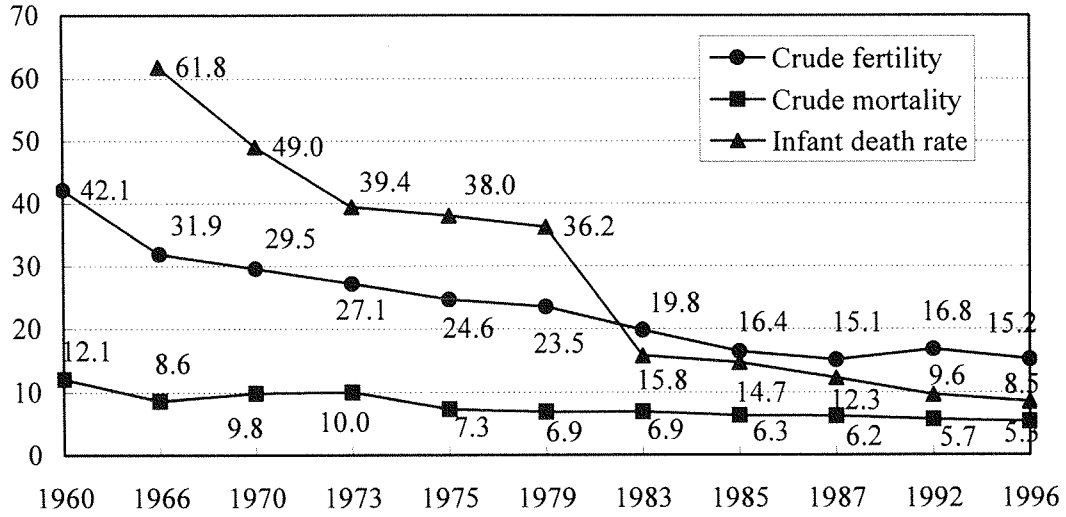
The third turning point in demographic transition occurred in 1990 when the average growth rate rapidly decreased to 0.5% which is comparable to the population growth rates of the advanced countries. Therefore Korea seems to have entered to a stable stage with low-fertility and low-mortality in demographic transition after 1990.

2. Fertility transition

A low fertility rate is the most important factor for a low population growth. Korea's crude fertility rate was very high at 42.1 in 1960. It declined rapidly to 31.9 in 1966 and continued to decrease afterwards. It fell below 20 after the late 1970's. It is 15.2 in 1996 (Figure 2). The same trend can be found in the total fertility rate (Table 2). The rapid decline in 1960's and a steady decrease since then can be observed. TFR started to decrease below 3.0 from the late 1970's, reached at replacement level, 2.1, in 1985 and decreased to 1.7 in 1995.

Figure 2: Crude fertility and infant death rate

(per thousand)



Source: 1) Tracing Korean Society,1995, N.S.O.
2) Annul Report On The Vital Statistics, 1997, N.S.O.

Table 2: Total fertility rate

Year	1960	1965	1970	1975	1980	1985	1990	1992	1995
	6.0	5.3	3.6	3.2	2.7	2.1	1.6	1.8	1.7

Source: 1) Population change and social development policy, 1996, J.P.S.
2) Annul Report On The Vital Statistics, 1997, N.S.O.

The declining trend of two fertility indexes after 1960 has been due to a strong fertility control policy and urbanization and industrialization by economic development. The Korean government tried to control fertility through various family plan campaigns, socio-economic incentives and administrative measures since 1962 when the government launched Five-Year Economic Development Plans.

The decline of infant death rates is another reason for the low fertility. Because the declining infant death rates narrows the difference between actual numbers and expected numbers of children (Figure 2).

The TFR and CFR went a little higher between the late 1980's and the early 1990's. This increasing trend was caused by the Korean government policy that started to withdraw the previous strong control policies as the TFR has decreased below replacement level at 2.1 since 1985.

3. Mortality transition

Korea has already been in a low-mortality stage since 1960 when the crude mortality rate was 12.1 persons per 1000 persons. In addition, it continued to steadily decrease to 5.3 in 1996 (Figure 2). Meanwhile, infant death rate declined very fast to 8.5 per 1000 live birth in 1996 from 61.8 in 1966. Especially, infant death rates in 1960's and in the early 1980's decreased even more rapidly than other periods. This drop in mortality has been due to improvements in medical service, public health and sanitation. The raising standard of living by economic achievement has also contributed to the mortality decrease.

According to a report by National Statistical office on the cause of death, 24.6% of deaths was by diseases of the circulatory system that is the first cause of death in 1996. The proportions of neoplasm (all kinds of cancers, leukemia and so on) and external causes of mortality (transport accidents, falls, intentional self-harm and so on) shared 21.7% and 14.5% of deaths in Korea in 1996 (Table 3).
There is no conspicuous structural change in the causes of death of 1996 compared to that of 1987. However, the shares of neoplasm, external causes of mortality, endocrine, nutritional and metabolic diseases and mental and behavioral disorders increased while the shares of diseases of circulatory system, diseases of respiratory system and certain infections and parasitic diseases decreased for 10 years reflecting a improved standard of living.

Table 3: Deaths by cause

	1987 (%)	1996 (%)
Diseases of the circulatory system	30.4	24.6
Neoplasm	17.1	21.7
External causes of mortality	13.2	14.5
Diseases of digestive system	8.6	7.0
Diseases of respiratory system	4.0	4.5
Certain infectious diseases	3.5	2.1
Endocrine, nutritional and metabolic diseases	1.6	3.6

Source: Annul Report On The Vital Statistics, 1997, N.S.O.

4. Family planning policy in Korea

As stated before the most important reason for the declining population growth was due to the family planning policy (FPP hereafter) by the government. The average annual growth rate of population was 3.0% between 1955-1960 recording the highest natural growth rate in Korean history. Considering that Korea was one of the poorest countries in the world in 1960's, Korean government at that time was under a great population pressure.

The military government tried to pursue economic development plans. The government regarded over-population as an economic burden because it has negative effects on national saving which was very important for economic development by capital formation. The government, therefore, established a

strong population policy in 1961, and from the following year, national family planning programs were included as a major component of Five-year Economic Development Plans.

The basic goals of the policies were to encourage family planning practice including sterilization operation and contraception use, to expedite the establishment of a social norm in favor of small family, to encourage industries to spend more for family planning and to eliminate the sex discrimination in social activities.

Family planning initiated by government proceeded in mainly three ways. First of all, the government used the administrative networks to provide family planning services. Most family planning services have been provided through the family planning workers in local governments and in local health care office. For instant, when providing contraception that was especially emphasized in the past, the central government assigned a substantial amount of sterilization operation to each local government and health care office. The government policy was alleviated as the TFR declines and it became inoperative since the late 1980's.

Secondly, the government employed a number of socio-economic incentives and disadvantages to influence the choice of family size. The incentives and disadvantages for family planning and social support policies developed in Korea before 1985 are explained in Table 4.

Table 4: Social and economic incentives for family planning

1974	1) Revision of the income tax law which allows tax exemption up to three children
1977	2) Revision of income tax exemption up to two children.
	3) Corporation (industry) tax exemption on expenditures for FP services to employees.
1978	4) Tax exemption on imported contraceptive raw material.
	5) Priority of allotting public housing to sterilization acceptors with two or less children.
	6) Revision of family law to improve the quota of women's inheritance of property.
1980	7) Reduction of child delivery charge for sterilization acceptors after first or second delivery in public hospitals.
1982	8) Provision of sterilization and menstrual regulation services in medical care insurance system.
	9) Priority of sterilization acceptors with two or less children for livelihood loans for the needy up to 2 million won and priority given for housing loans.
	10) Provision of monetary subsidies to sterilization of low-income acceptors to compensate for lost wages. 100,000 won to acceptors with two or less children, and 30,000 won to acceptors with three or more children.
	11) Provision of primary medical care services free of charge for preschool children of sterilization acceptors with two or less children.
	12) Family and education allowances for government employees with two or less children.
	13) Tax exemption on education allowance for first and second child.
	14) Field trial at one city and two rural countries on monetary incentive system for sterilization acceptors with two or less children.

1983	15) Inclusion of Primary Health Care posts for the provision of free medical care service for preschool children of sterilization acceptors with two or less children.
	16) Increment of monetary subsidies from 30.000 won to 100,000 won to low-income sterilization acceptors with three or more children.
	17) Revision of workmen's standardization law on paid maternity leave to be limited up to second child.
1984	18) Extension of medical care insurance benefit coverage to the lineal ascendant of married women.
	19) Revision of Marine Law so that female could be employees as seamen.
	20) Priority given to those sterilized with only one child for the welfare housing loan from the Bank of Housing.

Source: Fertility incentives and disincentives in Korea. 1985. J.P.S

Thirdly, campaigns and educational activities for smaller size family also had been implemented nationwide by government and civil organizations supported by government from the beginning of the introduction of family planning.

Thanks to the three synthesized measures by government the Korean population control policy has succeeded greatly. Since the TFR decreased to the below replacement level in 1985, the government tried to push hard for its implementation of FP practice and all the incentives and disadvantages disappeared in 1990's.

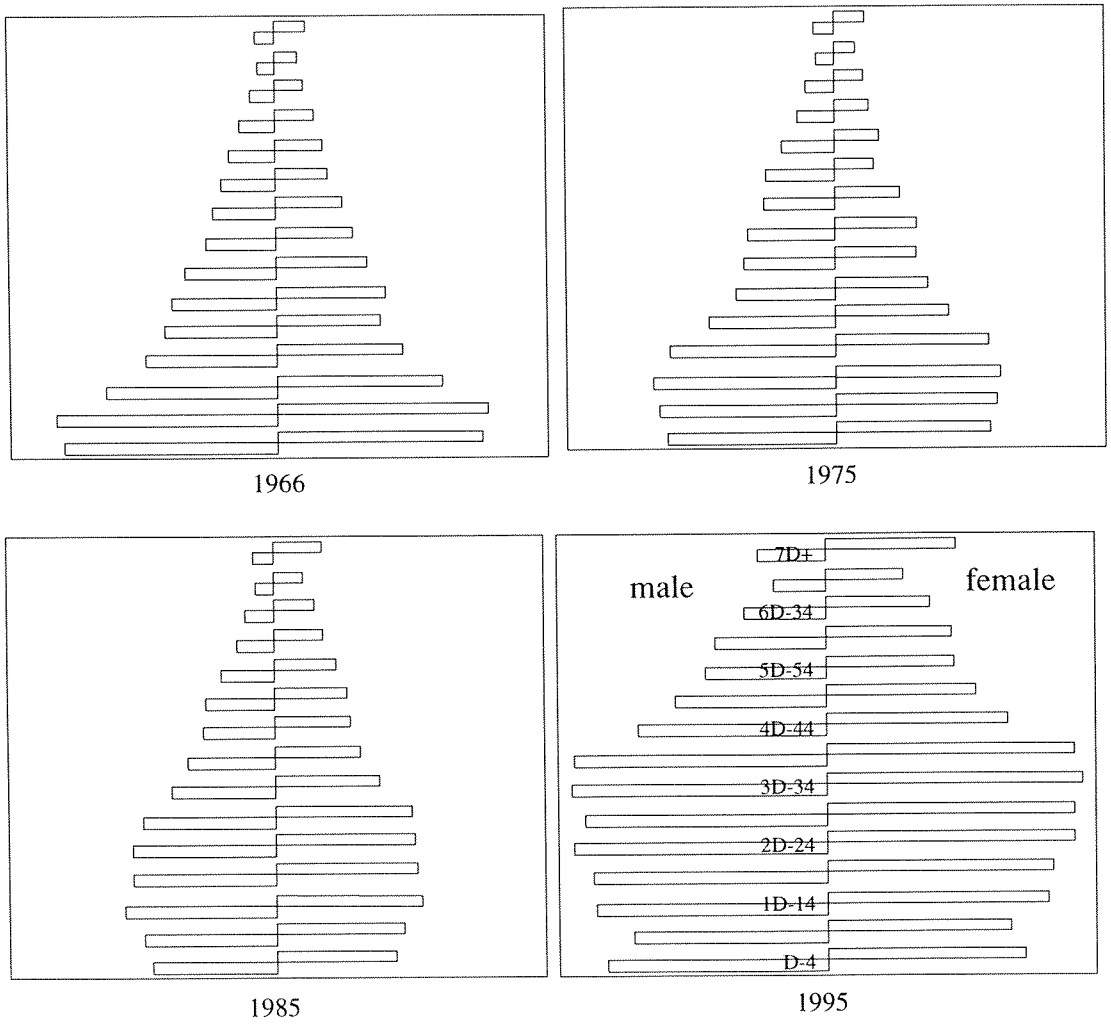
Two contrasting views on fertility policy have been suggested. One is that the present socio-economic incentives and social support policies should be re-examined. Because contraceptive practice and social norm in favor of having two or less children have already been established while other structural problems such as imbalance of sex-ratio of birth, aging of population and so on are developing. Especially it is emphasized that TFRs have been even lower than the replacement level since 1986. It is argued that even if TFP would increase due to the abolition of fertility control measures, it would not outnumber the replacement level. (Cho, et, al, 1995)

The other one suggests that fertility control to be considered importantly. Lee (1996) argues that low-fertility in Korea is not by-products of socio-cultural changes like western societies, but a result of strong government policy within a short term. Therefore it is always possible to return to traditional fertility pattern.

III. Structural Change in Demography

The demographic structure of Korea changed drastically in less than half a century. The structure and major characteristics of population changed from an underdeveloped country type to developed country type. In all aspects of population characteristics the change is abundant and salient.

Figure 3: Change in sex-age structure in Korea



1. Changing age structure

The overall picture of age structure is shown both in Table 5 and in Figure 3. In 1960s the age structure looks like a so-called bell type of underdeveloped countries. Within thirty years it changed to a barrel type of developed countries.

Table 5: Age-Sex Composition

(%)

Age	1966			1975			1985			1995		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
0-4	15.4	8.0	7.4	12.2	6.3	5.9	9.2	4.8	4.4	7.8	4.1	3.6
5-9	15.8	8.2	7.6	12.8	6.6	6.2	9.7	5.0	4.7	7.0	3.7	3.3
10-14	12.3	6.4	5.9	13.1	6.8	6.3	11.1	5.7	5.4	8.4	4.4	4.1
15-19	9.3	4.8	4.5	12.0	6.1	5.8	10.7	5.5	5.2	8.6	4.4	4.2
20-24	7.9	4.1	3.8	9.0	4.6	4.4	10.5	5.4	5.1	9.3	4.8	4.5
25-29	7.7	3.8	3.9	7.2	3.7	3.6	10.1	5.0	5.1	9.1	4.6	4.5
30-34	6.7	3.3	3.4	6.4	3.3	3.2	7.7	3.9	3.8	9.5	4.8	4.7
35-39	5.3	2.5	2.8	6.3	3.2	3.1	6.4	3.3	3.1	9.3	4.7	4.5
40-44	4.6	2.3	2.4	5.2	2.6	2.6	5.4	2.7	2.7	6.9	3.6	3.4
45-49	3.8	1.9	1.9	4.0	2.5	1.6	5.2	2.6	2.6	5.6	2.9	2.7
50-54	3.3	1.6	1.7	3.5	1.7	1.8	4.2	2.0	2.2	4.7	2.3	2.3
55-59	2.7	1.3	1.4	2.7	1.3	1.4	3.1	1.4	1.7	4.4	2.1	2.3
60-64	1.9	0.9	1.0	2.1	1.0	1.2	2.5	1.1	1.4	3.4	1.5	1.9
65-69	1.5	0.6	0.9	1.6	0.7	0.9	1.8	0.8	1.0	2.4	1.0	1.4
70+	1.8	0.7	1.1	1.9	0.7	1.3	2.5	0.9	1.7	3.7	1.3	2.4
Total	100.0	50.4	49.6	100.0	50.3	49.7	100.0	50.0	50.0	100.0	50.2	49.8

Source: Korean Social Indicators, various years, N.S.O.

The major causes of the change are as follows:

Lowered birth rate

As explained in the previous section the declining birth rate over a long run facilitated the change of age distribution shape

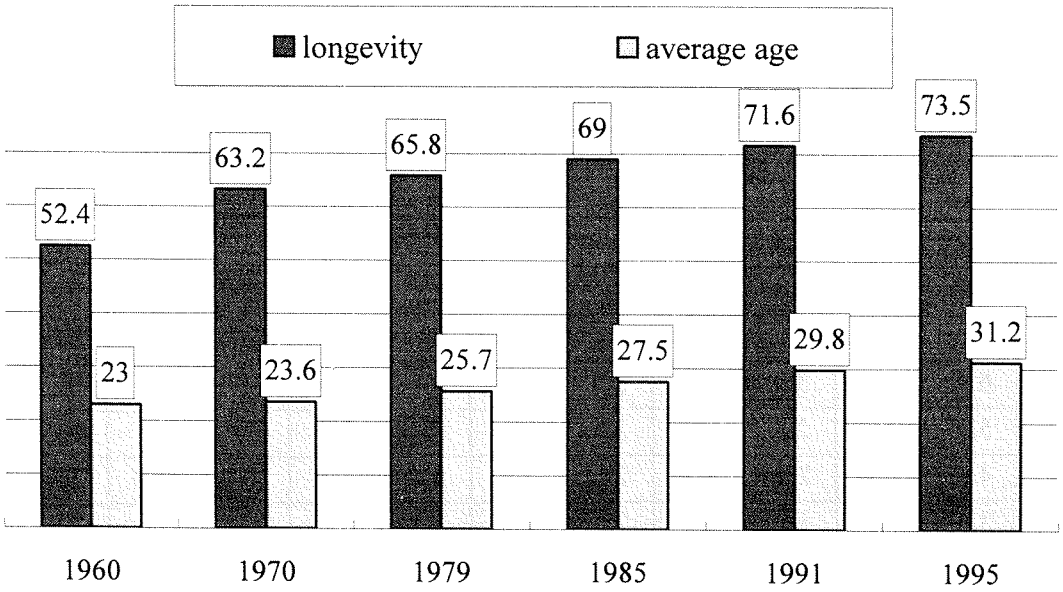
Increasing longevity

A drastic increase in longevity contributed in fattening of the upper part of shape. Even though the longevity of Korean population is approaching to the level of advanced countries lower birth rate makes the structure of shape changed (Figure 4).

Increasing income level

The rising income level and the opportunity cost of child rearing influenced in lowering birth rate. It also contributed in improvement of standard of living including lower infant mortality. The rising income level made the demand for better medical service available that contributed to lowering birth rate.

Figure 4: Longevity and average age in Korea

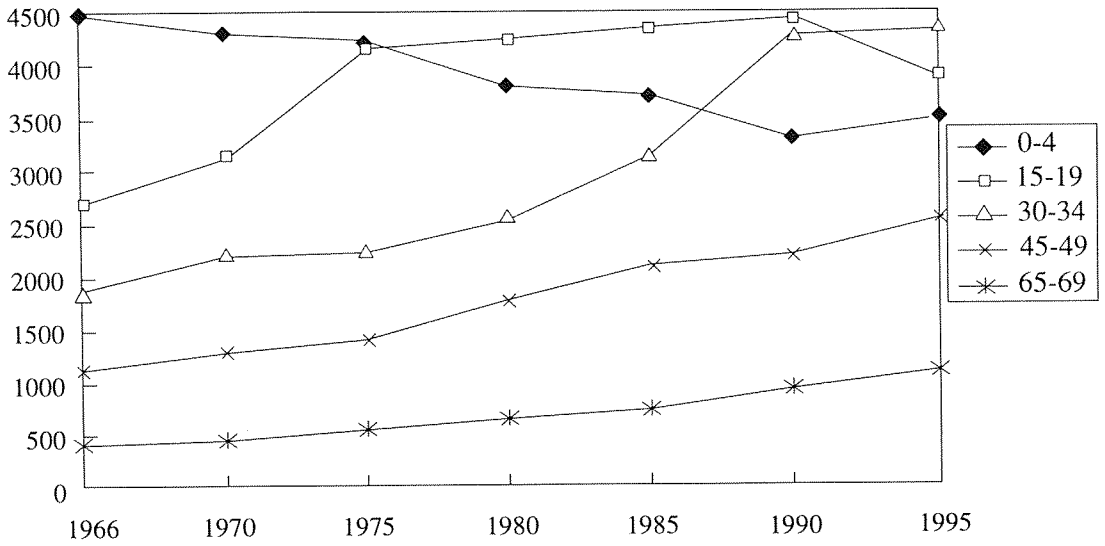


Source: Tracing Korean Society. 1995. N.S.O.

Therefore all the factors contributed in changing population characteristics of Korea into an advanced country type.

If we closely look at the age structure it is completely changed within 30 years as shown in Table 5 and Figure 5. The number of younger ages ranged between zero and under 29 continuously decreased over the 30-year period in addition to the decrease in composition rate. Instead the number of older age increased very rapidly both in absolute number and in composition rate. Figure 5 shows the trend of a few representative age group and it explicitly indicates the volatile change in younger age groups and the continual increase in older age groups.

Figure 5: Transit by age groups



(In thousand)

The most prevailing outcome of this structural change is the rapidly rising dependency ratio (Table 6).

The introduction of various social security systems will put the fiscal situation in a difficult position in the future because of the rising dependency ratio.

Table 6: Dependency ratio

Year	Total*	Young**	The aged***	Aging index****
1960	88.5	82.5	6.0	7.2
1970	83.8	78.2	5.7	7.2
1980	60.7	54.6	6.1	11.2
1990	44.6	37.4	7.2	19.4
1995	40.6	32.6	8.0	24.5
2000	38.8	29.4	9.4	31.9
2020	39.9	22.4	17.5	78.2

* Total dependency ratio = {{(65 +)+(0-14)}/(15-64)} × 100.
** {(0-14)/(15-64)} × 100.
*** {(65+)/(15-64)} × 100
**** {(65+)/(0-14)} × 100
Source: Korean Society Indicators, various years, N.S.O.

2. Imbalanced sex ratio

The overall sex ratio of entire population is relatively balanced (Table 1). However a very serious imbalance appears from early 1970s which is the period of effective birth control policy. Table 7 shows the sex ratio in favor of male baby has been steadily increasing. Because of this imbalance of new born babies the entire structure will be affected in the future.

Under the influence of Confucian heritage that prefers male baby to female, parents accepting birth control took various actions. For example, in the case of one child if the baby is male they may stop child bearing. If the baby is female they may try one or more baby continuously (Table 7).

The sex imbalance is prevalent in primary schools these days making number of boys are much higher than that of girls. In ten years from now this sex imbalance is likely to negatively affect the marriage such that male would have hard time in finding his spouse on average.

The Korean government has been trying to correct the sex imbalance in younger age groups. An equal opportunity policy in public office and equal or fair payment to a position regardless of sex are a few examples. However this problem is deeply related to social value, social culture and tradition. Therefore it would take time to correct the imbalance.

Table 7: Sex ratio by birth order

Year	Total birth	First baby	Second	Third	Fourth
1980	105.3	106.0	106.5	106.9	110.2
1981	107.2	106.3	106.7	107.1	112.9
1982	106.8	105.4	106.0	109.2	113.6
1983	107.4	105.8	106.2	111.8	120.0
1984	108.3	106.1	107.2	116.9	128.1
1985	109.4	106.0	107.8	129.2	146.8
1986	111.7	107.3	111.2	138.6	149.9
1987	108.8	104.7	109.1	134.9	148.8
1988	113.3	107.2	113.3	165.4	183.3
1989	111.8	104.1	112.5	183.1	201.1
1990	116.6	108.6	117.2	190.8	214.1
1991	112.5	105.8	112.6	181.4	201.3
1992	113.8	106.3	112.6	194.1	220.1
1993	115.5	106.6	114.8	205.3	246.7
1994	115.5	106.1	114.3	205.9	237.7
1995	113.4	105.9	111.8	179.4	213.9

Source: Annual report on the vital statistics. 1996, N.S.O..

3. Rising education level

Average educational level of population is related to the income level that is closely related to the birth rate. The causality between education level and birth rate is to be tested empirically.

The average educational level of entire population increased rapidly within a short period. As in Table 8 the average educational level increased by 3 years within 20 years. This level is expected to increase more rapidly in the near future as the lowly educated people pass away.

Table 8: Educational attainment in Korea

(%)

Year	Average Years	Composition of Population by Educational Attainment			
		Primary School Graduates & Under	Middle School Graduates	High School Graduates	College, University Graduates & Over
1975	6.62	65.5	14.8	13.9	5.8
Male	7.61	53.1	17.7	19.7	9.5
Female	5.70	77.1	12.1	8.4	2.4
1980	7.61	55.3	18.1	18.9	7.7
Male	8.67	42.8	19.8	25.4	12.0
Female	6.63	67.0	16.5	12.9	3.6
1985	8.58	43.4	20.5	25.9	10.2
Male	9.66	31.9	20.5	32.1	15.5
Female	7.58	54.1	20.5	20.2	5.2
1990	9.54	33.4	19.0	33.5	14.1
Male	10.55	23.3	17.6	38.9	20.1
Female	8.58	43.0	20.3	28.4	8.3
1995	10.14	27.6	15.7	37.5	19.1
Male	11.09	18.6	14.5	41.2	25.7
Female	9.26	36.2	16.9	34.1	12.8

Source: Social Indicators in Korea, 1996, N.O.S.

4. Impact of population policy

The most distinctive government policy on population has been control on birth rate. It is known that Korean population policy was the most successful in the world. Therefore it is obvious that the population policy affected the population structure. Other factors than government policy also influenced in the structural change. Even though the policy was the most important in the change in 1960s and 1970s, the magnitude of policy decreased afterwards and other factors became more important. Those other factors are mostly related to economic matters. After early 1980s the government policy became inactive and many policies including contraception and tax was abolished.

Rising income level, improved medical service, and change in social attitude made the population policy obsolete because these changes favored less children generally.

IV. Population Distribution in Korea[1]

1. Trends on population distribution

Korean economy initiated by the economic development planning of the government grew rapidly. The sustained high rate of growth in incomes transformed Korea from one of the poor economies with heavy dependence on agriculture to one of the industrialized economies. The rapid industrial growth helped to absorb labor into the urban-industrial sector and thus Korea has experienced a massive shift from rural to urban areas with its rapid industrial transformation over the last three decades.

As shown in Table 9, about 65% of total population lived in rural areas in 1966 because Korea at that time was heavily dependent on agriculture. Rural population has declined fast and imbalance of population distribution has increased since the early 1960's, the beginning stage of the economic development. Because rural-to-urban migration and urbanization have occurred since then and accelerated in 1970's and 1980's. The differentials in incomes between rural and urban areas caused by industrialization have influenced rural-to-urban migrants to leave for urban areas. Gaps in job opportunities and educational opportunities have also had effects on massive rural-to-urban migration.

Table 9: Urbanization trend in Korea

Year	1966	1970	1975	1980	1985	1990
Percentage of Urban Population	36.6	41.1	48.4	57.3	65.4	74.4

Source: Korean Social Indicators, various years, N.S.O.

In addition to imbalanced population distribution between rural and urban areas, there exists imbalance between regions. Seeing Table 10, all provinces in Korea can be classified into three groups by changes of absolute numbers and shares in population during the 1960-95 period. 1) Kyonggi and Cheju, and Metropolitan areas of Seoul, Pusan, Taegu, Inchon, Kwangju, Taejon where their shares in national population increased, 2) Central area and Kyongnam where their shares decreased but the absolute numbers of population increased, 3) Kaongwon, Chungnam, Chonnam, Chonbuk, Kyongbuk where the absolute number in population decreased.

The areas of the third group were excluded for industrialization in the early stage of economic development and still rely on agricultural industry relatively high compared to other regions. The shares of the third group in population therefore have dropped and correspondently the capital region and metropolitan areas classified as the first group have absorbed people throughout the entire period.

The imbalanced population distribution between provinces is also found in Table 11. The Gini coefficients of population distribution increased to 0.35 in 1970, to 0.43 in 1980, 0.53 in 1990 from 0.27 in 1960. The increasing values of gini coefficient indicate the unbalance of population distribution between provinces increased for the entire period.

1 Source: This section is partly from Kim, W.B (1988).

Table 10: Population by province

Province	1960	1970	1980	1985	1990	1995
Nation	24,989 (100)	31,434 (100)	37,436 (100)	40,448 (100)	43,411 (100)	44,451 (100)
Seoul	2,445 (9.8)	5,525(17.6)	8,364 (22.3)	9,639 (22.3)	10,613(24.4)	10,215 (22.9)
Pusan	1,164 (4.7)	1,876 (6.0)	3,160 (8.4)	3,515 (8.7)	3,798 (8.7)	3,809 (8.5)
Taegu	677 (2.7)	1,081 (3.4)	1,605 (4.3)	2,030 (5.0)	2,229 (5.1)	2,445 (5.5)
Inchon	401 (1.6)	643 (2.0)	1,084 (2.9)	1,387 (3.4)	1,818 (4.2)	2,304 (5.2)
Kwangju	314 (1.3)	484 (1.6)	782 (1.9)	906 2.2)	1,139 (2.6)	1,257 (2.8)
Taejon	229 (9.4)	407 (1.3)	652 (1.7)	866 (2.1)	1,050 (2.4)	1,271 (2.9)
Kyonggi	2,348 (9.4)	2,710 (8.7)	3,850(10.3)	4,794 (11.8)	6,156(14.2)	7,638 (17.1)
Kangwon	1,637 (6.5)	1,865 (5.9)	1,791 (4.8)	1,725 (4.3)	1,580 (3.6)	1,466 (3.3)
Chungbuk	1,370 (5.5)	1,480 (4.7)	1,424 (3.8)	1,391 (3.4)	1,390 (3.2)	1,395 (3.1)
Chungnam	2,229 (9.2)	2,451 (7.8)	2,304 (6.2)	2,135 (5.3)	2,014 (4.6)	1,765 (4.0)
Chonbuk	2,395 (9.6)	2,432 (7.7)	2,288 (6.1)	2,202 (5.4)	2,070 (4.8)	1,901 (4.3)
Chonnam	3,239 (13.0)	3,511(11.2)	3,052 (8.2)	2,842 (7.0)	2,507 (6.8)	2,066 (4.6)
Kyongbuk	3,171 (12.7)	3,475(11.1)	3,350 (9.0)	3,011 (7.4)	2,861 (6.6)	2,673 (6.0)
Kyongnam	3,018 (12.1)	3,119 (9.9)	3,322 (8.9)	3,517 (8.7)	3,672 (8.5)	3,842 (8.6)
Cheju	282 (1.1)	365 (1.2)	463 (1.2)	489 (1.2)	515 (1.2)	505 (1.1)

Source: Korean Social indicators, various years, N.S.O.

Table 11: Gini coefficients of population concentration

Year	1960	1970	1980	1990
Gini coefficients	0.2721	0.3520	0.4340	0.5254

* Gini coefficient was used to compute the index.

$Gi=\sum_{i=1}^{n} X_i y_{i+1} - \sum_{i=1}^{n} X_{i+1} y_i$ where X_i's and Y_i's are area and population shares of provinces. The coefficient can have values between zero and one. The coefficient of one means a complete concentration of population in one province

Source: Policies and countermeasures along with population size and structure change. 1995, Cho, et, al.

The imbalance of population between provinces may be due to the regional economic disparities. Economic resources allocation by government was very important for regional development in Korea and actually the regions included in the first group had benefits in some extent from the governmental unequal resource allocation.

Among regions classified into group 1, population growth of the capital region consisting of Seoul,

Inchon and Kyonggi is the most conspicuous. Most people have rushed to primate Seoul metropolis and its surrounding province of Kyonggi throughout the entire period where economic and political power is concentrated.

Table 12: Population concentration in the capital region

	1960	1970	1980	1985	1990	1995
Seoul(A)	2,445	5,525	8,364	9,639	10,613	10,215
Kyonggi(B)	2,749	3,354	4,934	6,181	7,974**	9,942
Capital region*(C)	5,194	8,879	13,298	15,820	18,587	20,157
Nation (D)	24,989	31,434	37,436	40,448	43,411	44,451
A/D	9.8	17.6	22.3	23.8	24.4	9.0
B/D	11.0	10.7	13.2	15.3	18.4	22.4
C/D	20.8	28.2	35.5	39.1	42.8	45.3

* Capital region = Seoul + Kyonggi

** including Inchon

Source: Korean Social Indicators, various years. N.S.O.

Population of Seoul grew rapidly for 20 years, 1960-1980. The face of growth in population slowed after 1980. At last the shares of Seoul in national population have slowed down for the first time by 1.3 percent point during the 1990-95 period while that of surrounding Kyonggido (including Inchon) has gone up very fast after 1980 (Table 12). Therefore population of the capital region has a trend to increase fast. In 1995, Seoul shares 22.9 percent in national population, Kyonggido (including Inchon) 22.4% and so the capital region 45.3%, a considerably high value.

The concentration in the capital region has been due to its role played as the best center in information, education, economy and almost all kinds of functions. The government made many efforts to disperse important functions to the other regions. However most of the policies implemented have failed by many reasons that will be discussed in population redistribution policy.

The above mentioned rapid population growth of Kyonggido(including Inchon) after 1980's has been mainly due to migrants from Seoul and migrants from other regions who could have moved to Seoul without increasing congestion cost of Seoul. That is to say, parts of Kyonggido near Seoul have grown and many new small-medium sized cities so called satellites cities have been built in that areas after the latter of 1980's.

2. Population redistribution policy

Government attempts to decentralize population away from Seoul began in the late 1960s. The major components of these plans were industrial dispersal, location of new educational and cultural facilities in local areas, and decentralization of secondary government agencies. Similar plans were made in the early 1970s. Laws were enacted to decentralize industry and population. These plans and laws, however, were not supported by substantial investments from the government. Not until the 1970s was the policy dealing with population distribution actually implemented. In 1971 the First National Land Development Plan was formulated to direct regional development based on the growth center approach. A number of programs and policy measures were implemented in a fragmented and uncoordinated

manner.

The Second National Land Development Plan (1982-1991) aimed at curbing excessive population growth in large urban centers and placed an emphasis on balanced development. The Plan had four principal elements;

a) To ensure balanced national development, the country is divided into twenty eight integrated regional settlement areas based on functional economic areas.

b) Potential migrants who are otherwise likely to move toward Seoul and Pusan will be accommodated in fifteen growth-inducement cities such as Taejon, Kwangju, Taegu, etc. To facilitate the redirection of migration, the government will strengthen public administration and management functions in the growth-inducement cities.

c) Underdeveloped areas will receive special attention to bring their levels of development up to a national standard.

d) To strengthen inter-regional socio-economic interactions, existing transportation and communications networks will be expanded and new facilities will be built in less-developed areas.

In spite of these efforts, the population concentration has been aggravating as discussed in trends of migration. Many reasons have been suggested. Choi(1996) points out historically, and actually unbalanced national land development as one of the reasons for the consistent trends of population concentration despite policies mentioned above. The government had mainly invested in two regions, the capital region and southeast coastal region in the early stage of economic development in order to take regional advantages of port and still invested primarily in the same regions so as to take advantage of agglomeration economy in the 1980s. According to Choi (1996), The central government spent 66% of the total investment for the national land development in the two regions, 39% in the Capital region and 27% in southeast region, respectively during 1982-1988.

Frequent changes in policy directions or vacillating commitment to them along with economic circulation was another reason for population concentration (Cho, et,al. 1995). A consistent policy is essential for both firms and individuals to be convinced that opportunities outside the core region are real and reliable. A firm political commitment also means substantial government investments and concrete development projects. However, those things did not happen. Symbolic gestures and lip service did harm the credibility of the government policies.

The government intended to develop other regions except the capital region through only controls and restrictions against the Capital region but they were not able to grow for themselves without any measures and to absorb people. It is also pointed out as one of the reasons. A policy dependent upon controls focusing on the core region does not solve the problem of concentration because such a policy cannot improve the development potential of the periphery, whether it is a rural area or lagging region. In order to help industrialists and individuals making their business and residential location choices, both central and local government should develop and publicize a detailed investment schedule for alternative locations outside the core region.

V. Labor Supply

1. Overview

The labor supply is determined by population size in the long run. However the labor force participation rate is most important in determining labor supply in the short run. Over the past forty years the labor force participation rate was steadily increasing. It was 57.0% in 1965 and increased to 62.0% in 1995. The most phenomenal change is increase in female labor force participation (Table 13).

Table 13: Prospects of labor supply

(In thousand)

Year	Population of 15 Years Old	Economically Active Population	Non-Economically Active Population	The Labor Force Participation Rate*		
					Male	Female
1965	15,367	8,754	6,613	57.0	78.9	37.2
1970	17,468	12,193	7,407	57.6	77.9	39.3
1980	24,463	14,431	10,032	59.0	76.4	42.8
1990	30,887	18,539	12,348	60.0	74.0	47.0
1995	33,558	20,797	12,761	62.0	76.5	48.3
2000	37,042	23,336	13,706	63.0*	-	-
2005	38,703	24,770	13,933	64.0	-	-
2010	40,538	26,350	14,188	65.0	-	-
2015	42,162	27,405	14,757	65.0	-	-
2020	43,345	28,174	15,171	65.0	-	-

* Assuming that it Would increase at 1% point per 5 years in the 2000-2010 period and would not change in the 2010-2020 period.

Source: Korean Social Indicators, various years, N.O.S.

The industrialization caused most labor forces in rural area to move into urban area. The abundant labor force was the source of perfectly elastic labor supply up to mid-1970s (Bae 1980). After mid-1970s the labor supply became less elastic and the market principle came into operation. By this trims five conflicting forces countered in the labor market: three positive and two negative directions.

A decrease in absolute numbers of young population group and the increased schooling reduced the labor supply. Instead increasing labor force participation rate in aged groups and increasing female participation rate moved into positive side and thus the total number of supply steadily increased by diminishing rate with different structure. The abundant good-qualified labor forces have been an important factor for economic development in Korea. However, it is no longer easy to obtain labor forces as many as it wants because demographic transition, from the phase of high-fertility and high-mortality to the phase of low-fertility and low-mortality, has been reducing the population growth rate and surely causing the aging of population rapidly.

2. Labor supply policy

There has been no consistent labor market policy in Korea. In the first stage (1960s and 1970s) family planning and redistribution policy from rural to urban area dominated and the supply of young and cheap labor forces was the major target of the policy in the period of industrialization.

A rapid economic growth, effective family planning and rising wage resulted in an unexpected outcome. There occurred in structural inconsistency in the labor market. The shortage of low paid workers and technology related specialist (high paid workers) was severe in the labor market. The Korean government changed the attitude to the family planning and began to relax the constraints explained in Table 4. The inflow of foreign workers from China and Southeast Asia helped relaxing the labor shortage problem in low paid jabs.

From 1990s the family planning policy was de facto abolished in Korea by relaxing all the regulation and disadvantages on more than two children even though the government did not officially denounce the policy. Instead the government promotes the policy for the equal opportunities by sex to adjust the bias in sex composition in younger age groups. The government also tries to increase labor supply by encouraging labor force participation of married female and the aged and by changing education policy emphasizing technical training.

Recently the government adopted two important polices: 1) Establishing both public and private child-care facilities to encourage participation of female workers in the labor market and 2) Establishment of human bank to avoid mismatch of job seekers with job demanders.

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Chapter IV

Population Profile and It's Policies in Indonesia

Population Profile and It's Policies in Indonesia

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I. Introduction

The efforts to establish population program particularly family planning encounters many and difficult constrains. When this agenda was tackled by a number of activist and prominent figures, the attitude of the Old Order Government, which was "**pro natalist**" since the beginning constituted a big constraint. During President Soekarno's era, there were some regulations which are was disavantageous to family planning movement. Because of this, the pioneers of family planning implemented the population movement in a quiet and limited way.

The transition from Old Order to the New Order Government in 1966, terminated the political constraint. Presiden Soeharto's commitment to put the population policy-which was influenced by the world population situation- enable the family planning movement to operate in an open, systematic, and integrated manner. Indeed, since 1970, the New Order Government has directly bandless the population problems. Furthermore, Indonesia participate actively in international discussion on population since 1974 World Population Conference in Bucharest, Rumania till the last conference in Cairo, Egypt (1994).

In the New Order government population planning has been considered a central role in development planning. Indonesia considers population as being central to sustainable development. The ultimate goal of Indonesian national development is the achievement of the "total human being" (*manusia seutuhnya*).[1] This central role puts population in the position as the determinant of sustained economic growth, sustainable development, and environmental conditions, while recognizing that population is also affected by the environment and development efforts. The importance of population programs is indicated by the fact that separated ministries are responsible for population, transmigration, health, education, and labor force. Since 1993, the overall coordination of population policy is the responsibility of the Office of the State Ministry for Population/National Family Planning Coordinating Board.

1: The concept of "the total human geing" refers to people with a prosperous and high quality of life, in a balanced and harmonious state in relations to all the surroundings, be their social, natural, as well as the manmade environment.

II. National Population Profile

Demographic Trends

(1) Population Size and Growth Rate

The population of Indonesia has increased by almost 50.5 percent during the past two decades. Thus, while in the 1971 population census the number of inhabitants in the country was only 119.2 million, in 1997 the total population is projected as much as 201.4 million. Table 1 presents the basic demographic indicators derived from the 1971 to 1997. The pattern of "demographic transition" which has taken place in Indonesia is not too different from which occurred in the developed countries. However, the speed is so much faster. Some of the provinces in Indonesia have already achieved replacement level in twenty-five years. The Indonesian population growth rate has slowed from nearly 2.32 percent in the 1971-1980 period to around 1.54% in 1997, due to rapid declines in the average number of children per mother. But, given the high growth rates of the past and the resulting young population, the absolute increase in population is expected to continue to grow, before it will stable in 2040 with the total number of population around 270 million.

Table 1: Basic Demographic Indicators 1961 - 1997

No	Indicators	1961	1971	1980	1990	1994	1995*	1997**
1	Population (million)	97.1	119.2	147.4	179.3	192.2	194.8	201.4
2	Annual Growth Rate (%)	1.56	2.1	2.32	1.98	1.63	1.66	1.54
3	Density (pop/ km^2)		62	77	93	95	96	99
4	% Urban	14.8	17.3	22.4	30.9	33	35.91	36.8
5	CBR	46	40.6	35.5	27.9	24.1		22.9
6	CDR		19.1	13.1	8.9	7.8		7.54
7	TFR		5.605	4.68	3.326	2.812	2.80	2.58
8	IMR							
	Male		158	118	79	63		58
	Female		134	100	64	50		46
	Both sexes	150	145	109	71	57	62	52
9	Life Expectancy at birth							
	Male		44.2	50.6	58.1	61.2		62.3
	Female		47.2	53.7	61.5	64.9		66.1
	Both sexes		45.7	52.2	59.8	63.1		64.3

Source : State Ministry for Population/NFPCB, 1994

* Data based on 1995 Intercensal Survey (SUPAS 95)

** Projection based on 1990 Population Census and it becomes a government target in Repelita VI

(2) Sex ratio and Age Composition

Table-2 presents the age structure in 1980 and 1995. The number of males was relatively less than that of the females (sex ratio 99 males per 100 females). Sex ratio by age group gives a different

picture. In 1980, for example, more males than females were found for the young age groups (under 15 years), but there were more females than males for older age groups, except for those in the age group 50-54 years.

The age composition of the Indonesian population is still considered "young" or "expansive"; most of each age cohort is significantly larger than the cohort born before. The declining of the population growth rate is marked by the changing of the population pyramids. This difference is directly attributable to the decline of fertility in recent years. Because of the age structure of the Indonesian population, the proportion of non-productive age groups is relatively large. Included in the dependent groups are those aged below 15 and over 59 years. In 1980, the dependency ratio was about 85.6. This implies that 100 active persons have to support 86 inactive persons. Although the number of aged people (60 years and over) has been increasing over the period 1971-1995, the dependency ratio has undergone a substantial decline to 68.6 in 1995. Due to the changing in age structure, the dependency ratio of young population (aged below 15 years old) has decreased from 76.26 in 1980 to 57.08 in 1995. On the contrary, the dependency ratio of old population (aged over 59 years old) has increased from 9.37 to 11.49 during the same time.

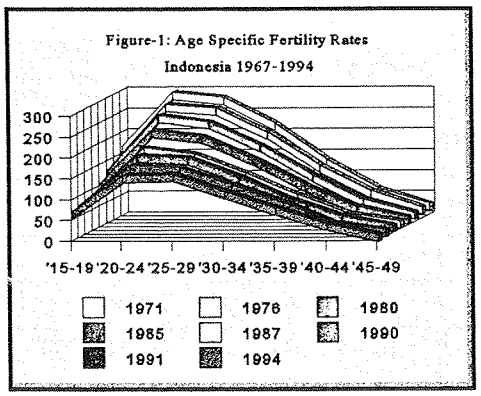
Table 2: Population by Age Group, Indonesia, 1980 & 1995

Age Group	Year			
	1980		1995	
	M	F	M	F
0-4	10,815,974	10,374,980	10,474,732	9,976,799
5-9	10,832,383	10,399,544	11,129,571	10,658,742
10-14	9,131,871	8,487,163	12,038,132	11,670,550
15-19	7,512,541	7,770,694	10,272,910	10,006,480
20-24	5,978,576	7,022,969	8,037,270	9,113,506
25-29	5,612,684	5,730,862	7,797,699	8,510,492
30-34	4,022,625	4,144,456	7,262,497	7,719,135
35-39	4,190,944	4,358,927	7,052,169	7,066,760
40-44	3,644,053	3,775,910	5,818,536	5,283,997
45-49	3,012,756	3,137,481	4,173,425	4,077,537
50-54	2,717,883	2,692,259	3,779,176	3,341,221
55-59	1,720,501	1,669,778	2,933,826	3,261,058
60-64	1,559,230	1,669,397	2,301,391	2,881,122
65-69	811,113	902,772	1,697,909	1,857,669
70-74	689,074	841,584	1,191,162	1,257,339
75+	68,442	836,951	969,526	1,124,470
Total	72,320,630	73,815,445	96,929,931	97,824,877

Sources : CBS,1981 & CBS 1996

The number of working age population (aged 15 and over) increased from 103.7 million in 1980 to become 128.8 million in 1995. The improved health and nutritional status of the population helps enhance the life expectancy and the life span of the population. From the age structure of population there is a the significant increase of the proportion of population age 60 and above. The number of elderly is relatively small in comparation with the number of those in the other age groups. In spite of it, the number tends to increase in absolute figures and in its proportion with the total population. Data from CBS show that in 1980 the number of elderly was 7.38 million or 5.05% of total population and it has increased to 10.44 million or 5.7% of total population in 1990. In 1995, the number of elderly has increased again to 13.30 million or 6.8% of total population. In other words, Indonesia is moving toward an aging population. The projection for the year showed the number of ageing population will exceed the population under 5 in the year of 2020.

(3) Fertility Trends



Source : Table 2

In Indonesia, the fertility transition did not begin until the late 1970s. However, once total fertility dropped below five, fertility has declined rapidly and steadily. The crude birth rate (CBR), which was 43 per thousand population in 1950, was still high in 1970 (41). However, the birth rate has been declining very significantly and it has declined to 24.1 per thousand population in 1994. Based on the 1990 population census, crude birth rate in 1997 is estimated to have declined to 22.9.

Table 3: Age Specific Fertility Rates (ASFR) and Total Fertility Rate (TFR), 1971, 1976, 1980, 1985, 1987, 1990, 1991 & 1994

Age Groups	1971 Census (1967-70)	1976 SUPAS (1971-75)	1980 Census (1976-79)	1985 SUPAS (1980-85)	1987 NICPS (1984-87)	1990 Census (1986-89)	1991 IDHS (1988-91)	1994 IDHS (1991-94)
15-19	155	127	116	95	78	71	67	61
20-24	286	265	248	220	188	178	162	147
25-29	273	256	232	206	172	172	157	150
30-34	211	199	177	154	126	128	117	109
35-39	124	118	104	89	75	73	73	68
40-44	55	57	46	37	29	31	23	31
45-49	17	18	13	10	10	9	7	4
TFR	5.61	5.20	4.68	4.06	3.39	3.31	3.02	2.85

Source : IDHS 1994

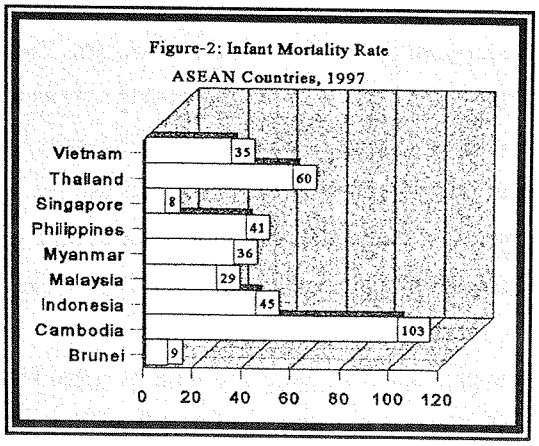
Note : Estimates for 1971 through 1985 and for 1990 were computed using the own children method, while the 1987 NICPS, 1991 IDHS and 1994 IDHS rates were calculated directly from birth history data

Table-3 and Figure-1 present the total fertility rate (TFR) and the age specific fertility rates (ASFR) derived from the 1994 Indonesia Demographic and Health Survey (IDHS) along with results from various other sources. It is important to note that the rates are not strictly comparable because of differences in data collection procedures, geographical coverage, and estimation techniques. Nevertheless, they serve the purpose of reflecting recent fertility trends in Indonesia.

The TFR has declined steadily in Indonesia since the late 1960s. The overall fertility rate for the period 1991-94 (2.9 children per woman) is half of that reported for the period 1967-70 (5.6 children per woman). The pattern of fertility by age group is the same as in the past, except that the peak in fertility has shifted from age 20-24 to age 25-29. Fertility has declined in all age groups. For example, in the youngest age group (15-19), fertility declined 60% between the periods 1967-70 and 1991-94, from 155 births per 1,000 women to 61 births per 1,000 women.

(4) Mortality Trends

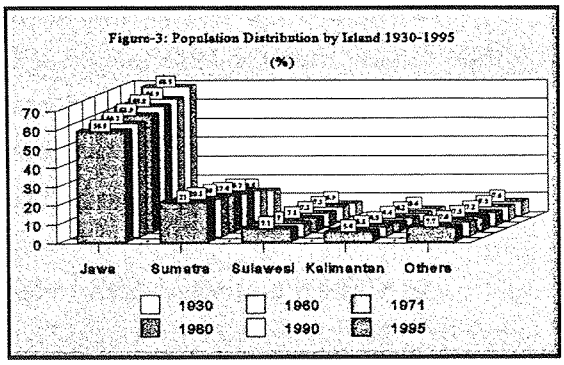
Lacking data from a registration system, the infant mortality rate (IMR) and other mortality indices have traditionally been estimated from census or survey data. Even the level of mortality (including IMR) has been decreased very fast during the last two decades (see Table-1) mortality rates in Indonesia, particularly for infants and children, remain relatively high compared to several neighboring ASEAN countries (figure-2). Similarly, the life expectancy at birth increased from 45.7 years in 1971 to approximately 64.2 years in 1995. Females live longer than males due to the female's infant mortality rate being lower than male. However, this gap in mortality levels is narrowing.



Source : Mantra & SUPAS-95

The decrease in mortality levels during the last two decades was apparently also accompanied by shifts in the causes of deaths in all age groups. Although the cause of death is still dominated by infectious diseases, there is a shift in the order of such causes of death. The shift in order of the causes of death from infectious to cardiovascular and degenerative diseases is one of the characteristics of the occurrence of the epidemiological transition. However the various data show the epidemiological transition in Indonesia is slightly different from what has occurred in European countries. The existing epidemiological transition cannot be classified into the classic form because the increase in non-infectious diseases is still accompanied by high incidence of infectious diseases. This means that the epidemiological transition has experienced polarization, which makes intervention more difficult.

(5) Population Distribution and Migration



One of many characteristics of Indonesia's population is its uneven distribution among islands and provinces like it is shown in Table-4. In 1995, Jawa island which is only 6.9% of total areas in Indonesia was inhabited by about 114.7 million people while Kalimantan island (28.1% of total population) during the same time was only occupied by 10.5 million people. Furthermore, according to the 1971 population census, the population density at the national level is 62 persons per square kilometer. This number continues to increase with the increasing size of the total population. In the 1995 population census, population density at the national level was 102 persons per square kilometer.

Population density varies across regions, not only among islands, but also among provinces in the same island. Jawa has the highest population density (868 persons per KM2), whereas Irian Jaya has the lowest density (4.2 persons per KM2). Although migration from the densely settled islands of Jawa, Madura, Bali, and Lombok to Sumatra, Sulawesi, Kalimantan and other islands with lower population density has been encouraged through transmigration programs and other efforts, the uneven distribution of populations still persists. The diversity of this population distribution is one of the obstacles to an equitable distribution of health and family planing services in Indonesia. Figure-3 presents the trend of population distribution in Indonesia during 1930-1995. The percentage of population distribution in Jawa island slightly decreased over the time while it has increased in other islands particularly in Sumatra.

Migration for the last two decades has also accelerated significantly, both in terms of intra and inter provincial mobility, as well as urbanization. Recent migrant (intra-nation) during 1975-80 was 3.7 million and it has increased to 4.3 million during 1990-95. Meanwhile the level of urbanization in 1971 was 17.3% and it has increased to 35.91 in 1995 and 36.87 in 1997. Jawa and Bali Islands are the most highly urbanized in Indonesia, with more than 48.7 million, or 41.2% of the total population settled in urban areas. The rate of urbanization in Indonesia takes place at a slower rate relative to economic performance, particularly if one compares urbanization in Indonesia with East and Southeast Asian countries. Urban growth has increased sharply. In 1950 there was only one metropolitan areas in Indonesia which was Jakarta while in 1990 there were eight metropolitan areas: Jakarta, Bandung, Surabaya, Medan, Semarang, Palembang, Bogor and Ujung Pandang. Furthermore, it is predicted the number of metropolitan areas in Indonesia will be becoming twelve in the end of this century.

For the last decade, international migration is beginning to take place at a meaningful rate; although, if compared to the total number of Indonesia population, the figure is still statistically insignificant. Number of Indonesian worker who work abroad tend to increase constantly. In 1983, the number of Indonesian worker who work abroad was 27,671 persons and it has increased to increased to 158,750 persons in 1992[2]. In Repelita VI (1994-1999), government predicted that the number of Indonesia worker who work overseas will increased to 1,2 million people[3]. Indonesian worker mostly work in Malaysia, Singapore, Hong Kong, Brunei, South Korea, and several countries in Middle East i.e. Saudi Arabia. Meanwhile the number of foreigner in Indonesia in 1995 was recorded as much as 57.177 persons.

Table 4: Population Distribution by Islands, 1930, 1961, 1971, 1980, 1990 and 1995

Islands	Areas (%)	Population					
		1930	1960	1971	1980	1990	1995*
		Million	Million	Million	Million	Million	Million
Jawa	6.9	41.7	63.0	76.1	91.3	107.5	114.7
Sumatera	24.7	8.2	15.7	20.8	28.0	36.0	40.8
Sulawesi	9.9	4.2	7.1	8.5	10.4	12.5	13.7
Kalimantan	28.1	2.2	4.1	5.2	6.7	9.1	10.5
Others	28.1	4.6	7.1	8.6	11.1	13.6	15.0
Total	100.0	60.9	97.0	119.2	147.5	178.7	194.7

Sources: Mantra, Ida Bagoes dan Nasruddin Harahap, 1993 (table 1.1)
* CBS, 1996

In term of economic share, there is a negative impact of international migration to economic development. Total cost for foreign workers is predicted as much as 2.5 billion US dollar per year in 1994/95 while the total remittences of Indonesian laborers in the year of 1993/94 is predicted only as much as 800 million US dollar. The difference is due to the level of human resource quality between in-and- out migrant.

(6) Social-Economic Changes

Demographic changes are closely link with social and economic development. The government policy on development is aimed at improving the people's welfare by ensuring the availability of adequate food, clothing and housing. Education and health are areas, which have also received considerable attention.

2: The number of female who work abroad has increased fastly compared to males. In 1983, 43.3% (11,995 persons) of total migrants was female while in 1992 67.49% (107,142 persons) was female. During 1993-1992 in average, the growth rate of female migrant was 12.1% per year while it was only 6.3% per male. The main destination of female migrant were Malaysia, Singapore, and Saudi Arabia.

3: Many scholars indicate that the level of illegal migrant even more than legal migrant.

In the last two decades, the Indonesia education system has undergone major improvement. The percentage of persons who never attended school has decreased, and the percentage of graduates at all levels of education has increased[4]. The Indonesia government dedication to education today can be seen through the nine -years school responsibility which was declared in May, 1993. The educational system now consists of nine years of compulsory education - six years of primary school and three years of junior secondary school.

Table 5: Economic Growth and Poverty Condition in Indonesia

Year	Average Economic Growth	Number of Poor People						Average Poverty Decline
		Urban		Rural		Total		
		(Million)	%	(Million)	%	(Million)	%	
1976		10.0	38.8%	44.2	40.4%	54.2	40.1%	
1981	4.68%	9.3	28.1%	31.13	26.5%	40.6	26.9%	(2.12%)
1985	2.05%	9.7	20.1%	20.3	16.4%	30.0	17.4%	(7.18%)
1990	7.2%	9.4	16.7%	17.8	14.3%	27.2	15.08%	(1.94%)
1993	6.5%	8.8	13.4%	17.2	13.8%	25.9	13.67%	(1.61%)
1996	7.9%	6.9	10.1%	15.7	12.6%	22.6	11.39%	(4.44%)

Source: Tjiptoherijanto, 1997

Indonesia has achieved substantial progress, particularly in stabilizing political and economic conditions. Per capita income has increased sharply, jumping from about US$ 50 in 1968 to US$ 386 in 1986. In recent years, per capita income has increased from US$ 400 in 1988 to US$ 1.100 in 1997. Meanwhile the level of poverty has decreased substantially (see Table-5). The number of poor people in Indonesia had dropped from 70 million in 1970 to only 22.6 million in 1996. Beside that, the income inequality measured by Gini Coefficient had also dropped from 0.38 in 1978 to 0.32 in 1990 but it has increased to 0.36 in 1996.

(7) The Development of Prosperous Family in Indonesia

The establishment of the Act No.10/1992 followed by the enforcement of Government Regulation No.21 of 1994 and Government Regulation No.27 of 1994 were pointing out the highly commitment of the government of Indonesia to the role of population and family on national development. In addition, the Population Development and the Development of Prosperous Family Law is becoming the legal aspect for all policies and programs for population and prosperous family

4: The literacy rate of persons 10 years of age and over has increased from 61 percent in 1970 to 84 percent in 1990. The percentage of children 7 to 12 years of age who are attending school has also considerably increased from 1971 to 1995. The figure for males were 62% in 1971 and 97% in 1995, whereas for females, the figures were 58% in 1971 and 93% in 1995. The percentage of primary school graduates increased from 20% in 1971 to 32% in 1995, whereas persons who completed junior high school and higher increased from 4% in 1971 to 13% 1995. At all level of education, the improvement in female education has been greater than for female.

development.

Approximately one year after the enforcement of the Act No.10, on June,29, 1993, the President of Indonesia announced the June 29, as 'The National Family Day'. With this decision, Indonesia expanded the strategic policies required to ensure the successful continuation of the family planning movement into the movement for the development of prosperous families. At the same time, institutions were established in all villages to help families develop themselves and become more prosperous.

Following the National Family Day, since 1994 the government of Indonesia conducted the regular schedule for national family registration. The purposes of this registration are to monitor the progress of prosperous family development and to evaluate the programs. The indicators in family data have compound the eight functions of family such as religious function, socio-cultural , sharing of love, etc. In order to monitor the progress of prosperous family, all indicators then translated to the various stages of welfare of the Indonesian families which are Pre-Prosperous level, Prosperous StageI, Stage-II, Stages-III, and Stage-III plus.[5] The data on the family welfare stages are then transferred to a 'working chart' developed to assist families throughout Indonesia to become self reliant.

Using the 1996 National Family Data Registration, in 1995, the compositions of welfare of the Indonesian families are 10.85 million families (27.54%) clasified in Pre-prosperous, 11.13 million families (28.25%) in Prosperous Stage-I, 9.23 million families (23.43%) in Prosperous Stage-II, 6.55 million families (16.62%) in Prosperous Stage-III, and 1.64 million families (4.16%) in Prosperous Stage-III Plus[6].

III. Population Policy, Planning, and Program Framework

1. Current Status of Population Policy

The 1993's State Guidelines (GBHN), Act No.10/1992 Concerning Population Development and Development of Prosperous Family, Government Regulation No.21/1994 concerning the Implementation of the Development of the Prosperous Family and Government Regulation No.27/1994 concerning the Management of Population Development elaborated population policy then in previous GBHN. It is then elaborated in more details in the Sixth Five-Year Development Plan (REPELITA VI). In the REPELITA

5: Pre-Stage Prosperous families are indicated by unable to fulfil the minimum basic needs such as spiritual needs (can not perform the religious prayers according to their respective religious denominations), food (minimal two meals per day), clothing (more than one pair of clothing) and housing (larger portion of the floor is not earthen), health and family planning (brought to the health center in the case of illness). Meanwhile the Prosperous Stage-I family is a family that has met their minimum physical needs but has not fulfilled the social and psychological needs such as family interactions, neighbourhood interactions, and jobs which determine a good living standard.

6: In other word, in 1995, there were around 21.26 million families in Indonesia classified as a poor family. Among all families in Pre-Prosperous stage, 7.19 million families were classified as a Pre-Prosperous becaused of the economic reasons and 3.66 million families were becaused of non economic reasons. Meanwhile, among families in Prosperous Stage-I, 5.04 million families were becaused of economic reasons and 6.09 million families were becaused of non economic reasons.

VI (1993/94-1998/99), the population policy has been formulated as follows: 1). To develop population quality;2) To control the size of the population;3).To guide population mobility; 4) To improve the population information system; 5) To develop a system of providing facilities for the aging society; 6) To develop family self reliance and to enhance the quality of the family; 7) To strengthen the instructional infrastructure of the family planning movement, and 8) To strengthen the international collaboration.

2. Policies on Management of Population Dynamics

The GBHN contains statements about the role of population control and population redistribution in the development process. There is a series of statements about the need to improve the quality of families through efforts in family planning in order to establish the small, happy, and prosperous family norm. All means already adopted to control the population growth need to be continued and even intensified. A balanced population distribution through a transmigration program, especially spontaneous transmigration, and internal migration activities also need to be maintained.

(1) Quantity Aspects

The aim of government policy in managing the size and growth of the population is to achieve fertility at replacement level by the year 2005-2010. To achieve this goal, the government of Indonesia has launched the following programs:

a. Family planning programs to allow planning of pregnancies and child bearing.
b. To increase accessibility of health services for all people.
c. Promoting to have ideal age of marriage.
d. Promoting a better of breast feeding practice.
e. Increasing educational levels of the general population.
f. Increasing the roles and participation of women in the development process and enlarging job opportunities for women.
g. Increasing coverage and quality of primary health care service (Posyandu).
h. Promoting a Small, Happy, and Prosperous Family.

(2) Quality Aspects

The government of Indonesia considers that poverty, ill health, and ignorance are the main cause of low population quality. Being poor makes the people unable to get good nutrition, limits the access to health facilities, and results in their being unable to pay school fees in order to obtain a better education. It was therefore decided to enhance the quality of the population through the following means:

a. Creation and enlargement of job opportunities to enable the general population to increase its per capita income.
b. Expansion of health facilities for the general population (or health for all).
c. Reducing infant mortality as well as maternal mortality from all causes of death.
d. Increasing school enrollment for the school-age population through extending compulsory education to nine years.
e. Strengthening of social institutional support for population and family development

(3) Distribution and Mobility

Population mobility, especially rural to urban migration, and migration from small city to metropolitan areas, has been increasing significantly during the last two decades in Indonesia. This is due to the fact that migration has become an option to improve the life and opportunities for people who migrate.

In coping with migration problems, the government has taken the following measures:

a. Redirection of population movement to areas or provinces which have labor shortages.
b. In redirecting the migration, the government of Indonesia is taking precautions not to adversely effect push away the local people.

In coping with the problems of urbanization, internal and international migration, the carrying capacity and capability of the environment (both the natural and socio-cultural environment) is taken into consideration.

(4) Enhancement of Prosperous Family

As stated in the 1993 GBHN, the main objective of the development of Indonesia is to develop the Indonesian people and the entire society to achieve happiness and a prosperous life, based upon the principles of a balanced life, benefits, and sustainability in order to develop the Indonesia human being in its totality.

In order to develop the total human being, the government pursues the quality of the family. Referring to Act No.10/92, the family, the smallest unit in society, consists of husband and wife or husband and wife and their child(ren), or father and his child(ren) or mother and her child(ren). The prosperous families at least have eight function which are : (i) religious function, (ii) socio-cultural function, (iii) sharing of love, including the process of democratization in the family, (iv) the family as sanctuary for the individual member, (v) the reproductive function, (vi) the socialization function, (vii) the productive function, (viii) the environmental protection function.

In order to help the family to perform these function, the government is taking steps to implement the following policies:

a. Managing and developing the population which is directed toward the control of the quantity of the population, enhancement of the quality of population, and the redirection of population mobility as potential human resources, contributing to the strength of development and national resilience, and optimizing the benefit for the people and increasing human dignity in all its dimensions.
b. Improving the quality of families through efforts in family planning in order to establish the small, happy, and prosperous family norm.
c. Increasing per capita income by expansion and creation of job opportunities for the available labor force.
d. Other necessary steps to elevate the welfare of the Indonesian family.

3. Population in Development Planning

The inextricable relationship between population and the achievement of national development objectives was an acknowledged focus of the REPELITAs[7]. There are a number of areas that must be considered in regard to the relationship of the population and development in Indonesia. For example, the result of agriculture technology, referred to as the Green Revolution, combined with a lower rate of population growth, has permitted Indonesia to become self-sufficient in rice production. A key concern in the relationship of the population to Indonesia's future is food security. This is characterized by the need to maintain self-sufficiency and reduce dependency on foreign sources of food supply. Maintaining an adequate domestically produced food supply reduces the need to use foreign exchange reserves which are needed for other commodity and capital equipment imports. These funds are also vital for economic growth and servicing of Indonesia's international debt.

The maintenance and further development of the education system are directly affected by population growth. Since the beginning of REPELITA IV, larger number of children have enrolled in schools. Without considerable new capital investment the country's 150,000 elementary schools, for example, could not be easily expanded to accommodate an increase in the number of school age children. A similar drain on education budgets would also occur in the secondary schools as well as the demand for more teachers. However, maintaining high level of basic literacy is essential to support the goal of enhancing quality of life for the population. On 2nd May 1994, Presiden Suharto had launched the 9 year Compulsory Education Movement (Gerakan Wajib Belajar 9 tahun) for every children in Indonesia. Through this movement, it is hoped to improve the quality of human resources, to become more productive and better support the goal of PELITA VI, to enhancing the quality of life of the people.

The areas of economic opportunity and employment are closely linked to population growth. Indonesia must continue to keep its growing labor force employed and reduce underemployment. Additionally, a certain quality work force will be required to accommodate the introduction of future industrial and production technologies. The goals for improving productivity in the private and public sectors are linked to a quality population base.

Ensuring adequate housing and efficient transportation systems are also related to the size and needs of population. Future development goals include improved shelter, safe and modern roadways and an effective mass transportation system that cannot be realized if the rate of population growth is not lowered, or maintained within the corresponding realities of national budgets and expenditures.

The impact of population growth on the country's development has been considered by the planners and strategists in the Indonesian Government. For example, as population pressure was beginning to be felt in Jawa and other areas, the country attempted to find solutions to the growing

7: In each REPELITA, Indonesia has focused on the improvement of the overall health and welfare of its people. It has progressively realized that population growth is related closely to an effective health and family planning infrastructures. Furthermore, the government has strengthened its national population policies. While the country is recognizing the role and importance of its population with regards to its development goals in the economic and social sectors.

population problem. One early approach to solve the problem was transmigration program[8]. Through transmigration program, Indonesia sought to redistribute the population at a rate of more than 100,000 households per year in order to solve the problems of densely populated areas. Concomitant effects of the program in the receiving areas assist in the development of unproductive and under utilized land, into productive areas by utilizing the potential manpower from the areas of origin. The transmigration program is not merely the activity to remove people from Jawa-Bali-Lombok islands, to other islands but this program is fully integrated with the regional and provincial development planning in destination areas. For example, farmer will be sent to the province where the development of agriculture sector is given to be high priority.

4. Profile of National Population Program

(1) Family Planning/Reproductive Health Program

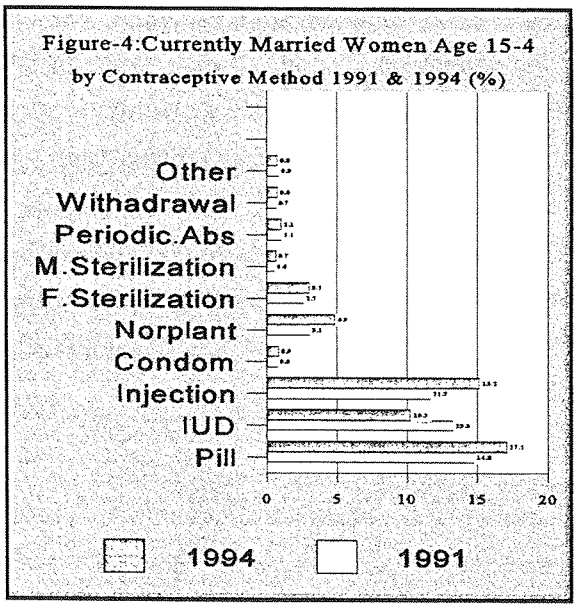
① Program Achievement

During REPELITA I, the family planning program covered six provinces on the islands of Jawa and Bali: Jakarta, West Jawa, Central Jawa, Yogyakarta, East Jawa, and Bali. At the beginning of REPELITA II, the program expanded beyond Jawa and Bali to ten large provinces on in other islands currently referred to as "Outer Islands I", i.e.: Aceh, North Sumatera, West Sumatera, South Sumatera, Lampung, West Kalimantan, South Kalimantan, North Sulawesi, and South Sulawesi provinces. In REPELITA III, the program extended to all 27 provinces of Indonesia. Now the program covers broader activities aimed at improving the standard of living for the family planning program acceptors. Indeed, since the beginning of the national family planning program, efforts were made not only to reduce the rate of population growth but also to improve family welfare, especially for mothers and children.

The creation of family planning posts (Pos KB) and acceptor groups (Kelompok Akseptor) through which women, under the auspices of the Family Welfare Movement (PKK), were assured a portion of the responsibility for designing and managing the local family planning programs. They began to distribute the contraceptives, such as pills and condoms, and gradually were given more responsibilities, such as motivating potential acceptors and consulting new acceptors. They received simple training and limited promotional materials for their work. In recent years, these village centers have penetrated deeply into the society with the establishment of family planning sub centers at the hamlet as well as the village level. The family planning program and other health programs are merged at the Center for Integrated Health Care (POSYANDU). Furthermore, income generating activities, cooperatives, agricultural extension, and literacy programs have become part of the activities of acceptor groups through PKK.

The program has also introduced a variety of additional contraceptive methods such as voluntary

8: In one view, a program involving the transmigration of people was considered a geographic solution to populations unequal distribution. In a more contemporary view, it was readily observable that areas such as Jawa, had a disproportionate ratio of the high population to a small land area, while, on the other hand, Kalimantan and Irian Jaya had a considerably smaller population distributed over a vast land area.



Source : IDHS, 1994

sterilization, injectable and "NORPLANT" implants. In order to develop security in the supply of contraceptives, factory have been built to produce oral contraceptives, IUDs, Injectable and condoms, domestically. The family planning program in Indonesia has made remarkable achievements in 20 years history. The results from the 1994 IDHS conform that Indonesia has continued to make considerable progress in providing effective, high quality family planning services to its people. As of 1994, 54.7% of all currently women were using some form of contraception and it has increased from 49.7% in 1991. Moreover Figure-4 show the percentage of currently married women age 15-49 using specific contraceptive method in the year of 1991 and 1994. Even though, pill is still the most popular contraceptive method among the married women, the largest increase was in the use of injection (from 12% to 15%). The pill has increased from 15% to 17%. On the other hand, IUD use decreased from 13% in 1991 to 10% in 1994.

A particularly encouraging development documented by the 1991 and 1994 IDHSs is the rapid expansion of self-reliant family planning (KB Mandiri) over the past seven years. For example, the percentage of clients acquiring family planning services through private sector outlets has increased from 11% in 1987 to 22% in 1991 and 51% in 1994. This dramatic shift in the composition of Indonesia's service delivery system has exceeded all expectations, and provides confirmation that KB Mandiri is achieving widespread acceptance among family planning clients.

② Program Strategy

In developing and carrying out the national family planning program, the Indonesian government was fully aware that the issue of family planning was a sensitive one and that the desired changes in reproductive behavior would not occur simply because the government requested it, nor could the program be unilaterally imposed. The concept of family panning has traditionally been a taboo subject. With this in mind, the government has taken the initiative to convince the community to participate in the family planning program through series of gradual steps. In later stages, the responsibility for program implementation has been transferred to the community itself. Political commitment, essential to the success of the family planning program, has been ensured by the People's Consultative Assembly (MPR), the highest political institution in Indonesia[9].

9: Since the family planning program is ensured by the MPR, the political commitment for supporting the family planning program has been established for all levels and in all sectors. This government commitment has resulted in increased support and participation by government agencies, as well as private institutions and the community.

Special acceptor groups and Village Family Planning Management Assistance (PPKBD) have also helped strengthen the community level support for family planning initiated by family planning field-workers. Acceptor groups usually consist of 15 to 30 female family planning acceptors[10]. Although the initial priority was in supplying oral contraceptives, these groups have become economically productive on the grass root level. Because the poorest sectors in the rural areas have almost no access to even small amounts of credit for capital or entrepreneurial purposes, BKKBN makes available small loans to these acceptor groups. The groups in turn establish rules for eligibility and use of the capital by individual members. Proceeds from profits are used to repay loans, establish self-perpetuating group revolving funds, and subsidize community-based family planning and health activities.

The PPKBD is a unit which assists the village chief in family planning related activities. The unit is supervised by the family planning field-workers, with activity reports going through the field-workers. The volunteers manage the center's function as part of the community rather than as part of a central development activity, serving an invaluable laison between the central development activity and the grass roots level. They also serve as family planning volunteers to motivate the local community and assist in resupplying contraceptives. They are given simple training and limited promotional materials for their work. In recent years, the concept of the PPKBD has penetrated deeply into the fabric of Indonesian society with the establishment of family planning sub centers at the hamlet level. There are currently about 76,000 village distribution center and 315,000 sub village distribution centers contributing to the program.

The active participation of informal and formal leaders has been a mainstay of the national family planning program since its inception. In addition, village leaders, religious figures and others participate in Information, Education, and Communication (IEC) activities at regular community meetings. The concept of family planning is disseminated through various channels, regular meetings commemorating special events such as Maulud, etc, and the use of printed and electronic media. Active participation by religious community leaders has proven highly beneficial to other Indonesian development activities, particularly in the rural community. These persons enjoy a very respected and trusted position within the community, thus playing a pivotal role, as local advisors concerning the program's moral and social acceptability, in the success of family planning. The national program managers routinely make personal contacts with religious and other community leaders for consultation, explaining the program before its onset, while simultaneously soliciting recommendations about implementation methods. Many religious leaders have received formal training, attended seminars, or taken part in other official activities offered by the family planning program, with expenses usually covered by the program. Once these leaders exhibit a positive attitude toward family planning, they often help the program by assuring the community that family planning is in accordance with Islamic teachings

10: The idea to establish the acceptor group is create a more favorable climate of opinion toward birth control, record program activities, and attempt to influence people not yet participating in or supporting the program. The groups exert a subtle, but firm, from of peer pressure on non contraception members of the community and discourage discontinuation of contraception. So, in broad sense, the goals of group are to strenghten community involvement in management of family planning activities.

and often act themselves as family planning motivators.

Religious institutions such as schools and Islamic boarding institutions (Pesantren) which number in the thousands throughout the country are potential chances to reach family planning target groups at the grass root level. Because of their strategic position in the community in relationship to both their students and the surrounding community, these institutions have proven to be very effective. Due to the fact that their privacy target groups are students, the family planning messages conveyed through these institutions are mainly related to family life education.

Meanwhile efforts at increasing women's participation in family planning have been targeted towards Moslem Women's organizations which have networks throughout the country and have the mission of expanding the role of women beyond that of the traditional role of household workers and childbearing. Through religious learning mechanisms, family planning messages are discussed and disseminated, supported with relevant verses from the Al Qur'an and Hadiths. Since the messages are considered role models among their followers, they are more efficient and easily accepted. The Family Welfare Movement (PKK), the Indonesian Women Congress Organization (KOWANI) and others, are some of the women's organizations in Indonesia which purpose to improve the family's quality of life by supporting programs which emphasize the physical and mental well-being of all families in society. PKK and KOWANI and others motivate the community to work for its own needs, by means of motivating and educating people, and by giving guidance and promoting activities.

There groups promote ten basic programs which are (i) the comprehension and practical application of "Pancasila" through simulations groups, (ii) to encourage mutual self-help (Gotong Royong) in all aspects of family life, (iii) to educate the family in health and nutritious and economic menus, (iv) to motivate the family in wearing clean and suitable clothing, (v) promoting hygiene housing and home economics, (vi) education of craft skills, (vii) health, (viii) the development of cooperatives, (ix) protection and conservation of the environment, and (x) sound planning. In the implementation of these programs, not every point of the ten basic programs has to be simultaneously carried out. Priorities for program implementation are determined by villagers based on their most felt needs.

The broadened family planning program extends beyond the objective of fertility control to the promotion of family welfare and improved quality of live. In pursing development objectives, such a broadened and ambitious program uses all available resources. One reason for this is to maximize scarce resource both in terms infrastructure and manpower in order to achieve optimum results. The general goal of this integrated approach is to realize the small, happy and prosperous family norm. To make family planning more acceptable and effective at the grass root level, various program activities use an integrated approach, which contain many components such as income generation, nutrition supplements, primary health care, agriculture, cooperatives, and educational scholarships. In this way, strong political and technical commitments are developed at the national and provincial levels. Important to the effectiveness of the family planning program is the transfer of responsibility from the national level into the hands of the community.

③ Program Activities

a) *Programs for Improving Mother and Child Welfare*

Health services, particularly in rural areas, have previously been inadequate. In the villages children under the age of five, pregnant women and lactating mothers, are the most susceptible groups to morbidity and mortality. Commonly, children are affected by a variety of conditions which have synergistic effects: malnutrition, diarrhea, respiratory infections and diseases, malaria, tuberculosis, eye disorders, and communicable diseases such as cholera, diphtheria, whooping cough and neonatal tetanus. Because of this, Indonesia has launched a number of integrated family planning and nutrition programs in 1979 which Called the Family Nutrition Improvement Program. This program is aimed at improving the nutritional status of the community, focusing attention on protein calorie malnutrition, Vitamin A deficiency, iron deficiency anaemia and diarrheal diseases. Currently, virtually all villages throughout the country participate in this program through the family planning program network of services. The communities themselves take an active role in executing the program. Cadres are guided by BKKBN field-workers and the Ministry of Health medical staff to became a vital link the transfer of nutrition information to mothers.

In March 1984, BKKBN, in collaboration with the Ministry of Health, launched the POSYANDU, an integrated project for the promotion of the small, prosperous and happy family norm. POSYANDU meetings are held at local level in community centers once a month and consist of five components.

a. Immunization of children under five years of age with BCG, DPT, polio and measles, and immunization of pregnant women with tetanus toxoid vaccines;
b. Prenatal care to identify and follow up high risk pregnancies, complete tetanus immunization coverage for women of reproductive age, extend delivery care by trained personnel for high risk pregnancies and quarterly visits for lactating mothers:
c. Family planning information and services;
d. Management of diarrhea: promoting home-based oral rehydration solution and oralite solutions in accordance with Ministry of Health guidelines;
e. Nutrition education and services

With technical support from professional and related government agencies, these POSYANDUs are organized and managed by local communities. Another new program which has been integrated into the POSYANDU is the Pre-school Children Guidance. This program enhances the knowledge, awareness and skills of mothers with children under five years of age to enable them to create an environment conducive to the full physical, spiritual, intellectual, emotional and social development of children under five. This program covers more than 5,000 villages in 27 provinces.

b) *Program for Increasing the Family Incomes of Acceptors.*

To facilitate the realization of the small, happy and prosperous family norm, BKKBN embarked on a novel scheme to integrate income generation into the existing family planning program, based on the premise that upgrading women's productive economic activities are an effective means of breaking the

cycle of poverty and high fertility. The social and economic rewards of this increased income promote rural development, raises the status of women, and alters their reproductive behavior. A project entitle Effort to Increase the Income of Acceptors Family (UPPKA) was established. The logical intervention point for the UPPKA is the existing acceptor groups. The purposes of the UPPKA are:

a. to increase the skills and income of acceptors through improvement of their economic activities;
b. to increase participation in the family planning program by means of an added economic incentive;
c. to increase the status of women by their active involvement in decision making and an improvement of their economic role.

c) *Program for Providing Long Term Security to Family Planning Acceptors and Their Children*

This activity improves work opportunities and the quality of life for family planning acceptors. Simultaneously, it encourages continued family planning acceptance by making scholarships available to children of acceptors practicing family planning continuously for ten years or more, and belonging to the lower socioeconomic strata of society. Priority is given to children displaying exceptional natural talents, diligence and intelligence. These scholarships are aimed at assisting children to complete their high school education.

d) *Programs for Enhancing Participation in Community Development*

Several population and family planning education projects operationing in Indonesia since the early 1970s have been specifically targeted to the youth. The objective of this approach is to integrate population and family planning education concepts into the formal and non-formal educational activities in the government school system, quasi-government institutions, and voluntary organizations. Efforts have also been made to involve the Boy Scout Organization (PRAMUKA), National Committee of the Indonesian Youth (KNPI), Village Youth Social Organization (Karang Taruna), Internal High School Student Organization (OSIS), Mosque Youth Association (Remaja Masjid), University Students Social Internship (KKN), and the Board of Advisors for Marriage Conflict and Divorce (BP4) by integrating population and family planning education into the their training program. The underlying goal of these youth activities is to encourage teenagers to postpone marriage and first pregnancy by creating activities which emphasize marriage and children as only one of many means of providing recognition and personal security.

Furthermore, family planning program leaders recognized the need for a more independent, contemporary approach for its program. The resulting new approach initially aimed at transfering the responsibility for their own family planning needs, including payment for services and supplies, if they could afford it. This approach is based on the belief that people should seek family planning services because of an internal motivation to provide a better life for their families. In support of this self-sufficiency effort, a special IEC campaign was developed utilizing social marketing techniques. It was called The Blue Circle campaign based on its logo. After a few years of implementation, the logo has been change to Gold Circle which indicates a more self-reliant condition.

BKKBN realizes that the implementation of family planning self-reliance will not be easy and can only be realized through good planning, dedication and hard work. BKKBN classifies family with regard to family planning self-sufficiency in the following ways :

a. Fully self-reliant groups : groups that can be fully responsible for their own family planning needs;
b. Partially self-reliant groups : groups that can provide only a part of the support for the family planning services they need;
c. Subsidize groups : groups that still need a full subsidy from the government in order to participate in the family planning program.

e) *Population and Family Planning Education*

The main activities of population and family planning education are to educate young generation to have reasonable and responsible reproductive knowledge, awareness, attitude and behaviors, regarding population problems in an effort to internalize and institutionalize the small, happy, and prosperous family norm. The population and family planning education is divided into in-school education and post school education. The target groups of post-school population and family planning education are the young generation who act as subject and object in the family planning movement. In order to clarify the targets, they are divided into intermediate targets and final target groups. Intermediate targets consist of (i) youth organizations, such as National Committee of the Indonesian Youth (KNPI), Boy Scout Organization (PRAMUKA), Village Youth Social Organization (Karang Taruna), Internal High School Student Organization (OSIS), Mosque Youth Association (Remaja Masjid), University Students Social Internship (KKN); (ii) government institutions, including other ministries directly or indirectly related to family planning education activities such as the Ministry of Education and Culture, Ministry of Social Affairs, Ministry of Labor, Ministry of Religious Affairs and State Ministry of Youth and Sport; (iii) public institutions, including PKK and Board of Nahdatul Ulama Family Planning Institution (LKK-NU). The ultimate or final target groups for family planning education are the entire youth generation, but with the priority given to those who are 15-24 years of age.

f) *Domestic and International Training Program for Family Planning Personnels*

Government puts special attention in the issue of education and training for family planning's field workers and other parties who directly dealing with family planning program. During 1994/95 there were 2,705 medical doctors and 5,370 mid-wives has been given a training in family planning field. During 1995/96, the number of trainees have been increased to 4,535 medical doctors, 8,124 mid-wives, and 9,146 field workers.

Furthermore, Indonesia officially commenced active International cooperation in 1987 by offering bi-lateral training programs to Bangladesh officials. This activity was funded by USAID. This bi-lateral arragement give rise to requests from other developing countries for training in Indonesia, thus leading to the establishment of the International Training Program (ITP) of National Family Planning Coordination Board (NFPCB). To date the international training unit of NFPCB has hosted a total of

2,694 participants coming from 85 countries.

(2) Health and Mortality Program

① National Health Policy

The objective to be achieved in health development is a capability in every person to live a healthy life which, in turn will, lead to an optimal health status of the population. This is one of the main public welfare elements of the National Goal. The notion of health includes physical, mental and social well-being and is not merely the absence of disease or infirmity.

Long term health development is directed at achieving the following main objectives:

a. increasing the ability of the community to help themselves in the field of health.
b. improving the quality of the environment to assure improved health.
c. improving the nutritional status of the community.
d. decreasing morbidity and mortality.
e. development of family welfare, including an increasing number of small families.

The Indonesian health policy goals, as articulated in REPELITA VI and in the Health Development Action Plan are to:

a. strengthen the emphasis on preventive and promotive health activities aimed at reducing maternal, infant and child mortality and morbidity, as well as fertility and improve nutritional status;
b. improve the quality of health services and associated referral systems;
c. achieve improvements in quality, efficiency, and effectiveness, and integration of health resources, actively promote the decentralization and integration of health plans and budgets;
d. strengthen local resource mobilization and financial management; and
e. strengthen interagency coordination to facilitate achieving goals.

Based upon the priority problems and policies under health development, the main health activities have been defined. These include strengthening of heath services, nutrition improvement, promotion of environmental health, prevention and control of disease, food and drug control, promotion of occupational health, strengthening of management and legislation, health manpower development and health research and development. Following the principles for the next long term period, the following priorities for health efforts include: (i) Strengthening of health efforts, (ii) Health manpower development, (iii) Food and drug control, (iv) Nutritional improvement and promotion of environmental health, (v) Strengthening of health service management and legislation.

In order to ensure that health activities are implemented effectively and efficiently, it is necessary to incorporate the implementation of these activities within the basic structure of the National Health System. The basic structure provides for the following: (i) Implementation and development of health efforts will be executed with in the basic structure or patterns of health centers, community participation and health referral activities, (ii) Health management, (iii) Health resources, and (iv) Health regulations.

② **Health Program Activities**

a) *Primary Health Care (PHC)*

In Indonesia, health services in rural areas are mainly delivered through health centers and sub centers. In order to increase the coverage of the services to the people Village Community Health Development (VCHD) activities are being promoted in the village. The principal element of VCHD are: (i) Self-help activities by the community, (ii) Village health insurance, (iii) Village drug dispensary of health post, (iv) Village (health) cadres, (v) income generating activities, and (vi) Referral system.

With regards to an operational from of PHC, the health center functions include: (i) Training of cadres for village health team development, (ii) Technical assistance, supervision and consultation on various aspects of VCHD, (iii) Resource assistance to the community, (iv) Motivation of the community and cross-sectoral officials. Multi sectoral agencies contribute directly to the income generating activities of the community. Beside that, various sectoral programs are directed toward improving the quality of life, e.g., housing renovation program, agriculture, environmental improvement program, electricity, education including non formal education, etc.

There has been further strengthening of the health infrastructure at the national level for supporting health care delivery by front line primary health care workers. This effort includes training more than 11,000 midwives every year such that within five years each village will have a midwife. Interest has also been evidenced in urban primary health care aimed at the provision of health services to slum dwellers and other undeserved and unserved population groups in the cities. Case studies in urban primary health care for ascertaining the extent of the problem and involving suitable programs for their solution has been undertaken in a number of cities.

Future actions should strive to consolidate the gains made in the health program, to expand the POSYANDU activities, and to expand health insurance to those in industrial employment and organized communities. Community-based health funds activities are likely to expand, probably in conjunction with POSYANDUs. In fact, all approaches to an expansion of socially based health financing will be explored. Over the coming decade, it will be necessary for the health sector to adapt to changing disease patterns associated with urbanization, economic growth, and changing social conditions. To cope with management problems, more decentralization to district health service institutions is taking place. Regional planning capacities are being improved to guarantee more realistic planning. The Districts are encouraged to exploit local resources further and to utilize them in more rational ways.

b) *Maternal Child Health and Child Survival*

Income, environmental improvement, and nutritional gains along with fertility decline probably account for much of the impressive fall in the infant morality rate. Another contributory factor has been increased coverage of immunization against childhood diseases. Access to immunization and other preventive and curative health services expanded with the establishment of POSYANDUs. In addition to this program, the government introduced an immunation program for the bride. Despite these gains, Indonesia continues to face community health and nutrition challenges. The results of 1994 IDHS reveals

a disturbing stall in the previous rate of improvements in coverage of basic preventive programs, particularly immunization of infants and pregnant women. Most obvious perhaps, are problems relating to the very high levels of maternal mortality and morbidity which, in the context of the increasing proportion of all infant deaths that occur in the perinatal period, suggests a need to improve the quality and effectiveness of care during the birth process itself. Moreover, pockets of low nutritional status are evident across the country, and micronutrient deficiencies, particularly of iodine and Vitamin A buttress unacceptably high levels of infant and child mortality, especially among the poor, and in the eastern islands.

Although child and infant mortality fell sharply over the past ten years, maternal morbidity and mortality indicators show less rapid decline. There are no accurate measures of the national levels of maternal mortality because of the lack of vital registration in a society where over 75 percent of all deliveries take place in the home. Estimates vary from 150 to 720 maternal deaths per 1.00,000 live births, with 450 as the best estimates that the national maternal mortality rate. Recent studies suggest that further reductions in both infant and maternal morality will require more concentrated attention on problems associated with maternal health and nutritional status prior to and during pregnancy, as well as improved availability of suitable ante natal services and medical care at birth.

Data show significant increases in average caloric intake, and reduction of the prevalence of moderate and severe malnutrition among young children. These advances are attributable to growth in food production and rural employment, and better monitoring of shortages and improved management and distribution of food supplies. Another factor, was the inter sectoral Family Nutrition Improvement Program (UPGK), or the POSYANDU, which uses monthly village meetings to promote nutrition education. Nevertheless, malnutrition, a biologically fundamental obstacle to improved maternal and infant health status, continues in many areas of Jawa/Bali and is unacceptably high throughout the eastern islands.

The remarkable decline in fertility directly contributes to reduced risks of maternal mortality through reduced number of pregnancies. Thus it is likely contributing to better infant health status through reduction in the number of risky births. Future progress in family planning will require efforts to maintain and expand both the quantity and quality of family planning and maternal and child health services.

There are several important linkages among these aspects of community health and nutritional status. Maternal health is closely linked with child health. The poor health and nutritional status of the mother are major underlying causes of an infant's low birth weight or premature delivery. Women who are undernourished or in poor general health are more prone to maternal morbidities and complications, and therefore mortality. While Indonesia has made clear progress in child health by preventing immunizable diseases and by reducing diarrheal deaths, further improvements will require sharper attention to maternal health status related to pregnancy and birth and to improving nutritional status.

c) *Community Health Services*

Indonesia has made substantial investments in development of the basis infrastructure and human resources for a comprehensive primary health care delivery system which also serves as the support base for outreach services. At present each of the country's 3,400 subdistricts has at least one PUSKESMAS, although the distribution of facilities is significantly less dense in the eastern provinces. In some cases, principally in very densely populated or remote areas, health centers are equipped with up to 10 beds and provide simple in-patient care. Below and linked to heath centers, health sub-centers (PUSKESMAS Pembantu) are supposed to provide basic care, including health education.

The planning targets are a ratio are of three or four health sub centers per health center, each staffed by a nurse or a midwife. The system also includes an ambitious community out-reach program aimed at reducing infant, child and maternal mortality and fertility. The program focuses on the delivery of some interventions-MCH services (typically antenatal care), immunization, diarrheal control, family planning and nutrition, child weighing, growth monitoring, distribution of iron and vitamin A capsules as well as nutrition education and counseling at POSYANDU which are established by community organizations such as (PKK) and assisted by health center staff. Activities are conducted by village volunteers (cadres) with technical assistance from BKKBN and Ministry of Health's staffs from the health centers and sub centers level.

Secondary and tertiary level services are provided by general public and private hospitals. Public sector hospitals is classified according to the number of beds and degree of specialization. Class A and B hospitals located in major cities are teaching hospitals and major referral centers. Class C (100-400 beds) and Class D (25-100 beds) are based at the district level. The former staffed with specialists in surgery, internists, obstetrics and gynecology, internist and pediatrics, while the latter are typically staffed with general practitioners. For the Class D hospitals, the government has provided additional equipment and a wider skill mix. Significantly improved protocols for managing the quality of care, to be able to provide sufficient clinical backup and referral services for community-based safe motherhood and child survival programs, is a major effort which is implemented by the Government.

The growing recognition of perinatal and maternal health risks as major health problems, in conjunction with the need to improve the accessibility and utilization of more effective family planning methods, has led the Government of Indonesia to develop a National Safe Motherhood Movement (GSI). The Safe Motherhood Movement recommends that the following major activities become the focus of the Government's action:

a. increasing awareness and the commitment of leadership to Safe Motherhood goals,
b. improving the availability and use of information about maternal mortality and morbidity,
c. strengthening maternal health care including nutrition and family planning services at village, sub-district and district levels,
d. improving skills for traditional birth attendants, midwives and other health professionals,
f. strengthening the management and supervision of MCH services, particularly at the district and province levels,
g. improving information on the status of women.

h. the strategies also included also the development of specific plans for Safe Motherhood for each province.

The Government of Indonesia realizes that achieving significant change in infant and maternal health and improving nutritional status ultimately will require fundamental behavior change. Many of the government's interventions concern behavior related to aspects of life style, such as food and eating patterns, weaning patterns, pregnancy care and birth management, and the use of new or different technologies and forms of health care. Experience confirms that achieving these changes requires changing beliefs through the provision of information and education directed at specific behaviors. Health system are designed to have the capacity to effectively deliver educational and promotional messages, regardless of their stage in the epidemiological transition. Effective steps to prevent cardiovascular diseases and other chronic conditions typical of aging populations must include successful change in behavioral patterns such as smoking, improved food habits and promotion of physical fitness. Developing improved capacity to promote improved infant and maternal health messages could, therefore, contribute to long as well as short term needs in the health sector.

d) *HIV/AIDS*

Although the extensive spread of HIV/AIDS in South East Asia and Indonesia began only in the mid 1980s or even later, the progress of this pandemic disease in this region has been very rapid. Data show that in 1993, the government estimated that around 172 cases of HIV infections were detected in Indonesia. Among those 130 cases have the HIV positive and 42 AIDS cases were reported. The figure then has increased to 590 HIV infections in 1997 (446 HIV positive and 144 AIDS). While provinces Jakarta, Bali and Irian Jaya account for the majority of reported infections, rapid HIV/AIDS spread into other provinces have been seen elsewhere in Indonesia.

The increase in HIV/AIDS cases has raised concern that HIV/AIDS may become divesting in Indonesia. However, because HIV/AIDS treatment is not yet available, a prevention program is the most effective strategy. Initial step to overcome the HIV/AIDS problem has been taken by the Indonesian Government. This includes information, education and communication efforts.

In anticipating the possible future HIV/AIDS problem, the government will further improve our multi sectoral National AIDS programs (NAP) under the coordination of the coordinating Minister for People's Welfare. Cooperation with international and national organizations/agencies will also be further improved and intensified pararel to the increasing level of NAP Coordination. In ASEAN region, the cooperation will be carried out through the ASEAN Task Force on AIDS. NAP 1993 objectives are:

a. To consolidate all achievement up to the of 1992 and to have a strong foundation for future NAP activities.
b. To improve all NAP infrastructures and strengthen commitments of all involved sectors, NGOs and professional organizations.
c. To accelerate all NAP activities to be in advance of the speed of the epidemic. To have an adequate acceleration an appeal to some international agencies and donors were already given

through consultations to participate in an effort to make a successful NAP in Indonesia. They were requested to accelerate all their bureaucratic procedures so that they could be real participants of our NAP in the near future.

d. To increase the level of multi sectoral NAP coordination from the level of the Minister of Health to the level of the Coordinating Minister of People's Welfare.

NAP uses both biomedical and non biomedical approaches. The main NAP activities which are based on a biomedical approach are: (i) IEC (Information, Education and Communication) implementation; (ii) Establishing surveillance including sentinel surveillance; (iii) Establishing blood banks and expanding laboratory services; (iv) Condom promotion; (v) Implementation of universal precautions; (vi) Case management and counselling; (vii) Screening of blood donations (not blood donors); (viii) STD case detections and treatment; (ix) Developing environmental (socio-economic and cultural) epidemiology; and (x) Develop family health and welfare.

Furthermore, the government also launched a non biomedical approach which are: (i) Strengthening of family ties and responsibility; (ii) Controlling risky sexual behavior by persuading people to avoid practicing it; (iii) Strengthening healthy-good sexual behavior through IEC activities; (iv) Developing healthy-good sexual behavior in young generation; (v) Changing risky sexual behavior to be healthy-good sexual behavior whenever it is possible; (vi) Preventing all negative HIV/AIDS impacts; (vii) Preventing the third HIV/AIDS epidemic/it third wave; (viii) Preventing the increasing trend of sex permissiveness in the community including pornographic permissiveness; (ix) Preventing drug abuses especially narcotics; (x) Preventing the increasing trend of alcoholic culture; and (xi) Developing individual internalization of feeling ashamed at making other people HIV/AIDS phone, and strengthening idealism to prevent sex permissiveness/preference to enjoy irresponsible instant/short period sexual activity.

In addition to the above mentioned activities, there are supporting activities, consisting of: (i) Training; (ii) Broadening and improving infrastructures; (iii) Research and development; (iv) Multi sectoral coordination meeting; and (v) Implementation of Anti-HIV/AIDS cooperation at all level.

(3) Population Mobility and Population Distribution Program

① National Population Mobility and Population Distribution Policy

Population mobility in the near future will become an interesting phenomenon. The differences on economic development among countries, openness of information, communication and transportation have a great impact on the increasing number of population mobility across the nation border especially among the labor force. This is why Indonesian government take a serious consideration regarding the international migration especially labor migration. Could the Indonesian labor compete with labor from other countries? In this matters, human resource development also become a central issues.

Beside international migration situation, government also considers on internal migration of labor. Uneven population distribution across the country creates some problems in sustaining economic

growth and environment. Densely areas on one hand may maintain the high economic growth since there are enough labor supply in these areas. However, the economic growth is not sustain because densely area are closely related to environment degradation. On the other case, it is very difficult to reach a high economic growth in less densely areas because there is not enough employment in those areas as well as economic market. Therefore, it is needed to direct the population especially employment from densely areas to less densely areas i.e. from the densely settled islands of Jawa-Madura, Bali and Lombok to Sumatra, Sulawesi, Kalimantan, Irian Jaya and other islands with lower population densities, and from rural to urban areas.

There are two approaches in distributing the population which are direct and indirect approach. Indonesia at the earlier of 1970s has had several direct population policies. Transmigration program at the earlier development is considered as direct population distribution policy since this program put the number of people that removed from Java-Bali and Lombok islands to others islands as a primary program target. However, at the later stages of development, transmigration program take more consideration on the development of destination areas rather than putting the target on the number of people that could remove. Indeed, in the earlier 1970s, local government of Jakarta proclaim Jakarta as a 'restricted area' for people from other areas. The purpose of this policy is to control the population growth of Jakarta city.

Meanwhile, the indirect policy is try to redistribute people through distribute the economic activity. Many countries both developed and developing countries accommodate this approach for distributing their population. Distributing the economic activities to rural areas could reducing the rural-urban migration. Theoretically, economic activity could generate the employment opportunity and it could followed by the in coming migrants to those areas. However, this model could not work in the remote areas, in the areas where the number of population is too small. In this case, the economic activities are not visible to developed. This is a major problem for island country like Indonesia.

Government of Indonesia then combine the direct i.e. transmigration program with the indirect policy for example regional development policy to distribute the human resource. The transmigration is still continue but this program combine with the effort to develop the economic activities and employment opportunities in the destination areas of transmigration.

② National Population Mobility and Population Distribution Program Activities

a) *Transmigration Program*

Transmigration is the voluntary migration of Indonesian population from one region within Indonesia to a different region, also within Indonesia. These people will become part of stable and sedentary settlements in the receiving areas. Transmigration is coordinated by the Indonesian Government as a contribution to national and regional development. According to Act. No. 15/1997, concerning the basic stipulation for transmigration, transmigration is defined as "the removal and/on transfer of population from an area to settle in other area determined upon within the territory of the Republic of Indonesia, in the interests of the development of the country, or for other reasons considered

necessary by the Government, based on the stipulations made within this Statute."[11]

The objectives of transmigration development are: (a) an improvement in living standards, (b) regional development, (c) a balanced distribution of the population, (d) equitable distribution of development throughout Indonesia, (e) utilization of natural and human resources, (f) national union and units, and (g) strengthening of national defence and security in the receiving area (transmigration area). Aims of transmigration at the destination areas are: (i) increased human resources and labors, (ii) utilization of natural resources, (iii) increase financial resources and investment, (iv) increased means and development of the infrastructure, (v) transfer of technology, (vi) increased of production, and (vii) increase of new development centers. While in the area of origin, transmigration aims to decrease population and labor density, to decrease rural-urban migration, to preserve nature and the environment, to avoid natural disasters and security disturbances or casualties, and to implement project which requires dislocation of population.

Based on the implementation and financial resources, transmigration is divided into three types: (1) sponsored transmigration (transmigrasi umum), spontaneous transmigration (transmigrasi swakarsa), and (3) self-reliance transmigration (transmigrasi swakarsa mandiri). The sponsored transmigration is financed by the government, whilst spontaneous transmigration is financed by the private sector or by the transmigrants themselves with some government subsidy. The self-reliance transmigration is fully financed by the private sector and the transmigrant themselves. The government in this case only provide the land. Based on the basic types of transmigration job opportunities the types of transmigration settlements consist of the usual pattern of food crop agriculture plantations, industrial forest transmigration plantation, fresh water as well as sea water fishery, public services, and industry. This diversification of settlements is necessary so that all interested citizens, as candidates, can participate in the program based on their own skills. For those who are interested in the non agricultural sector, they can participate actively by choosing transmigration to public service and industry projects.

A general transmigration candidate should come from a predetermined area, defined by Presidential Decree. The transmigration program is one of many government efforts to alleviate poverty and improve the quality of life of the population. Therefore, a government subsidy for transmigration is usually directed to poor farmers, labors in agricultural sector, fishermen, forest squatters, unemployed, and school dropout. The areas of origin of the transmigrants are selected on the following criteria: (a) population density above the environment carrying capacity, (b) area affected by natural disasters, and (c) area that had been affected by development projects.

The transmigration program not only builds houses in the area of destination, but also create job opportunities. The settlement program provides land, settlement infrastructure, houses, and public facilities and provides job or enterprises to the transmigrants. For example, at the moment seven types of activities are implemented: (i) integrated agriculture, (ii) plantation, (iii) forestry, (iv) fresh water fishery,

11: Act No.15/1997 is a modification of act No.3/1972. In the previous law, transmigration is defined as "the removal and/on transfer of population from Jawa-Bali-Lombok islands to outside Jawa Madura-Bali-Lombok islands". So the concept of transmigration in the act No.15/1997 is much broader than the concept of transmigration in the previous one.

(v) sea water fishery, (vi) service and, (vii) industries. It should be noted that the transmigration program is a multi sectoral activity which many ministries are involved.

The implementation of transmigration programs during the First Long Term Development Plan (PJP I: 1969/70 to 1993/94) has already contributed a sustainable development of the area as by conserving environments and raising the standard of living of the people. The results achieved during the PJP I include, amongst others, resettlement of 1.5 million families or approximately 8.5 million persons with a multiplier effect in building 55,000 Km of roads, 69,000 meters of bridges, opening up more than 1.5 million hectares of new agricultural land, building up of 827,000 housing units both by government or other entrepreneurs, raising of food production to support self-sufficiency in rice, adding hundreds of thousands hectares of estate crops especially oil palm and rubber, hundreds of thousands of hectares of industrial (man-made) forest plantations, provision of additional workers who have expedited developments in the receiving areas. The transmigration programs has also contributed to building up and maintenance of more than 1,600 villages with an overall population exceeding 3 millions, has shifted and resettled 50,000 families of forest squattersin Lampung and another 15,000 families from various provinces of Jawa, Bali, East Kalimantan, Jambi, West Sumatra and Bengkulu.

Along with such input, the Government also provides guidance and physical facilities for about five years, by conducting routine supervision, consolidation for stabilization and improvement of social, environmental settlement, production enterprises as well as social institutions. These development efforts can be grouped into two fields, 1) socio-cultural development and 2) development of economic enterprises. In general, socio-cultural development consists of health guidance and services. Economic enterprise development consists of activities such as: inputs for agricultural production (seedling, composite, lime etc.), training, development of food crops farming system, tree crops, animal husbandry, fisheries, and cooperative and marketing improvement. government efforts to alleviate poverty and improve the quality of life of the population.

People are becoming increasingly aware of the benefits of the transmigration programs towards improving their standards of living. A principal indicator of this awareness is the fact that the number of self-reliance transmigration has increased steady over the year. In 1993/94 the number of general transmigration was 19,412 families and it has increased to 23,676 families in 1994/95 and 26,375 families in 1995/95. The number of spontaneous transmigration during the same time has decreased from 30,028 families to 25,724 families and then to 22,947 families (Republic of Indonesia,1997). On the contrary the number of self-reliance transmigration has increased from 15,000 families in 1994/95 to 27,000 families in 1995/96. The general transmigration is still needed by people since not all families could afford the cost of moving from origin to destination area. However, the above data show that in the recent time, the total number of self reliance transmigration has already surpassed the total number of general transmigration. The data also imply that the transmigration program could become a pull factor for migration as long as the program is managed professionally.

b) *Regional Development*

National development strategies have an impact on population distribution. There are three different path of macro economic policies which influenced the population distribution in Indonesia. First, macro economic strategies during 1966 to 1980. During that time, the combination of import-substitution policies and foreign investment in Indonesia's manufacturing sector began to accelerate the polarization of development in the Jakarta metropolitan region. Between 1974 and 1979 Jakarta and its surrounding province of West Java increased their shares to the total value added in medium and large scale manufacturing in Indonesia from 38 percent to 42 percent. Equally important to the polarization process was the concentration in Jakarta of a rapidly expanding civil and military service, establishing the financial institutions, and the inflow of foreign businesses and employees working for oil companies, donor agencies, foreign enterprises and consultancy firms was greatly responsible for the development of a housing market and to create new market for higher order services.

All of these factors lead to an acceleration of the growth of Jakarta and its immediate hinterland. Furthermore the government policy for giving the Jakarta's position as the nation's principal port is also expanding the position of Jakarta in the national economy. In addition to the acceleration growth of Jakarta, the second major spatial trend was the expansion of key port cities linking Java's northern coast with resource enclaves and ports in the outer islands. As cities on Sumatra, Kalimantan and other islands begin to expand around oil and timber ports and cash crop plantations, northern port cities of Java expanded their roles in the inter island trade of consumer goods from Java in exchange for raw materials from the outer islands.

Trend of economic and industrialization during those areas lead to the phenomena of urbanization which rapid out-migration of labor from rural areas of East Java, Central Java, and Yogyakarta to the urban areas of Jakarta, Surabaya and other cities along Java's northern coast. The failure of advances in rice production to significantly expand employment in agriculture and non farm employment in rural areas in Java was manifested in the growth of cities whose economic base was in inter island transport, government services and import substitution manufacturing growth. Rural areas, remained low level services and having only those basic functions that can be sustained by the generally very low income of the households in their immediate hinterlands. Meanwhile urban areas (large and small cities) that located away from Jakarta and the expanding inter island are also remain stable and growth at the low level.

Second, by the early 1980s, the import substitution industry had accomplished the easier tasks of developing a basic industry and a national textile industry. However many of them were running well-below capacity and particularly in the case of the large number of state-owned enterprises which dominate natural resource-based processing industries. Those conditions were related to poor management and without incentives to improve their performance. The industrial sector itself was highly dependent upon the export of oil and other natural resource and cash crops to create domestic markets for its products. Finally, with the expected persistence of substantially lower prices for oil into foreseeable future, the driving force of Indonesia's industrialization process under the formula of 1970s could not be

relied upon to carry the economic forward. Added to the fall of oil prices was a extensive drop in prices for Indonesia's other natural resource and cash crop exports. Meanwhile the ban placed on further log exports, to be applauded from both an environmental and longer-term economic perspective also deeply cut into outer island's export.

Even though the development of industry in outer islands were slowing down, manufacturing development was continuing high concentration in Java. In 1985, 76 percent share of all manufacturing employment are held in Java island. While 72 percent of rural and urban construction work located in Java island especially around Jakarta and northern coastal. On the contrary, rural employment in the manufacturing sector was in very low productivity. The rapid spread of mechanization in agriculture during the early 1980 lead to the lower use of labor force and it followed by high migration rate from rural areas to urban areas. All of these changes had been influencing the urbanization process during the 1980s. During those times, there was a significant slowing down of rural-urban migration in the outer islands and an focus on Jakarta and other major northern coastal cities on Java.

Meanwhile the massive transmigration program during the 1980s also influences the spatial redistribution especially urbanization process in Java and outer islands during that time. Most of the transmigrants come from the East Java, Central Java and Yogyakarta. At the same time most the in-migration to Java island from other islands come to Jakarta and its surrounding areas including West Java.

Third, in the second half of 1980s, government has an intention to develop the eastern part of Indonesia and rural areas. Policies such as tax-holiday for company, which invests in Eastern part of Indonesia or special credit agreement for rural people are an example of government intervention in redistribute the population across the country. Government also encourages the system of bapak-anak **angkat** in controlling the rural-urban migration. Using the '**bapak-anak angkat**', the movement of rural people to big cities is to be apprentices in companies, factories, or offices. The apprentice position is recommended to increase and stimulate motivation in the future, when they are ready and able to start their own business in rural areas. Furthermore, in the earlier of Repelita VI, government through the National Development Plan Bureau (Bappenas) projected that the total government investment in eastern part of Indonesia will increase from 26% in 1993 (early year of repelita VI) to 27.6% in 1998(the end of Repelita VI). The increasing of government investment is followed by private sector from 11.4% to 12.6% at the same time. Therefore, the total investment in eastern part will increase from 14.% to 15.3%. On the contrary, the total investment in western part of Indonesia will decrease from 85.7% to 84.7%. It is interesting to see whether this policy will impact on population movement to eastern regions. Based on above scenario, government projected that in 1998, there are around 2.6 million job opportunities in eastern regions (see **Ramelan,1994**).

How is the national development strategies affect the population distribution and mobility?. In 1995, about 58.9% of people live in Java island. This number was slightly decreased from 63.8% in 1971. Meanwhile the percentage of people who live in Sumatra island tend to increased from 17.6% in 1971 to 21% in 1995. This trend also followed by the Kalimantan island where the percentage of

population in this island increased from 4.4% to 5.4% during the same period. The percentage of people who live in urban areas increased from 22.4% in 1980 to about 36.9% in 1995. The rate of growth of urban population during 1980 to 1995 was about 5-7 % per year.

The old pattern of population migration in Indonesia is still going on where the area of movement is still between Java and Sumatra, both among provinces within an island and between islands. Immigration to Sumatra tend to decrease slightly, while immigration to other islands, especially Kalimantan, tend to increase. This is related to the national development policies in Eastern Part of Indonesia. It is interesting that since 1985, DKI Jakarta had a negative recent migration netto. On the other hand, West Java had a quite large number of positive recent migration netto. Apparently, about 48.4% of in-coming recent migrants to West Java during the period of 1990-1995 was coming from DKI Jakarta (i.e. 541,031 out of 1,117,615 people). Furthermore, in the period of 1990-1995 West Java was the main target of interprovincial migration in Indonesia. Around 25.99% of recent migrants in Indonesia during 1990-1995 occured in West Jawa (i.e. 1.117.615 out of 4.3 million migrants). It is noted that during 1980-1985, DKI Jakarta was still the migrant's main target.

c) *Rural Development*

Rural-urban migration studies in Indonesia show that the main reason to migrate to urban area from rural area is to find a job. This is why GOI has implemented various schemes of micro finance in rural areas under the umbrella of rural development plan. The notion's first micro-finance program established in 1898, was the Village Credit Institution (Badan Kredit Desa), village-based institution which provides loans and accepts savings. It is operated by residents of the respective villages. Currently, there are more than 3,000 of such BKDs operating in rural areas of Java. Since 1994, the government has created new BKD-type institutions throughout Indonesia. The new institutions are called Center for Savings and Loans Services. Other micro-finance schemes are the Farmer Micro-enterprise Credit, Rural Credit and Savings, Micro-enterprise Credit, Credit for Income Generating Projects for Marginal Farmers and the Fishermen, and the People's Education Credit. The main purpose of all credit schemes is income generating of rural people and promoting the economic activities in rural area.

At least there are two benefits will be obtained by promoting the industrialization in rural areas which are first, the level of rural-urban migration can be controlled and even urban population will move to rural areas, and second, the level of urbanization growth will increase remarkably since the status of rural area change become an urban area. In line with rural industrialization, GOI through the **State Ministry for Population/NFPCB** initiated the policy and program called '**Rural Urbanization**'. The concept of rural urbanization refers to the condition where certain areas are still having a physical circumstance like rural area but people who live in those areas are having a modern way of life such as the shifted main industry from agriculture to non agriculture, utilize the modern financial institution, highly motivated on education, etc. The reason to initiate rural urbanization in Indonesia is based on the fact that urbanization is closely related to the level of economic growth. Data show that most of industrial countries are having a level of urbanization at least 75%. This is why government of Indonesia

endeavors to accelerate the level of urbanization in order to inspire the economic growth through rural development. However in order to avoid the urban problems, which may occurred during the high urbanization process such as environmental degradation, government more focus on changing of the way of life rather than putting highly physical investment in rural areas.

Recently, GOI initiates two vital programs to generate the economic activities in rural areas. In December, 1993 government lauched Presidential Decree Program No.5/1993 (**IDT Program**) concerning Poverty Alleviation in less-develop village and it was officially implemented on the first of April 1994. The government is also aware that poor families are not only located in those poor villages in the remote areas, but also in the other places which are less remote. After implementing the IDT program for two years and the various programs for the development of family welfare, government has decided to link the program for family development with poverty alleviation schemes.

The State Ministry of Population and National Family Planning Coordinating Board, collaborating with other Ministries such as Ministry of Interior, Ministry of Agriculture, Ministry of Cooperatives and Small Enterprises Development, the National Development Plan Board, etc, then formulating policies and program to accelerate the transition of family welfare because the economic reason. Those programs called Prosperous Family Savings (Takesra) and Prosperous Family Loans (Kukesra). The innovation of Takesra and Kukesra programs can not be separated with the Act No.10/1992 concerning the Population Development and the Development of Proseperous Family. Under the Act No.10/1992, government has an responsibility to formulate the policies and to develop the programs in order to improve the prosperous family. The law then implemented in Presidential Instruction Number 3 (Inpres No.3/1996) which guide the government's officers how to empower the pre-prosperous and prosperous stage I family because the economic reasons. Therefore, the Presidential Instruction No.3/1996 concerning the Prosperous Family Development in the Poverty Alleviation's Framework can be called as a legal aspect of Takesra and Kukesra programs. The IDT program and the Movement to bring urban values to families in the village (Pembangunan Keluarga Modern dalam Suasana Kota di Desa=Banggasukadesa) themselves are the movement to accelerate the rural urbanization, rural development, and poverty alleviation.

d) *International Labor Migration Program*

Like other developing countries, Indonesia has problems in dealing with employment. This is a primary reason for people to migrate to other countries. Indeed, the level of wages in Indonesia are far below the neighboring countries such as Malaysia or Singapore. Realizing the employment situation in the country, government promotes the international migration of Indonesian labor. Beside to control the level of unemployment and under employment, international migration also expects to have a positive impact on national economic development through the occurrence of remittances.

Number of Indonesian worker who work abroad tend to increase constantly. During **the Fifth Five-Year Development Plan (1989-1994)** the Ministry of Manpower predicted that the number of Indonesian workers who work legally abroad were 641 thousand workers. The number of Indonesian

worker who work abroad are much higher if the illegal workers are taken into account. During **the Sixth Five-Year Development Plan (1995-1999)**, government expected that the number of Indonesia worker in abroad will around 1.2 million workers.

Considering the international migration, the use of foreign manpower is done selectively in the framework of the optimum use of the Indonesian manpower efficiently, and to urge the transfer of technology. On the contrary, government encourages the export of skilled workers to other countries. In the planning of fulfilling the labor force needs abroad, there are several strategic alternatives which are necessary to support the efforts to solve the problem of manpower nationally, among others are concerning labor marketing, preparing , placement, and protection. The marketing problem is closely related to the planning of fulfilling the labor force needs abroad, especially in the promotion system in every target country, the placing system, and the quality of the manpower.

Accurate labor survey should be implemented in preparing and placing the manpower, according to the plan of labor force requirement which, in the realization of the recruitment, selection, training, and placement process, there are facilities in accordance with the prevailing rules. The labor force protection connected with the planning of the labor force needs abroad it is necessary to prepare protection support aspect since the pre employment period, employment period, and post employment period, among others are the professional Labor Force Service Enterprise (**Perusahaan Jasa Tenaga Kerja Indonesia / PJTKI**), reliable banking system and Labor Force Social Security (**Jaminan Sosial Tenaga Kerja**), employment contract and waging system, and labor returning to their original place.

In accordance with this matter, the right mechanism should be developed for labor force placement abroad, and the use of labor market abroad without forgetting about the nation's dignity and reputation and the labor force protection. The improvement of manpower placement affectivity and efficiency abroad aims to increase the country's income. According to the above matter, it is necessary to deregulate the labor recruitment and training, which is supported by an effective organization. To achieve the above target the marketing of Indonesian labor force abroad priority is given to skilled and professional labors.

It is necessary to reduce the sending of half skilled labors and in stages increase the sending of skilled and professional labors till the end of **Repelita VI**. Arranging of the planning of labor demands abroad, where the program has to be implemented intergratedly between **Department of Manpower, PJTKI**, and the related authorities, based on the concept of the Indonesia Incorporated (**Direktorat Jasa TKLN, Depnaker, 1994**).

e) *Senior Citizens Management*

Policies on senior citizens, adopted by the government of Indonesia, are divided into two basic categories,which are: (1) comitments or initiatives which are spelled out in laws and regulations; and (2) operational measures pursued to manage problems encountered by the elderly. Furthermore, there are two levels of policies adopted to manage senior citizens issues, which are (1) policies adopted by the central or national government; and (2) policies adopted by regional or local administrations.

Policies adopted by the national government pertain basically to commit on allocation of financial assistence to be disbursed by regional or local administrations. Meanwhile regional and local administrations are responsible for disbursement of such assistance. Regional or local policies generally concern the operational aspects of assistance to the elderly people.

Operational policies on the management of senior citizens implemented independently by offices of the Ministry of Social Affairs, Ministry of Health, and Ministry of Manpower. Unfortunately, present and past efforts at managing senior citizens issues and providing guidance to the elderly were sporadic. They were still untargetted and unintegrated and remained sectoral. There are, however, community organizations involved in managing and providing guidance to senior citizens. Most of these community organizations are active nationally and relatively few of them work in the regions and local communities. Consequently, government policies on regional and local management of senior citizens issues are limited and sectoral. They are confined to promulgation of national programs or delivery of financial assistance to the regions.

(4) Population Data Collection and Analysis

① National Policy on Population Data Collection and Analysis

A multi-complex National Development process needs some appropriate development planning in the efforts to attain successful development targets. Consequently, various statistical data are required to develop the optimum policy. Without population data and some other related data, population development and its impact is hard to monitor and evaluate effectively. That is why statistical data and analysis have an important role in Indonesia and Government of Indonesia (GOI) endeavors to improve the quality of population information.

As a matter of fact, the statistical population data and related information are needed first to formulate the program and the policy foundation and then to monitor or evaluate the implementation and results of the development, in order to carry out a number of development activities, especially if population development is to be done effectively and efficiently. Of course, the quality of the population data and other related variables, should be improved to meet the continuous information being required by the users. With proper data, the policy decision makers and the analyst can work to solve the population problems.

② Program Activities

The population data in Indonesia generally are obtained from the three major resources: (a) the population registration, (b) the population census and (c) other related surveys such as the Intercensal Survey (SUPAS), the National Socio Economic Survey (SUSENAS), the National Labor Force Survey (SAKERNAS) and other special survey such as Indonesia Contraception Prevalence Survey (SPI), Indonesian Demography and Health Survey (SDKI), Household Health Survey (SKRT).

a) *Population Registration*

Based on the decree by the President of the Republic of Indonesia No. 52/1977, population registration system should be carried out as an administrative activity on the routine basis. Statistical population data that is derived from vital registration such as birth, death and mobility of population will provide significant information required for developmental planning. Historically, vital registration has been conducted since The British Colonial period (1815). It is now under the coordination of the Home Affair Department. Starting in 1970, the vital registration activities has been expanded to all whole area of Indonesia, with The Presidential Decision No. 52/1977 (KEPRES No. 52/1977) as the policy foundation of the vital registration system. However, the coverage and quality of the vital registration should be improved. For that reason the State Ministry of Population coordinates necessary efforts to improve the quality and coverage of vital registration.

b) *Population Census*

Since independence, the Indonesian government has conducted Population Censuses four times, i.e.: 1961, 1971, 1980 and the 1990. According to Act No. 6/1960, the population census should be conducted every 10 years, in the year ending with a "0" (zero). But for some reason, the first two censuses were conducted in the year 1961 and 1971. All of country's population census cover data on demography, education, labor force, housing facilities, etc.

c) *Surveys*

In addition to data from censuses and vital registrations, there are some population data which are obtained from several surveys conducted by either Central Bureau of Statistics or other institutions. The enumeration method of a survey is different with the population census. Many surveys are conducted by the Central Bureau of Statistics, for example:

o. Intercensal Surveys

The intercensal survey is conducted every ten years, in the year between two sequential census year. So far, intercensal surveys has been conducted three times, in 1976, 1986 & 1995. The coverage of this survey is large enough to be able to estimate the number of the population and others demographic, social, economic, and cultural characteristics.

o. National Socio Economic Surveys

This survey is conducted periodically every three years but with the different statistical module which appears alternatively in every year. Those modules are social and culture, education and health, consumption and education.

o. National Labor Force Surveys

This survey covers the characteristics on the labor force. It is conducted quarterly each year.

o. National Household Health Surveys (SKRT)

This survey covers the detail characteristics of health condition of household. To date, the surveys have conducted three times i.e. in 1984, 1986 & 1991. After 1991, the household health survey is

integrated into the National Socio Economic Survey.

o. Special Surveys

These surveys are conducted to obtain data which is required for a certain purpose, such as the Indonesia Contraception Prevalence Survey (1987) and the Indonesia Demographic and Health Survey (1987,1991, 1994 & 1997).

o. Other Surveys

Other surveys which are intended to obtain the micro, macro, and sectoral data are conducted by some institutional bodies other than the Central Bureau Statistics.

d) *Improvement of the Quality of the Population Data*

The enhancement of the development process will automatically results in either the increasing need for population data or the demand for accuracy and the timeliness of the data presented. The increasing need for the large, accurate, and up to date data will influence the efforts to improve data quality. With the efforts of communication, information, and education, there will be a good cooperation between the community as respondents and the data collectors in order to obtain better population data.

Furthermore, GOI also tries to improve the quality of a data bank. A data bank is a collection of various data, while a data base is data from various resources that have been integrated to make possible the analysis of the cross sectoral data. So far, a data base is used as a main part of the government central data base, within the government information network system. This network system is the information network system which is connected though the government computer systems. Several activities are being done by government to improve the utility of the population data base.

The other aspect of data collection is the population data dissemination and analysis. The dissemination of the population registration, census, and surveys are generally in the form of some publication, printed matter, or diskettes etc. Several indicators prepared by the Central Bureau of Statistics are population indicators, family planning, migration, education, social and culture, religion, health, nutrition, labor force, security, housing, environment which are routinely published and disseminated.

(5) Women in Development

① National Policy and Program on Women in Development

The development policies in Indonesia are based on the principle of equality between men and women. This principle is deeply ingrained, in our State Ideology, Pancasila, and our Constitution of 1945. Consequently, this principle of equality is also embodied in all regulations and legislative acts of the Republic of Indonesia, including the GBHN adopted every five years by the People's Consultative Assembly, which provide direction for the formulation of the Five Year Development Plan. Indonesia, in 1984 also ratified the convention on the Elimination of All Forms of Discrimination Against Women, with Act. No.7/1984.

One of the major achievements during the UN Women's Decade was the inclusion of a special

chapter on the Role of Women in nation building in GBHN of 1978 and subsequently of 1983, 1988, and 1993. The 1993 GBHN contains the basic concept of: (i) equal rights, obligations and opportunities for women and men in all aspects of civic life and in all development activities; (ii) woman's harmonious role in the family and society; (iii) respect for women's dignity and protection of women's specific biological characteristics/reproductive function; (iv) develop a favorable socio-cultural climate and enhance women capabilities for wider participation of NGO, including among other the Family Welfare Movement, to promote family welfare, and (v) to increase woman's and policy maker's ability to use science and technology such that have more chances to participate in development process and sensitive to the national and international changes.

This strong political will is supported by substantive capability of the government and the community to translate it into action. Various programs for enhancing the role of women in development, both integrated and programs specifically designed for women, are carried out in all sectors and fields of development.

In Indonesia, our endeavor to enhance the role of women in development has always been an integral part of our national development. Therefore, it is carried out within the context of: (i) poverty alleviation; (ii) improved human quality and the quality of life; (iii) equitable development; (iv) greater community participation; and (v) sustainable development. In line with the overall national development policy, women's development programs are primarily targeted at: (i) women in the low-income group in the rural, urban and coastal areas; (ii) women in isolated places and transmigration areas; (iii) women heads of household; and (iv) young women of 15-29 years old.

The objectives of the policies and programs are to enhance the role of women in their own right, as wives, mothers, community members, economic providers, leaders at all level, citizens and members of the world community. A holistic strategy is pursued in our effort to uplift the situation of women. This holistic approach should be understood in its multiple dimensions:

a. In term of their role in development, both as agents and beneficiaries efforts are being directed not only to ensure equal opportunities for women, but also to enable them to take advantage of the available opportunities to participate in and to benefit from development.
b. In line with the GBHN, efforts are also being directed toward enhancing the harmonious role of women in the family and society.
c. Due to the multidimensional nature of women's issues, measures in the social, economic and political sectors are being carried out in a complementary and mutually supporting manner.

Besides general policies mentioned above, more specific policies have been developed for enhancing woman status. Within the framework of agricultural development policies, the agricultural policies on women aims at promoting women's role as beneficiaries and as program planners, managers and implementors. These policies are implemented through various programs such as: training in agricultural technology for women farmers, agricultural extension services, application of appropriate technology in fish processing industries, formation of women farmer's groups and promotion of collective group activities, provision of credits and support women's access to land, increased utilization

of home gardens for improving family nutrition, establishment of demonstration plots for women farmers, etc. Special attention is given to women in fishing villages and coastal areas which constitute the poorest segment of the community.

② **Program Achivement**

The successes of population programs, particularly fertility control, in Indonesia has far reaching impact on the status of women. As a consequencies of fertility decline i.e. TFR, from 5.6 in 1967-1970 to 2.9 in 1993, women have an extra time to looking for another activities besides traditional role as a housewife. Even though the level of labor force participation among women is substantially lower than among men i.e 72.4% for men compared to 41.9% among women in 1995, the growth rate of labor force among women has found to be higher than among men. During 1980 to 1995, labor force participation among women has increased from 32.6% to 41.9%. Meanwhile during the same time labor force participation among men has increased only from 68.8% to 72.4% respectively.

Due to the role of women in health development, Indonesia has succeeded in reducing its infant mortality rate very sharply. Infant and maternal mortality is not only important indicators of child welfare but also women's socioeconomic status. The health policy recognizes the importance of women in three roles: as direct beneficiaries, as mothers and family members and as health workers, especially as front line health workers outside the home. In promoting health, women have been active participants in these three roles. Their participation is reflected in the running of the community-based POSYANDU which was formally established in 1985. The POSYANDU provides five basic services for children under five and mothers: nutrition improvement, immunization, diarrhoeal disease control, mother and child care, and family planning. The availability of these various services at the same time and place, without charge and close to people's home is a major breakthrough in primary health care.

The rapid expansion of POSYANDU shows how communities have increasingly taken on the major responsibility for their own well-being. And women are the primary driving force for this awareness-raising and social mobilization. A nationwide and community-based movement of female volunteers devoted to improve the well-being of families called Pembinaan Kesejahteraan Keluarga, popularly known by its initials PKK, plays a crucial role in establishing community participation and management of activities at the POSYANDU. In addition, most women's organizations (there are more than 60 major women's organization with membership exceeding 25 million women) carry out health programs. Some of them run maternity clinics, which also provide family planning services.

Furthermore, the figures show that the growth of female labor force participation is much faster than male labor force participation rate. In the 1980 Census, the female labor force participation increased from 17.3 million to 26.5 million in the 1990 Census. During the current Sixth Five-Year Development Plan (1993/94-1998/99), of the total 11.9 million people entering the labor force 47.5 percent or 5.6 million are women. The rapid growth of female labor force participation is brought about by the increase in women's educational attainment, the success of family planning and the development of the economic sector. The need to improve family economic conditions has caused substantial number

of women to leave their traditional role as a house keeper.

Unfortunately, women's participation in national development is not preserved by proper quality of human resource yet. For example, in 1993 the percentage of women graduated from university were only around 36.99% compared to 63.01% of men. Percentage of illiteracy among women in 1995 was 17.14% while among men was 7.87%. The difference quality of human resource i.e. in education aspect causes the difference performance achievement in working-circumstance. For example the number of women who could achieve the high rank in government officer position is substantially lower compared to men. The number of women in parliamentary is only around 11% of total members.

While the number of female work force has increased, their status in terms of employment rank, productivity, and salary remain lower than that of male labor. This unfortunate situation is not because of discrimination against women in the work-place but because of low educational attainment and training. In this connection, special attention is given to the improvement of women's education and training, health and welfare as well as protection and improvement of their working conditions.

Sixty to seventy percent of the female labor force work are in the informal sector. In view of the fact that the informal sector will continue to be an important source of livelihood for the majority of unskilled women, due attention is being given to the improvement of their welfare, working conditions and protection. At the same time a productive linkage between the formal and informal sector is being established to promote female labor productivity and to increase women's income.

To increase women's access to capital, the government provides several kinds of small financial credit. In recent years small credit schemes without collateral has been introduced to women in the informal sector. The programs depicted above open wider opportunities for women to play a more active role in economic development. However, such still needs to be done to enable women to take full advantage of the opportunities and facilities.

(6) Poverty Alleviation

① National Policy on Poverty Alleviation

CBS used poverty measurement based on the need of calory per day (2100 calory) and other non food expenses.

In 1996 was decided poverty line in rural area as of Rp. 27,413/month/person or Rp. 914/day/ person and in the urban area of Rp. 38,246/month/person or Rp. 1,275/day/person. Based on that poverty line, in 1996 it was still 22.6 million or 11.39 percent from total population in that time who are under poverty line. The poverty rate in 1996 has certainly dropped if compared to data on 1970 of 54 million or 40.1 percent. Government is targeting that at the end of Repelita VII (2003), the number of absolute poverty in Indonesia will be decreased to less than 2 million people or in term of percentage is less than 0.1% of total population in Indonesia.

② Poverty Alleviation Program

Aware that the issue of absolute poverty and inequality have negative impact on the

development and national integration in general, the government in the 1990's decade re-emerge the program of poverty alleviation and inequality as one of the central issue from the perspective of national development. In the last four years, government of Indonesia established several policies and programs in order to accelerating the poverty alleviation such as Inpres Desa Tertinggal (IDT Program), Prosperous Family Savings (Takesra) and Prosperous Family Loans (Kukesra) programs, mutual partnerships between large-medium-small scale business, and improving the quantity and quality of Cooperatives movements. The first two programs are little bit different than previous previous credits schemes since the creditors are given the special treatment regarding the interest rate and also time limit for returning the credit.

a) *Inpres Desa Tertinggal Program*

IDT program or Presidential Decree Program Number 5/93 (INPRES 5/1993) concerning Poverty Alleviation was officially implemented on the first of April 1994, the first year of the Sixth Five-Years Development Plan. The IDT program has three important objectives, first, to trigger and accelerate the national movement for poverty alleviation, second, to reduce social and economic disparities in the community, and third, to reactive the people's economy by empowering the poor. The program contains three basic components which are first, a government grant of Rp.20 million (US $9,000) per year to each village for three consecutive years, second, the provision of facilitators to help the 'self help' group of the poor to develop their micro enterprises, third, the building of rural physical infrastructure in the for of rural roads, bridges etc, to the amount of the Rp. 100 million to Rp. 130 million (US $ 40,000 to US $ 60,000) per village, starting in 1994 and up to 2004, if needed.

Planners and implementers of development programs have long acknowledged the importance of poor households's access to credit, especially in rural areas. Credit enables households to start or expand business activities and at the sometime increase production and create financial surpluses. This will promote better living standards and development sustainability.

In IDT program, a grant ranging from US $ 10,000 to US $ 30,000 is provided by the central government to self-help groups in each 'left behind' village as '**working capital**' to finance microenterprises of individual members. These IDT groups called Pokmas, deliver funds to members as credits which must be paid back to the group after certain period of time, may be 6 months, 12 months, or 24 months, depending on the consensus within the group. Whether or not members pay interest on the loan, is also determined by members in the group themselves. The fund is not paid back to the government but become an 'eternal' working capital for the members of the group. Groups are advised to introduce an intra group loan system, in which the process of capital accumulation can take place, among others, by introducing loan service fees to members.

Launched at the end of 1993, the program targets groups whose socioeconomic conditions are categorized as poor by local (village) standard. After three years, the program has covered 28,223 of the least-developed villages or 43% of total villages of the country. Beneficiaries consist of 123,000 self-help groups called "kelompok masyarakat (Pokmas)" comprising 3.4 million poor households. One group

consists of about thirty poor families, and there can be several such groups in a village, depending on local necessity. In 1997/98 fiscal year, government of Indonesia provides the budget for this program as much as 131.9 billion rupiahs or about US$ 35 million for 6.573 eligible villages all over the countries. However, till September 1997 the total amount that was absorbed only 18.4 billion rupiahs or around 14.06%.

b) *Takesra and Kukesra Program*

Following the successful of IDT program, government initiates the other special credit in rural areas which called Prosperous Family Savings (**Takesra**) and Prosperous Family Credit (**Kukesra**) programs. However, unlike the IDT program which based on village approach, this microcredit scheme is based on family approach. The initiation of Takesra and Kukesra programs is based on the fact that even one village is classified as non 'left behind' village but not all families in that village are classified as rich family. That is way the target group of Takesra and Kukesra programs is poor family outside the IDT program. Only families which are classified as a Pre-Prosperous and Prosperous Stage-I, have access to Kukesra and Takesra schemes. The family firstly invited to joint the Takesra saving fund with an initial saving of Rp.2,000 or US $ 0,75. Then the depositor will be able to get a credit for an amount of maximum 10 times of the Takesra balance, so that the first credit will be maximum Rp.20,000 or US $ 9. In the following stage, 10% of the Rp.20,000 loan is then deducted, adding up to the saving so that the saving becomes Rp.4,000. With this saving, then the second credit will be Rp. 40,000.- and so forth up to credit of Rp.360.000.- or around US $ 160 per family.

In order to accelerate the transition of prosperity stages, interventions or development supports both from government and private sectors are needed. For example, to accelerate the number of families from Pre-Stage to Prosperous Stage-I, it is needed to assist the families to improve their living standards in wide spectrum such as encourage families in practising the religious aspects, to encourage a person to use any health facilities if necessary, or to convince them to joint family planning and other reproductive health cares. In this matter, the role of 'Family Welfare Centre' which located in every village throughout the country, is very important in guiding the families to have a better welfare.

To accelerate the transition of prosperity stages because the economic reason, government decided to link the development of prosperous family with the poverty alleviation schemes beside the IDT program that already launched before. However not like the IDT program, where the funding is provided by the central government, the family prosperity transition program is funded outside the government's budget. The target for funding resources are companies, businessmen and people who aware poverty alleviation program is an honorable responsibility. In order to legalize the Takesra and Kukesra activities and to mobilize the funds from companies and businessmen, government launched several regulation which are (1) the Presidential Decree Number 90 (Keppres 90/1995) on December 30, 1995, concerning the participation from companies or businessmen in poverty alleviation through Takesra and Kukesra programs. The Presidential Decree stated that companies which gain the benefit over hundred million rupiahs or approximately US$40,000.- after tax and businessmen who have an

income over hundred million rupiahs after tax are encouraged to donate up to 2% of their gain or income to Takesra and Kukesra Program. Therefore, the philosophy of Keppres 90/95 is voluntary not compulsory, (2) Presidential Instruction No.3/96 (INPRES 3/1996) concerning the legal aspect of Takesra and Kuksera programs in poverty alleviating in Indonesia, (3) Presidential Decree No.92/1996 which is modification of Presidential Decree 90/1995. The later Decree stated that companies with after taxed profit of over a hundred million rupiahs or US$40,000.- and businessmen with after taxed income of over a hundred million rupiahs have to expend 2% of their profit or income to Takesra and Kukesra Program. Therefore the philosophy of new Presidential Decree is now compulsary and not voluntary anymore.

The prosperous family saving scheme (Takesra) and Small Credit for Prosperous Family Program Scheme (Kukesra) is a government program for poverty alleviation beside the IDT program. Only families which are clarified as a Pre-Prosperous and Prosperous Stage-I, have access to Kukesra and Takesra schemes. The family firstly invited to joint the Takesra saving fund with an initial saving of Rp.2.000 or US $ 0.75. Then the depositor will be able to get a credit for an amount of maximum 10 times of the Takesra balance, so that the first credit will be maximum Rp.20.000 or US $ 9. In the following stage, 10% of the Rp.20.000 loan is then deducted, adding up to the saving so that the saving becomes Rp.4.000. With this saving, then the second credit will be Rp. 40.000.- and so forth up to credit of Rp.360.000.- or around US $ 160 per family.

Till July 1997, which is means one and half years after the Takesra and Kukesra programs begun, the total amount has collected by YDSM (i.e. foundation which manage the Takesra and Kukesra funds) was around 765 billion rupiahs or around US$250 million. However, those amount can not fully absorbed by the creditors. A poor society usually has a limited business activity. The ability in opening opportunity is also limited. Until July 1997, even though the Takesra and Kukesra fund programs have been dropped in the bank from YDSM's account at Rp.223.7 billion rupiahs for Kukesra, the absorption was around 163.9 billion rupiahs or about 73.25%.

IV. Future Direction

A central point in the Indonesian population plan of action is the view that population as an integral part of socioeconomic development aims at improving the quality of life of all people and at achieving sustained economic growth, and sustainable development. The review and appraisal by the Government shows that the challenges that face Indonesia are population quality, population growth, and population distribution.

As stated in the GBHN 1993, there are three main population issues which will continue to dominate for the next 25 years as they have before. These issues are: relatively low population quality, continuing large population due to a high growth rate, and an uneven distribution of the population. Issues associated with previous and continuing high rates of population growth remain important and

complex issues in Indonesian developmental planning. In particular, the huge cohort currently working their way through the school systems and presenting themselves for entry into the labor force provides a major challenge to development planners.

The growing number of older people is viewed as a challenge and an opportunity, although it may also cause economic and social burdens for the country. Fortunately, since the Indonesian culture still strongly supports respecting the elderly, it will help them to have the spirit of life. It is still common in Indonesia for elderly people to live together with their children or even their grandchild. The other key issue regarding to elderly people is how to increase participation of the aged population in the development process.

Uneven distribution of the population both among the islands and the regions will impact on environment degradation and un-sustain economic growth. The government tries to direct population movement or redistribute the population, mainly implemented through transmigration and regional development programs. This approach continues to be a challenge and an opportunity to improve the quality of life of the Indonesian people as well as alleviate poverty.

The consideration of policies on fertility and human resource development is vital. It should be noted that human resource development should go hand to hand with economic development and it is not a matter of choice between one or the other. Issue of human resource development is more crucial since Indonesia is facing inside and outside challenges. Inside challenge related to the problem of continued population growth in Indonesia, which essentially creates an employment problem. The working-age population will continue to increase rapidly until the turn of the century, at a rate considerably more rapid than for the population as a whole. Rapid growth of the working-age population means a rise in the labor force, especially women workers. Outside challenge related to the issues of globalization and free-trade and free-investment era in the 21st century.

Poverty alleviation is also a central issue in population policy and program. Aware the issue of absolute and relative poverty have an negative impact on sustainable development, GOI initiates the prosperous family movement. It is hoped that at the end of Repelita VII, Indonesia could eradicate the absolute poverty. Rural development and the development of cooperation and small-scale business are becoming a priority in national economic strategy nowadays.

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Chapter V

Main Demographic Issues in Rapidly Developing Malaysia

Main Demographic Issues in Rapidly Developing Malaysia

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I. Background

Malaysia's demographic trends need to be discussed in terms of the multi-ethnic composition of the society. Population growth rates vary widely amongst the various ethnic groups. Variations also exist between populations in Peninsular Malaysia (with 11 states) and the East Malaysian states of Sabah and Sarawak on the island of Borneo. The country has three main ethnic groups and based on the 1991 Census, 61.7 per cent were Bumiputera (comprising Malays and the indigenous populations), with the Chinese and Indians comprising 27.3 per cent and 7.7 per cent of the population respectively. These various groups have different cultural and religious background and attitudes, norms and practices. Annual growth rates have been highest for the Bumiputera in Sabah and in Peninsular Malaysia, and lowest for the Peninsular Chinese. Overall growth rates have also been significantly higher in Sabah (5.7 per cent per annum between 1980 and 1991) than in Peninsular Malaysia (2.4 per cent) or Sarawak (2.5 per cent).

The population of Malaysia has doubled in slightly less than 30 years since Independence in 1957, and is enumerated at about 18.4 million in 1991. As a whole, the population density in Malaysia is still relatively low. In 1991, the population density in Peninsular Malaysia was about 107 persons per square kilometre, as against 24 persons in Sabah and 13 persons in Sarawak. Between 1991 and 1995, the population is estimated to have grown at an average annual rate of 2.7 per cent to some 20.69 million (Government of Malaysia, 1996, p. 105). Part of this high growth reflects the inflow of foreign workers into the country. The domestic population during the period was estimated to have grown at 2.2 per cent per annum.

In the last 30 years, there has been some decline in the rate of population growth. The population of Malaysia is estimated to grow at 2.4 per cent per annum, a rate which could double the population in approximately 29 years. The present rate of population growth is considerably higher than those of the industrial market economies, which have been growing at an average rate of 0.4 per cent per year (United Nations, 1995, p. 99).

With a per capita gross national product (GNP) of US$3890 in 1995 (World Bank, 1997, p. 215), Malaysia's development has been guided by the New Economic Policy (NEP) (1970-1990) and the New Development Policy (NDP) (1991-2000), which aim at eradicating poverty and restructuring society to attain a balanced development of the economy. As part of the development strategies, the Government

has instituted measures to promote Malay participation away from traditional agricultural activities to trade, business, industry and professional positions.

There is also greater urbanization of the population; the urban population increased by 4.5 per cent per annum from 9.5 million in 1991 to 11.3 million in 1995 (Government of Malaysia, 1996, Chapter 4). The proportion of the population residing in the urban areas therefore increased from 51 per cent in 1991 to 54.7 per cent in 1995. The high rate of urbanization was due to natural increase and migration flows. For example, rural-urban movements made up 17 per cent of the total inter-state migration during 1986-91 and 23 per cent of total inter-district or intra-state migration.

In terms of sanitation, the national water supply coverage increased from 80 per cent of total population in 1990 to 89 per cent in 1995 (Government of Malaysia, 1996, p. 362). The urban coverage in most states exceeded or was the same as the national urban coverage, which increased from 96 per cent in 1990 to 99 per cent in 1995. The national rural coverage also increased from 67 per cent in 1990 to 77 per cent in 1995. Provision of sewerage facilities also improved; the proportion of households covered by centralized sewerage systems, individual septic tanks and pour-flush latrines increased from 42.3 per cent in 1990 to 52.7 per cent in 1995. At the same time, to further accelerate the provision of sewerage services as well as reduce river pollution by domestic and animal waste, the sewerage system was privatized in 1993. The privatization of the sewerage services is expected to contribute to the modernization and centralization of the sewerage system throughout the country.

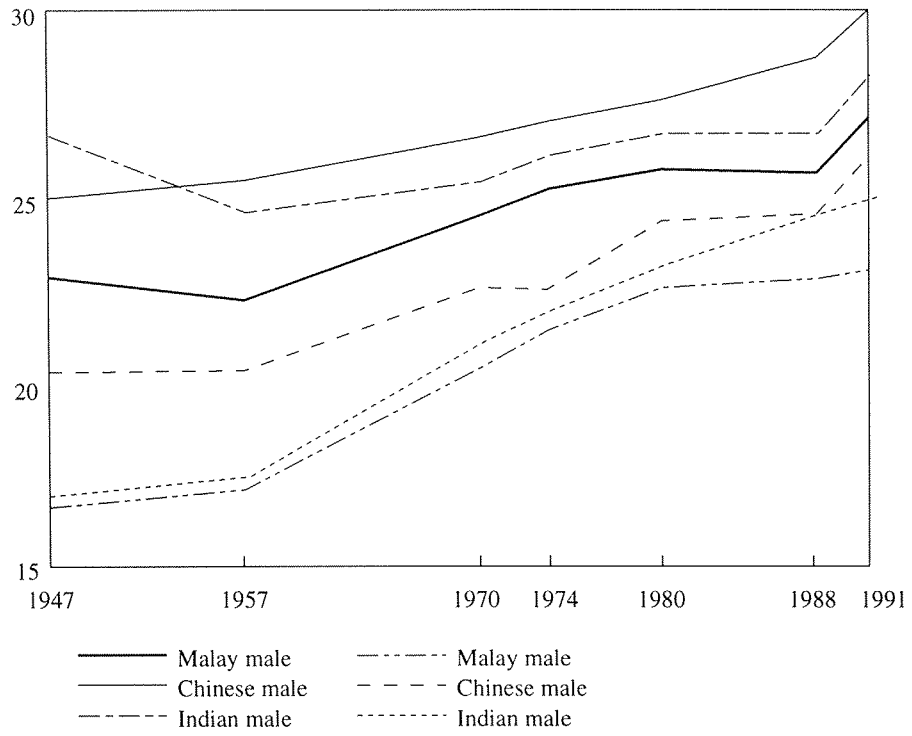
II. Demographic Levels and Trends

Concomitant with development, Malaysia's demographic levels and trends have changed accordingly. It is therefore appropriate at this juncture to discuss the main demographic changes before looking at the national population policy and programmes. Invariably, one has to take cognizance of the fact that the coverage and completeness of data vary, with Peninsular Malaysia having better quality data than the East Malaysian counterparts.

1. Nuptiality and Fertility

Age at first marriage has been rising in Malaysia. Evidence of marriage postponement is found for all ethnic groups, with the Chinese marrying much later than the Malays or Indians (Figure 1). The age at first marriage also remains higher in the urban than rural areas (Khalipah, 1992). It is pertinent to remember that age at first marriage is commonly used as a measure of timing of entry into marriage. However, this measure suffers from data censoring and truncation as it does not capture the age at first marriage of those at young ages who have postponed marriage. Hence, in a population where marriage is increasingly delayed, less and less of the actual marriage experience of younger cohorts would be captured by such a measure.

Figure 1: Median Age at First Marriage by Ethnic Group by Sex, 1947-1991, Peninsular Malaysia



Note: Calculated by the indirect method, using marital status by five-year age groups and linear interpolation. This method results in higher age at first marriage estimates.

Source: Jones, 1980; Calculations based on the 1980 Census, 1991 Census and 1988 Malaysian Family Life Survey.

The proportion never married at various ages over time also clearly illustrates the delay in age at first marriage. For example, based on data from the population censuses, the proportion not married in the age group 20-24 years, increased from 43 per cent in 1970 to 62.3 per cent in 1991 for females, and from 75.4 per cent to 86.8 per cent for males over the same period.

The rising age at marriage may be explained by a multitude of factors but rapidly expanding educational opportunities, especially for girls, may have resulted in marriage postponement to enable them to complete their schooling. A further delay may have occurred as they sought jobs in the modern sector upon completing higher education. Other reasons include increasing female independence and work participation away from the home before marriage, and increasing freedom in the choice of marriage partners (Tan, 1983, p. 55-56; Jones, 1995, p. 190). With urbanization and higher migration and mobility of young people, and sex segregation in terms of field of expertise that is pursued and labour market segmentation, there are few opportunities for male and female members to meet and socialize (Tan and Tey, 1993b). Evidence of a marriage squeeze is reflected in the fall in age difference of recently married couples compared with couples who had married earlier, with husbands being generally older than their wives. This is true of all ethnic groups, with the Malay couples having a wider age gap than those of other ethnic groups (Tan et al., 1986, p. 75-76; Hamid et al., 1988; NPFDB and RAND

Corporation, 1992).

Among the three main ethnic groups, divorce/separation was highest among the Malays, while the Indians were more likely to be widowed (Tan and Tey, 1996; Department of Statistics, 1995, p. 69). Widowhood increases rather sharply with advancement in age, especially among elderly women. As many as 43 per cent of the women were widowed at ages 55 years and over in 1991. Relatively more men remain currently married as compared to women, on account of spouse age difference and a higher remarriage rate amongst the former (Tan and Ng, 1995).

The delay in age at first marriage is largely a result of the rise in education. As couples delay their marriage, they also delay childbearing until fairly old ages, which means that such families are likely to comprise older parents with fairly young children. Couples who marry later are likely to be financially independent and hence also more inclined to establish their own nuclear families.

During the immediate post war period, the rise in crude birth rate from 42.9 per thousand population in 1947 to 46.2 in 1957 set the stage for a high momentum of population growth. Socio-economic development and the implementation of the National Family Planning Programme (renamed National Population and Family Development Programmes since 1984), the crude birth rate fell steadily to 29 per thousand population in 1995. The total fertility rate declined from about 6.8 children per woman in 1957 to 3.4 in 1993.

In 1957, the Malays had a total fertility rate of 6 children per woman, while the corresponding rates for the Chinese and Indians were 7.3 and 8.0 respectively. With a more gradual fertility transition, the Malay fertility level had overtaken the Chinese by the early 1960s and that of the Indians by the late 1960s (Hamid and Tey, 1988, p. 32). In 1993, the total fertility rate was estimated at 4.1 for the Malays, 2.6 for the Chinese and 2.8 for the Indians.

2. Family Planning and Breastfeeding Practices

The Contraceptive Prevalence Rate (CPR) for any method has increased, from 8.8 per cent in 1966/67 to 50 per cent in 1988 (the most recent data source) for Peninsular Malaysia (NPFDB and RAND Corporation, 1992). In terms of modern methods, such as hormonal methods, barrier methods and spermicides, the increase over the same period was from 5.3 per cent to 33.0 per cent. A Knowledge, Attitude and Practices (KAP) survey was first conducted in 1989 in Sabah and Sarawak by NPFDB as part of the Population and Family Survey. The CPR in Sabah in 1989 was 50 per cent, with 30 per cent using modern methods while in Sarawak it was 70 per cent, with 55 per cent using modern methods (NPFDB, 1992a and 1992b). Variations exist across ethnic groups; in 1988 in Peninsular Malaysia, the Chinese showed the highest percentage, slightly more than 70 per cent, practising contraception, with the Malays the lowest, some 54 per cent in the urban areas and 44 per cent in the rural areas. The Chinese which form about 30 per cent of the population in Sarawak also show a higher prevalence rates than for the other groups.

Breastfeeding provides nutrition to babies and has a fertility-inhibiting effect. In spite of continued promotional efforts, differences in the initiation and duration of breastfeeding are found across

the various ethnic groups. It is found that the Malays and those from the rural areas were more likely to breastfeed and did so for a longer duration than other groups (NPFDB and RAND Corporation, 1992). The proportion who breastfed and the duration were 96 per cent for 9-12 months for the Malays, 74 per cent for 3-6 months for the Indians and 45 per cent for 1-3 months for the Chinese.

3. Mortality, Morbidity and Life Expectancy

Mortality rates in Malaysia has been steadily declining since the end of World War II. In 1947, the crude death rate was 19.4 per thousand population and this has declined to less than 5 per thousand population in recent years. The present mortality level is low by international standard and is in part due to the young age of the population. Infant mortality has also declined for all ethnic groups and regions. In 1994, the rate of 11 infant deaths per thousand live births, was only slightly higher than the level of about 10 prevailing in many developed countries (United Nations, 1995, p. 119). Nevertheless, wide differentials in infant mortality rates are observed for various subgroups in the population and are higher in the East Malaysian states. Toddler mortality rate was reported to be 0.8 per thousand in 1995 (Department of Statistics, 1996, p. 168).

Maternal mortality has progressively declined over the years and in 1995, the rate was 0.2 from 1.79 per 1000 in 1966. There are some variations across subgroups in the country, linked closely to safe delivery at birth and a number of contributory factors, such as high fertility, low access to health care, lack of resources and knowledge, poor nutrition, early marriage and early and frequent childbearing.

Over the years, life expectancy at birth and at various ages has improved substantially. Overall, male life expectancy at birth has improved from about 53 years in 1957 to about 69 years by 1990, and that of the female has improved from 58 years to some 74 years during the same period. Among the ethnic groups, the Chinese have the highest life expectancy. In fact, the level recorded among Chinese women is comparable to those found in developed countries.

Disease pattern has increasingly changed with the rising affluence and longevity of the population, and the changing lifestyle to follow the pattern observed for developed countries. Nevertheless, there are still some infectious and vector-borne diseases as well as chronic diseases associated with changes in lifestyle, such as diabetes, cardiovascular diseases, cancer and accidents.

Malaysia has also not been spared the threat of Human Immunodeficiency Disease (HIV) and AIDS. The known number of infections is relatively small but there is a definite cause for concern due to the increase in the number of detected cases, substantial intravenous drug use problem and the thriving sex industry in nearby Thailand with an estimated 500,000 HIV-positive cases. The number of HIV infections detected in Malaysia increased from 206 in 1989 to 10,034 by the end of 1994, in part due to routine and mandatory testing of street drug dependents.

4. Migration and Population Redistribution

Large-scale immigration of Chinese and Indians was predominant during the early part of the present century. However, with the enforcement of a stringent immigration law after World War II,

population growth was due more to natural increase, although one cannot discount the recent influx of migrants from the neighbouring countries, particularly Indonesia and the Philippines.

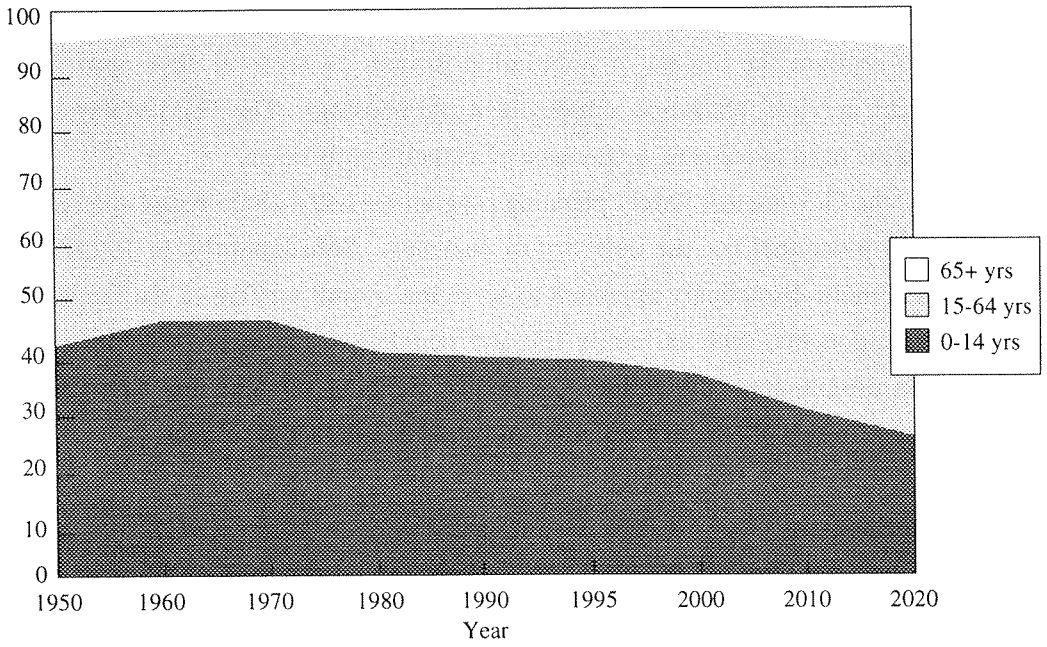
For a number of reasons, such as industrialisation, urbanization and socio-economic development, the Malaysian population has become more mobile over the years. There are those Malaysians who have emigrated to other countries in the ASEAN Countries and the Middle East as well as Western Countries. Internal migration is also on the rise. For example, the proportion of population who have migrated at least once during the five years preceding the census dates increased from 18 per cent in 1980 to 28 per cent in 1991. Interstate migratory streams have also undergone significant changes during the last decade. The bi-polar foci of destination (the Klang Valley and Pahang) in the 1975-80 period has given way to a single focal point in Selangor by 1991 (Tey and Liaw, 1995). The young form a large proportion of the migrants; for example, those aged 15-34 years made up 60 per cent of the inter-state migrants during the 1986-91 period (Department of Statistics, 1995, p. 97). Consequently, internal migration exerts significant impact on both the sending and receiving areas, particularly the small geographical localities.

5. Population Structure

The population structure is still relatively young. Nevertheless, the median age of the population has increased over the years, from 17.6 years in 1960 to 21.6 years in 1995.

Consequent upon continuing decline in the levels of fertility (due in part to delayed age at marriage) and mortality, the age structure of the population has undergone significant changes. The proportion of population aged below 15 years has declined steadily from 45.0 per cent in 1970 to 37 per cent in 1991 and is projected to decline to 24.5 cent by the year 2020 (Figure 2). On the other hand, the proportionate share of those in the working ages has risen and is expected to rise further. The proportion of those in the older ages (65+ years) has remained at around 3-4 per cent, but is projected to increase rather sharply to about 7 per cent by 2020 on account of declining fertility and longer life expectancy. Older persons are expected to increase from 680 thousand today to close to 1 million by the turn of the century and 2 million by 2020. The old-old (75+ years) have almost tripled in number between 1970 and 1991, and is expected to continue to grow rapidly. Due in part to longer life expectancy, many of the older persons will be women.

Figure 2: The Changing Age Structure, 1950-2020, Malaysia



Source: Department of Statistics, 1995; United Nations, 1994.

III. National Population Policy and Programme Directions

1. Historical Development*

The successive five-year development plans have incorporated population factors in a number of ways. A sharp rise in fertility in the post-war period contributed to the organized family planning activities in the country, largely to safeguard maternal and child health. The first voluntary Family Planning Association (FPA) was established in Selangor in 1953. The Federation of Family Planning Associations of Malaysia (FFPAM) was formed in 1958 and became affiliated with the International Planned Parenthood Federation (IPPF) in 1961. By 1962, each state in Peninsular Malaysia (then Federation of Malaya) had a voluntary FPA in the urban areas.

The Government in the 1960s decided to take positive measures to reduce the rate of population growth, and incorporated family planning and population issues into government policy. This was first stressed in the First Malaysia Plan 1966-1970. The Government aimed at reducing the population growth rate of around 3 per cent per annum in 1966 to 2 per cent by 1985. The Family Planning Act was passed in 1966 and the National Family Planning Board (NFPB) was established under the Prime Minister's Department with statutory powers and a certain degree of autonomy. The family planning programme served two broad sets of interrelated objectives, one that centred on family health and welfare, and the other to do with medium- and long-term economic and social development. This programme remained

* This and other sections are based largely on UNFPA, 1993, and the Government development plans and documents.

an integral and sizable component of all successive five-year development plans, although its position in relation to the broad development goals shifted, especially since 1984. The Second and Third Malaysia Plans took into account the impact of population growth on sectoral development (especially the provision of health services, education, employment and housing). The Third Malaysia Plan 1976-1980 also emphasized the need to enhance acceptance of a small family norm.

Initially, the Government family planning programme had a clinic-based approach, using medical and paramedical personnel for the delivery of services. Subsequently, in 1973, it expanded to a multisectoral and multi-disciplinary approach to serve the overall welfare of the family and community. Among other components, such as family life and population education, together with nutrition and health education programmes, the delivery of family planning services was strengthened in the rural areas through the Ministry of Health's maternal and child health (MCH) clinics.

2. Recent Development

The global recession of the early 1980s highlighted the vulnerability of Malaysia's small domestic market. This together with the emerging labour shortages in certain sectors led the Government to promulgate a New Population Policy in 1984 advocating a population target of 70 million by the year 2100. Towards this end, the total fertility rate is targeted to decline to 3.5 in the year 2000, 2.4 in the year 2055, and subsequently stabilizing at 2.05 by the year 2070. The National Family Planning Board was renamed the National Population and Family Development Board (NPFDB) to acknowledge and support its diversification of activities beyond the coordination and provision of family planning services.

The NPFDB continued to provide family planning services in the 1980s but the emphasis was more on the contribution of family planning and child-spacing to population health and family development (which embraces family health and welfare) rather than aimed at merely achieving national population targets. During the past decade, there has been no high visibility campaign aimed specifically at motivating people to use modern methods of contraception or accept a small family norm. The emphasis by various agencies, including NPFDB and the Ministry of Social Welfare, is to promote an integrated programme that encompasses family health, family welfare, child care, family life education, values of family formation and family planning, among other aspects to maintain a happy family.

In macroeconomic and social development planning, population issues have increasingly been tied to manpower and human resources development. Consequently, demographic issues have become implicit in many aspects of the planning at national and sub-national levels. For example, the health development programme implemented since the Fifth Malaysia Plan 1986-1990 is to attain health for all by the year 2000. While the Ministry of Health is responsible for the provision of a comprehensive and easily accessible medical and health care services, the extensive network is supported by several statutory bodies and local government, as well as the private sector. Besides curative programmes, various preventive and promotional health programmes, including Applied Food and Nutrition Programme, a Rural Environmental Sanitation Programme, and occupational health programmes, have been given emphasis. Family health and welfare information is also spread through nationwide immunization

campaigns for hepatitis and rubella. There is a move towards greater community involvement and the privatization of health services in reducing morbidity and mortality differentials among population groups and areas in the country.

In terms of population mobility and distribution, policies have been more "population-influencing" than "population-responsive". The policies have centred on regional and urban development, land development and industrial dispersal, that is influencing internal migration, rather than serving the needs of any specific groups of migrants. International migration is confined to those foreign workers required to serve sectors facing labour shortages and these are limited by employment passes and work permits for a definite duration. Illegal immigration has, however, posed serious problems and despite various measures taken to date, it is expected that it would be difficult to estimate the extent of such migration or to deal with the issues adequately for some time to come.

Hence, the Government of Malaysia has implemented interventions which target at fertility directly (explicit population policies) as well as those that have demographic impacts through means which are motivated by other concerns which change other aspects of life as well (implicit population policies). It would appear that the approach in population policy in Malaysia has evolved with the international population movement away from the notions of population control to notions of reproductive health. The reproductive health approach helps people enjoy sexual relations without fear of infection, unwanted pregnancy or coercion, regulate fertility without risk of unpleasant or dangerous side-effects, go safely through pregnancy and childbirth, bear and raise healthy children and the empowerment of women (see Basu, 1997, for example, for a discussion of the reproductive health approach in relation to the traditional population policy). While economic and social development in turn influence the costs and benefits of children in terms of a lower demand for children, it is difficult to know how such policies and events at the macro-level affect fertility decisions at the micro level. Implicit policies can reduce the demand for children due to increased costs and reduced benefits in the social and economic circumstances. These include, among others, compulsory education, increased participation of women in the labour force, a ban on the use of child labour, rising aspirations for children and escalating costs in the upbringing of children. For example, compulsory universal primary or even secondary schooling, especially for females, is an important implicit population policy as it not only contributes to a decline in fertility but also lifts families out of the poverty trap imposed by illiteracy and low skills.

IV. Development Achievements

The Government adopts a multidisciplinary approach in dealing with the various aspects of development to improve the quality of life of the people in Malaysia. In this regard, it is without doubt that demographic variables become an integral part and parcel of the development process. This section highlights some of the main development achievements to date which have strong demographic impacts

and which are closely linked to population policies. The national population policy provides a long-term framework for the evolution of integrating population and development policies to achieve greater economic progress, facilitate social engineering and improve the standard of living. It is therefore imperative that for effective planning at sectoral and spatial level, many parameters other than population size must be incorporated within the overall framework.

1. Educational Achievements and Manpower Training

A good indicator of educational achievements is the proportion of the population aged 10 and over who had ever attended school (Government of Malaysia, 1996, Chapter 4). It is found that in 1991, the percentage was 85 compared with 72 per cent in 1980 and this increased to 91 per cent in 1995. One of the major achievements is the rising proportion among females and the narrowing of the sex differential in the proportion of those who have ever attended school. While in 1980, only 64 per cent of the female population aged 10 and over had ever attended school, it had risen to 80 per cent by 1991. For males, the improvement was from 80 per cent in 1980 to 90 per cent in 1991.

Universal primary education resulted in an increase in primary school enrolment of 16.7 per cent between 1990 and 1995. Nevertheless, it was reported that some 4 per cent or 18,000 children did not complete their primary education, in part due to some of them enrolling in private primary schools (Government of Malaysia, 1996, Chapter 10). The classroom-student ratio improved slightly from 1:38.3 in 1990 to 1:36.4 in 1994, but due to the rapid increase in enrolment, primary schools conducting double sessions (morning and afternoon classes) rose from 15.5 per cent in 1990 to 18.3 per cent in 1994.

Enrolment at the secondary level also rose in Government and Government-aided schools by some 23.1 per cent between 1990 and 1995 (Government of Malaysia, 1996, Chapter 10). The transition from primary to lower secondary rose from 83 per cent in 1990 to 84.5 per cent in 1995. With the policy to gradually implement the extension of basic education from nine to eleven years, the transition rate from lower to upper secondary level improved from 68 per cent in 1990 to 83 per cent in 1995, while the participation rate at the upper secondary level rose from 50.4 per cent in 1990 to 63.7 per cent in 1995. About half or 721 secondary schools continue to conduct double session classes to cater to the rise in enrolment and 14.3 of these classes had more than 40 students per class.

To meet the demand for higher-level manpower at the professional and sub-professional levels, intensified efforts were made to increase enrolment of science and technical students in the local universities and to establish and upgrade new and existing universities and training institutes (Government of Malaysia, 1996, Chapter 4). During the period 1991-95, about 149,580 skilled and semi-skilled manpower were produced by both the public and private education and training institutions. A Human Resources Development Fund (HRDF) was established in 1992, with a matching grant from the Government, to stimulate private sector involvement in the training and retraining of workers. As at the end of 1995, out of a total levy of RM229.9 million collected by the HRDF, 60.8 per cent was disbursed during 1993-95 for post-employment training programmes. A number of tax incentives were introduced in 1995 to promote private sector involvement in technical and vocational training. Amongst them is an

investment tax allowance of 100 per cent for 10 years for companies which establish vocational and technical institutions or for existing training institutions to undertake additional investments. Materials, machinery and equipment used for training are also exempted from import duties, sales tax and excise duties.

2. Health and Infectious Diseases

The country has been promoting both promotive and preventive health programmes, such as health education, immunization, control of communicable and non-communicable diseases, environmental health and sanitation, nutrition, and occupational safety and health. Health education programmes to provide knowledge and information towards ensuring a healthy lifestyle include efforts to eradicate alcohol and substance abuse, prevent sexually-transmitted diseases as well as instill the habit of regular exercise and the need for a balanced diet. These programmes are being implemented through the media, schools and community groups.

With an expanded immunization programme, about 91 per cent or 502,000 infants received complete immunization in 1994 as against 79 per cent in 1990. This, in turn, contributed significantly to the reduction of childhood diseases and hence improving infant and toddler mortality rates.

The programme on the control of communicable diseases gives priority to the reduction of the incidences of tuberculosis, malaria and dengue as well as containing the spread of AIDS. The Ministry of Health has mounted an active campaign within its Healthy Lifestyle programme to control HIV transmission via information, education and motivation strategies through the mass media, public education and talks and dissemination of materials. A number of non-governmental organizations are also involved in AIDS prevention, notably the Malaysian AIDS Council and Pink Triangle. In 1993, the Ministry of Health set up a National Council of Non-Governmental Organizations on AIDS to coordinate funding and other activities in support of the government programme. Among others, the Malaysian AIDS Council has also recently set up the Malaysian AIDS Foundation to raise funds for AIDS related activities. In 1994, advertisements on condoms were allowed in the mass media to relay messages for disease prevention.

The Malaysian AIDS Charter, which sets out the rights and responsibilities of individuals, organizations and government bodies pertaining to AIDs and in relation to testing, confidentiality and access to information and education, was launched on 1 December 1995. There is now also an emerging recognition on the need to focus on adolescents, and the need for sex education in school.

3. Status of Women

Until the Third Malaysia Plan 1976-1980, gender was not considered an issue in development planning. Even then and subsequently, there were only paragraphs mentioned on the role of women. It was only in the Sixth Malaysia Plan 1991-1995 that any serious attention was paid to the contribution and the role of women in the development process. This is consistent with the National Policy for Women, which was formulated in 1989, reflecting the Government's commitment towards the

advancement of women and in promoting their role and position in society. There has also been review of various legislations and the enactment of new ones to protect the rights and dignity of women. Women continue to make progress in greater participation in the economy and the labour market as well as have improved access to education and health (Government of Malaysia, 1996, Chapter 20). While they constitute about half of the population, about 48 per cent of the females are in the working ages 15-64 years. However, only a third of the labour force are female. Female labour force participation rate has risen; it rose from 45.8 per cent in 1990 to 47.1 per cent in 1995. The low labour force participation rate was in part due to a lack of affordable and quality childcare services and flexible working condition for women. Various measures are being undertaken by the Government to address the low participation of women in the labour market, including the provision of tax exemptions to employers to establish creches near the work place, job training as well as better career prospects.

While there is no male-female wage differentials in the public sector, these differentials continue to persist in private sector establishments, albeit these differentials have narrowed somewhat. For example, the wage differentials of female production operators in the electronics subsector have narrowed considerably such that while in 1990, female earnings formed 82.7 per cent of male earnings, this increased to 92.5 per cent in 1993.

Equal access in education is provided to both males and females. In fact, female intake into universities expanded rapidly from 37.2 per cent in 1990 to 49.5 per cent in 1994. Although more females are engaged in the arts courses, an increasing number of them are enrolled in vocational courses; female enrolment in these courses doubled from 22 per cent of total enrolment in 1990 to 40.4 per cent in 1994.

Responding to the United Nations declaration of the Decade for Women, the Malaysian Government appointed a National Advisory Council on the Integration of Women in Development (NACIWID) in 1976 to (a) serve as a consultative and advisory body to the Government and between the Government and women's organizations; (b) raise the consciousness of women about their roles and responsibilities in national development; (c) ensure women's full participation in development; (d) develop women's potential to the maximum; and (e) promote peace. The Council consists of members appointed by the Prime Minister from government agencies, the private sector and women's organizations.

In 1983, HAWA was established in the Administration and Finance Division of the Prime Minister's Department to promote women's participation in development and the integration of women into national development plans through the provision of equal opportunities and adequate facilities. Its specific duties and responsibilities include: (a) serving as the secretariat for NACIWID and its three bureaus for Family and Health, Community Development and Education, and Economy and Manpower; (b) monitoring the implementation of policies and projects for women; (c) organizing courses and seminars for women; (d) identifying areas for required research; (e) monitoring the development of women's NGOs in the country, including giving advice and guidance and supporting development-oriented activities; (f) acting as liaison with international agencies dealing with women's affairs; and (g)

collecting and disseminating information on women. In line with the Government's growing concern for women's issues, a Deputy Minister in the Prime Minister's Department was specifically assigned direct responsibilities in 1986. In October 1990, HAWA was placed in the Ministry of National Unity and Social Development.

In East Malaysia, there also has been growing official concern with women's issues. In Sabah, the Majlis Penasihat Wanita Sabah (Sabah Women's Advisory Council, MPWS) was set up in 1988, with 12 members appointed by the Chief Minister for one-year term of office. Its purpose is to serve as the coordinating, advisory and consultative body to the state government on measures to improve the position of women in society and to promote the integration of women in Sabah's development. MPWS also coordinates the activities of the 19 women's organizations in the state and channels their requests for assistance to the appropriate state departments. MPWS has formed educational, social, legal, economic and publicity committees. To serve MPWS, a secretariat, the Unit Hal Ehwal Wanita, was establised in the Chief Minister's Department. In Sarawak, too, a Women's Bureau was set up under the Ministry of Social Development to serve as the secretariat to the Women's Council, which is the advisory and consultative body to the state government, and to act as liaison between the government and women's organizations. Both the Sabah and Sarawak Women's Councils are represented on NACIWID at the national level.

There are some 200 women's organizations in the country, about 150 of which are active, according to HAWA. An umbrella body for these organizations, the National Council of Women's Organizations (NCWO), has been in existence since 1963. Non-communal, non-political and non-sectoral, NCWO has as its primary aim to bring together women's organizations in the country to work more effectively in promoting the welfare and advancement of women and children. It has played a major role in lobbying for legal reforms to benefit women. Other organizations, such as the Women's Aid Organization, set up in 1982 to cater to the needs of battered women by providing shelter and counselling, the All Women's Action Society and the Association of Women Lawyers, have been active in drawing attention to issues of violence against women, pushing for reforms to the rape laws under the Penal Code and setting up women's crisis centres. The Domestic Violence Act was passed in Parliament in 1994 to provide more protection for women against wife battering and other forms of domestic abuse (Government of Malaysia, 1996, p. 627). Measures have also been taken to heighten awareness of women of their legal rights.

4. Quality of Life of the Ageing Population

The rising share and number of older persons expected at the turn of the century has resulted in increasing attention being paid by the government. In 1996, a National Policy for the Elderly, which covered issues related to their welfare, care, social security, housing and community participation, was announced. The developmental perspective of population ageing has recently been given some due recognition with the implementation of programmes aimed at integrating older persons in the mainstream of society and encouraging them to continue to participate actively in communal and other productive

activities together with younger members. Prior to this, the needs of older persons were considered as an integral part of the disabled and disadvantaged groups in the country. The National Welfare Policy promulgated in 1990 had identified elderly persons 60 years and over as one of it many target groups.

Under the National Policy for the Elderly, a number of strategies and action plans have been drawn up to achieve the objective of "creating a society of elderly people who are contented and possess a high sense of self-worth and dignity, by optimizing their self-potential and ensuring that they enjoy every opportunity as well as care and protection as members of the family, society and nation" (Government of Malaysia, 1996, p. 571; Tan and Ng, 1997). To monitor the implementation of the action plans which cover various aspects ranging from education, health to productive activities, welfare, social security and research and development, a National Advisory Council was set up under the Department of Social Welfare of the Ministry of National Unity and Social Development.

A National Council on Health was set up under the Ministry of Health in 1996 to develop a health policy for the elderly as well as setting norms and standards in line with the National Policy for the Elderly (Nor Aini, 1997). Among others, the health policy provides adequate health care and support to enable older persons to achieve independence in accordance with their rights and dignity, through improved awareness and knowledge and skills and cooperation among agencies in planning and delivering a comprehensive health service for them. The specialised health care services such as geriatric care and counseling are only beginning in this country (Nor Aini, 1997).

5. Demographic Research and Basic Data Collection

Malaysia has an excellent statistical data system, which is used extensively in the planning process. The Department of Statistics (DOS) is the main government agency entrusted with the responsibility to collect, compile and disseminate statistics. DOS conducts all censuses and nation-wide surveys, as well as special demographic surveys when needed. The first population census covering the entire country, including Sabah and Sarawak, was conducted in 1970. The most recent census was conducted in 1991.

Civil registration is under the jurisdiction of the National Registration Department which supplies copies of birth and death certificates to DOS for compilation of vital statistics. Civil registration has been in force for more than 40 years. DOS has been responsible for the compilation and publication of vital statistics since 1963. Its report on vital statistics, compiled on the basis of birth and death certificates, is more comprehensive than the Registrar-General's annual report, which is based partly on tabulations in the vital registration system in Peninsular Malaysia. Although registration of vital events is considered complete in Peninsular Malaysia, under-coverage of vital events in Sabah and Sarawak is a serious limitation on monitoring fertility, mortality and population trends for these states and Malaysia as a whole. The DOS also publishes population and other estimates on a regular basis.

Another important survey contributing to population-related statistics is the annual Labour Force Survey conducted by DOS, primarily for information on the structure and distribution of the labour force, employment and unemployment. However, questions on internal migration and demographic

characteristics are included. Results from this survey are published under the Labour Force Survey Report as well as the Internal Migration Report.

NPFDB has added to the pool of demographic statistics by conducting important demographic surveys from time to time. Specific smaller scale surveys and studies on population are conducted by universities and other agencies and interested individuals on an ad hoc basis.

Numerous surveys by NPFDB in recent years have contributed substantially to the pool of demographic statistics. Some of the demographic surveys conducted by NPFDB are as follows:

a. Malaysian Fertility and Family Survey 1974/1975;
b. Staff Baseline Survey in the Intensive Input Demonstration Areas 1975;
c. Family and Health Survey in the Intensive Input Demonstration Areas (IIDA) 1976/77;
d. Family and Health Survey in the Federal Territory and Petaling Jaya, 1977;
e. Family Planning Acceptor Survey, 1977;
f. Second Family and Health Survey in Intensive Input Demonstration Areas (IIDA), 1979;
g. Malaysian Population and Family Survey 1984;
h. Migration and Employment Survey, 1986;
i. Survey on the Consequences of the Ageing of Population, 1986;
j. Malaysian Family Life Survey II, 1988; and
k. Population and Family Survey in Sabah and Sarawak, 1989
l. District Population Survey, 1992; and
m.Malaysian Population and Family Survey 1994.

The three main agencies involved in the implementation of the family planning programme are the Ministry of Health, NPFDB and FFPAM. Though each agency has its own administrative structure and information system in terms of recording and reporting, NPFDB is responsible overall for monitoring and evaluating the programme through its Family Planning Management Information System (FPMIS).

The main institutions responsible for population research and training are the Population Studies (PSU) of the University of Malaya, other national institutions of higher learning, NPFDB, and the Human Resources Section of the EPU in the Prime Minister's Department. The PSU was created in the Faculty of Economics and Administration (FEA), University of Malaya, under the second UNFPA programme of assistance to Malaysia and strengthened under the third programme in the areas of teaching, research, publications and dissemination of research findings and teaching materials, staff development and the establishment of a population information centre. In November 1987, the University of Malaya Council endorsed the PSU as part of the university structure, and the University now assumes all administrative costs incurred by PSU.

NPFDB research activities are related to its mandate for integrating population variables into national development at the macro level and are part of its evaluation mechanisms for monitoring population dynamics and their demographic implications for socio-development. The Board has also functioned as a focus for population-related research through joint research with other national and international agencies and through the channelling of research projects and funds to local institutions.

The Library and Documentation Centre of NPFDB provides services such as lending books and other documentation, conducting literature searches, compiling newspaper cuttings and publishing abstracts and other current materials. The Library has computerized all information pertaining to population and family planning that is available in the main libraries of institutions of higher learning and public libraries in the country.

The Human Resources Section of EPU has been responsible mainly for population-related research in line with the concerns for human resource development and the needs for drafting the country's five-year development plans. Among others, it has carried out a number of researches with local and foreign consultants in both population and human resources for development planning.

6. Information, Education and Motivation

Information, education and motivation (IEM, previously better known as information, education and communication, IEC) were considered as important components of the population programme from the beginning. The early efforts focussed primarily on educating and motivating new family planning acceptors, creating awareness of service availability and accessibility, and in the proponent of family planning as an integral part of family life.

IEM activities were implemented through both formal and informal channels, such as talks, exhibits, films, materials, seminars and orientation courses. Besides the NPFDB, which spearheaded these activities, the Ministries of Agriculture, Health and Education also played an active role in IEM activities together with FFPAM. In the early years, the emphasis was on improving the capability and capacity to plan and implement IEM activities through in-country and overseas training. In the 1970s and early 1980s, IEM activities increased tremendously with a multisectoral approach and the strengthening of capabilities and capacities in a number of agencies, NPFDB, FFPAM, Ministry of Education, Ministry of Health and KEMAS (the Coomunity Development Division of the Ministry of National and Rural Development). Since the announcement of the New Population Policy there has been confusion and misunderstanding and many IEM activities have been watered down without any explicit messages in many of the materials and activities.

V. Conclusion

The population of Malaysia is expected to grow at the rate of 2.3 per cent to reach 23.36 million by the end of the decade (Government of Malaysia, 1996, Chapter 4). Some 63 per cent of the total population are expected to be in the working age group of 15-64, with those below 15 years expected to decline from 35 per cent in 1995 to 33 per cent in the year 2000. The labour force is expected to grow at the rate of 2.8 per cent per annum to reach about 9.3 million by the year 2000. The labour force participation rate is expected to rise from 66.9 per cent to 67.1 per cent, with the rate for females going up from 47.1 per cent to 47.5 per cent. Due to greater access to educational opportunities and the

increasing emphasis on human capital investment, a better educated and trained labour force will emerge.

While the Government has provided a long-term framework for integrating population and development planning, the expected rise in population size and the various demographic issues calls for greater efforts to incorporate such components more systematically from the sectoral and spatial perspectives. It is essential to recognize that development planning is aimed at improving the quality of life of the population and hence for effective development planning, it is imperative that the relevant demographic variables and issues are considered. Perhaps, among others, development planners should become more aware of the importance of demographic factors in ensuring successful and effective planning. It may be necessary to incorporate relevant training in demographic applications for all policy makers as well as programme implementors. Monitoring is also an integral part in ensuring that systematic and periodic evaluation of population development policies and programmes is carried out, and it is important to have this relevant component emplaced in the overall system.

Population research should further enhance the utilization of demographic knowledge for planning purposes. However, there is as yet no established or formal network of population information or research utilization cutting across all agencies. Sub-national and sectoral projections should be carried out by a single agency, which would also serve as the clearing house to facilitate the use of data and research into various aspects of development planning.

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Chapter VI

Philippine Population Policy: Continuity and Change

Philippine Population Policy : Continuity and Change

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I. Current Population Situation

On 16 August 1996, President Fidel V. Ramos declared the official Philippine population to number 68,614,162 persons as of 1 September 1995 (Proclamation No. 849). This number included 2,830 Filipinos living in embassies abroad but excluded 2,374 Mangyans (one of the cultural minority groups). If the latter are included, the 1 September 1995 population would sum up to 68,616,536, signifying that the annual inter-censal growth rate was 2.32 per cent.

In the recent past, death rates have ebbed slowly while birth rates remain relatively high. As a result, natural increase (births minus deaths) averaged 3 per cent in the sixties, 2.6 in the eighties and 2.2 during the period 1990-1995. If the latter rate continues, the Philippine population could double in 30 years. In contrast, the Thai population averaged about 2.1 per cent in 1981, falling to around 1.5 per cent a decade later. Indonesia's corresponding natural increase during the eighties averaged some 2 per cent yearly, and was estimated to be around 1.6 per cent in 1995.

Average Filipino life expectancy at birth during the current quinquennium 1995-2000 is in the neighborhood of 65.6 years for males and 70.8 years for females. Between 1950 and 1990, the expectation of life at birth lengthened by some 22 years.

Youthful Population, Future Growth

The Philippine population is still young, a result of the long history of elevated birth rates and, to a lesser extent, the more recent reductions in infant and child mortality. According to the 1995 mid-decade population census, at least 38 per cent of the population is under age 15, the same as that of Bangladesh. In contrast, 21 per cent of the Canadian population and 16 per cent of Japan's population is below 15.

The youthful age structure imposes an economic burden because a significantly greater share of development resources must cover the immediate requirements of the young. For example, education currently commands some 15 per cent of the 1997 national budget (up from 10.3 per cent in 1993). The large percentage of children generates a built-in momentum for future population growth. Even if fertility were to fall immediately to the "replacement" level of a little over two children per woman, births would still exceed deaths and population would continue to grow for at least 50 more years.

In reality, of course, reduction of the present high fertility rate to replacement level is not

expected to take place before 2010. The 1995 Census-based national medium variant projection foresees a population of 76.3 million Filipinos at the end of the century. By 2025, the country's population could reach 111.5 million (NSO, 1997). These projections assume that the total fertility rate (TFR) will drop from 3.6 children per woman in 1995-2000 to 2.1 in 2020-2025. The TFR is the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age-specific fertility rates.

Population Aging

The mid-decade Census of 1995 found that the proportions of elderly (60 years and older) were 5.8 per cent for women and 5.0 per cent for men. Thirty years later, it is anticipated that these fractions will swell to 11.7 and 10.3 per cent for women and men, respectively. At present, the country's population is characterized by a feminization of the elderly, a disproportionate growth of the very old 80 years and older, a lengthening life expectancy and a growing aged dependency.

The analysis of fertility and mortality effects on age structure leads to several important policy implications. First, even if fertility and mortality were to remain constant at current levels, the aging of the Philippine population will move forward in the coming decades. Demographic history has already built in an age-cohort structure that makes population aging almost unavoidable in the future. Second, although the population is considerably younger than those of developed countries, it is foreseen that this country will not only follow the course of population aging experienced by the latter but surpass its aging pace. Finally, it should be stressed that until nearly the middle of the 21st century, the growth in the size of the population 60 years and older will be determined solely by mortality variations because these persons have already been born.

Migration

The Philippine population is still distinctively rural. But the country has been urbanizing at a fast pace, fueled by a constant stream of migrants from the countryside and the high rate of natural increase in the cities themselves. Population movements during the 1960s signaled a definite shift from a frontiersward to an urbanward orientation as development policies shifted to industrialization as exemplified by import-substitution schemes (Pernia, 1985). The United Nations (1991) estimated that the urban population increased nearly fivefold between 1950 and 1990, from 5.7 million to 26.6 million. (The actual Filipino urban population as enumerated in 1990 reached 28.5 million.) By 2025, according to the UN, the urban population could well attain a total of around 73 million. The city and town dwellers, only 27 per cent of the 1950 population, made up 47 per cent of the 1990 Philippine population and could even constitute a third of the population by the year 2025.

In recent decades, overseas contract workers (OCWs) have been a notable feature of the population landscape. The search for better-paying jobs in the Middle East, Hong Kong, Japan, Malaysia, Singapore and Southern Europe has attracted large numbers of Filipinos of both sexes, many of whom are undocumented and therefore, risk arrest and repatriation. The magnitude of such labor

movements can be impressive. There are reportedly more than half a million women and men workers deployed in many parts of the world. The majority of these workers are female.

II. History of Population Policy

Population policy in the Philippines has focussed mainly on family planning (FP). Its history may be roughly divided into five time periods (Carino, 1995:89):

1. **Before 1969** - FP as concern solely of private organizations.

2. **1969-1974** - Onset of FP as government policy.

3. **1974-1986** - FP and population as part of total development.

4. **1986-1992** - FP embodied in maternal and child health (MCH).

5. **1992 to date** - Policy balancing population with resources and development.

1. FP as concern solely of private organizations

Population gradually became a policy issue only after Independence in 1946. A 1954 UN manpower study team found the reported population growth rate (PGR) of 1.9 per cent during World War II incongruent with an age-sex pyramid conformable to a population with a much higher rate of population growth. The team set a PGR of 2.3 per cent as more realistic but failed to recommend the issuance of a national population policy.

The confluence of various events in the 1960s provided momentum to FP. In 1963, the Planned Parenthood Movement of the Philippines (PPMP) was organized preceded by the establishment of the Family Relations Center (FRC), a Protestant counselling clinic. The following year, a Population Institute was set up within the University of the Philippines (UPPI) with the assistance of the Ford Foundation.

Catholic leaders formed the Family Planning Association of the Philippines (FPAP) in 1965. During the same year, physicians from the Manila City Health Department, supported by the Mayor, instituted the first governmental FP training seminar.

Republic Act (RA) 4729 was approved in 1966 limiting the sale, dispensation and/or distribution of contraceptive drugs and devices to duly licensed drug stores or pharmaceutical companies and upon prescription of a qualified medical practitioner.

On Human Rights Day 1967, President Marcos joined other world leaders in signing the UN

Declaration on Population which recognized "the population problem ... as a principal element in long-range national planning" (Concepcion, 1976:2)

The Institute for the Study of Human Reproduction was established in 1968 at the University of Santo Tomas, the country's oldest Catholic university, with assistance from the Ford Foundation. An agreement between the Philippine Government and the US Agency for International Development (USAID) led to the organization of the Project Office for Maternal and Child Health (POMCH) in the Department of Health.

The government and private organizations received support from many sources, notably from foreign governments and universities and private foundations. Many of these agencies duplicated activities, got in each other's way and negatively affected performance in the field (Warwick, 1982:84-85).

2. Onset of Family Planning as Government Policy

In late 1968, Mr. Rafael Salas, then Executive Secretary to President Marcos, attended the UN General Assembly in New York where discussions on the population problem took place. On his return, Salas convened a small group of concerned Filipinos "to study all aspects of the population situation and recommend policies and programs related to economc and social development" (Concepcion, 1976). This group became the nucleus of an ad hoc Commission on Population, established by President Marcos on 19 February 1969 under Executive Order (EO) 171.

The group of 22 was composed of cabinet and sub-cabinet officials; representatives from the Roman Catholic, Protestant and Muslim leadership; and academics and representatives of medical associations and of family planning groups. Despite its disparate membership, the Commission agreed that "reducing population growth was an urgent national need". It recommended that the State set specific and quantitative population goals, pursue an FP program under the principle of free determination by couples, and adopt policies on the spatial aspects of population. These recommendations were placed in the context of family life and national welfare, relating them to health, education and overall development. The Commission also suggested regular contact with international organizations concerned with population issues (Concepcion, 1976:5).

President Marcos approved the Commission's recommendations on 6 December 1969. It complemented the legalization of the importation of contraceptives earlier in April. In June, the two Houses of Congress passed a Joint Resolution which recognized "the grave social and economic challenges posed by a high rate of population growth (Concepcion, 1976:5).

On 25 January 1970, President Marcos in his State of the Nation address, announced that FP would be an official policy of his administration. Four months later, he promulgated EO 233 establishing a Commission on Population (POPCOM) differing from the 1969 body on two aspects: (1) it was given the responsibility for operating the national population program; and (2) its membership was reduced to five and excluded representatives of religious groups.

POPCOM was altered again by RA 6365, signed into law on 16 August 1971, which declared that:

"...for the purpose of furthering national development, increasing the share of each Filipino in the fruits of economic progress and meeting the grave social and economic challenges of a high rate of population growth, a national program of family planning which respects the religious beliefs of the individuals involved shall be undertaken."

With functions similar to the Commission it replaced, the new POPCOM consisted of 12 members. Added were three cabinet members and representatives of four private organizations.

On 21 September 1972, the President declared martial law. As sole legislator, one of his first acts was to amend RA 6365. This time, Presidential Decree (PD) 79 (1972) limited Board membership to four cabinet officials and the UPPI Dean.

In related acts, PD 442 (1974) restricted paid maternity leave to the first four deliveries only. It also required business enterprises with 200 or more employees to maintain a clinic offering free FP services and tasked the Department of Labor to develop and prescribe incentive bonus schemes to encourage FP among married female workers.

Another decree (PD 166, 1973) once again altered the POPCOM Board composition. Two members were added from the private sector who would be appointed by the President for a term of three years.

Despite the many shits in legislation governing the population program, its emphasis on fertility reduction remained constant. Within that, the basic policy was non-coercion whereby couples had the right "to choose their own method of family planning, consistent with their moral convictions and religious beliefs" (Lorenzo, 1976:66).

In line with the administrative strategies of integration, multi-agency participation and public and private sector partnership, the non-government organizations (NGOs) worked alongside government. In August 1969, the FPAP and the PPMP merged to become the Family Planning Organization of the Philippines (FPOP), an affiliate of the IPPF.

Apart from Presidential Decrees, various Letters of Instruction (LOI) and General Orders (GO) concerning the population program were issued by President Marcos from time to time. To illustrate, in GO 18 (1972), President Marcos enjoined all government offices, NGOs, religious organizations, the private sector and academe, to promote the concept of family welfare, responsible parenthood and FP.

In the same year, LOI 47 directed the Department of Education and Culture (DEC) to inform all schools of medicine, nursing, midwifery, allied medical professions and social work to integrate FP in their curricula and to require from their graduates sufficient instruction in FP as a prerequisite to qualifying for the appropriate licensing examination.

3. Family Planning and Population as Part of Development

Population concerns were included in the national development plan following discussions on the implications of population statistics and projects for planning in eight sectors during the **1974 Conference on the Population Dimension of National Planning** convened by the National Economic and Development Authority (NEDA).

The Total Integrated Development Approach (TIDA) aiming to promote FP as a way of life

emerged from the **1974 National Population Conference** which also linked population and development, this time with the former as the starting point. Adopted in 1975, TIDA moved away from a clinic orientation to one bringing information, education and communication (IEC) to communities with the cooperation of local governments. But TIDA was short-lived. In its stead, the National Population and Family Planning Outreach Project (NPFPOP) was implemented in 1976. Funded by USAID, the NPFPOP fielded full-time outreach workers (FTOWs) who organized Barangay Service Points (BSPs), following TIDA's community orientation.

In 1974, the Population Center Foundation (PCF) was established by First Lady Imelda Marcos with funding from USAID and the Rockefeller Foundation. Through the PCF, Mrs. Marcos identified herself as a benefactress of population issues. The PCF Executive Director was included in the POPCOM Board in 1975 (PD 803).

In the early 1970s, the Marcoses did appear in full support of the population policy. Population experts viewed this period as the program's apogee. Indeed, betweem 1970 and 1975, the PGR decreased from 3.01 per cent to 2.78 per cent (NEDA, 1984a:183). The proportion of contraceptive users grew from 16 per cent in 1968 to 26 per cent in 1973 (NEDA, 1983a:170).

Towards the end of the decade, however, the statistics became less remarkable, as the PGR declined by a mere 0.06 percentage point in 1980 (NEDA, 1984a:183), although the ceontraceptive prevalence rate (CPR) shot up to 37 per cent in 1978 (NEDA, 1983a:170). As the program "faced organizational, mamagerial and technical shortcomings" (Pilar, 1992), the government decided to review the Philippine population program.

The Special Committee to Review the Philippine Population Program (SCRPPP) was constituted (LOI 661, 1978) to evaluate policies and programs related to population in the context of the country's overall development goals and to prepare and recommend population program and policy directions for the future.

The SCRPPP recommended that "fertility or family planning policies and programs should be formulated within the context of the family welfare objective" (SCRPPP, 1978:122). The Committee also recommended setting population level targets in the light of desirable standards of living, income redistribution goals, and guidelines for the advocated number of children and age at marriage. It should be recalled that the welfare and development context and quantitative and redistribution targets were already in the 1969 Study Commission's recommendations.

The "new" emphasis was to be accompanied by increased government support. In 1972, when FP was first provided government appropriations, the program received P8 million. Appropriations grew ninefold to P73 million in 1977.

Increased self-sufficiency was foreseen as foreign funding was expected to diminish progressively between 1978 and 1982. This continued the trend set in the 1970s. From P15 million in 1970, almost solely provided by USAID, foreign donations were about equal to Philippine appropriations in 1975 (around P60 million). In 1977, external assistance amounted to less than P50 million, accounting for only 41 per cent (Data from SCRPPP, 1978:79).

To strengthen local government participation, LOI 435 (1976) authorized Provincial Governors and City Mayors to assume the responsibility of funding all population and FP-related activities and projects agreed upon between them and the POPCOM. Simultaneously, LOI 436 (1976) directed all local government unit heads to integrate population and FP in their overall socio-economic development plans.

Meanwhile, PD 965 (1976) required all marriage license applicants to receive instruction on FP and responsible parenthood. In this regard, a Family Planning Office headed by the city or municipal health officer was set up in every city and municipality to provide such instruction.

The SCRPPP Report was approved and adopted by the NEDA (Resolution 23, s. 1978). Hence, on 11 November 1978, LOI 765 directed all government agencies and institutions involved in population program activities to revise their respective plans and programs and reorient their activities to conform with the SCRPPP recommendations.

4. Family Planning under Maternal and Child Health

The year 1986 was a turning point for the country as the People's Revolution unseated Marcos who was replaced by Corazon Aquino. By then, the PGR was estimated at 2.44 per cent (NEDA, 1986), an imperceptible change from the 1983 figure of 2.49 per cent (NEDA, 1984b:27). Yet Marcos' last Development Plan targeted the PGR to average 2.2 per cent in 1983-87 (NEDA 1983b:123). The CPR which rose from 37 per cent in 1978 to 45 per cent in 1982 (NEDA, 1983a:170) was reported to be 36 per cent in 1984 on the eve of Marcos' fall (NEDA, 1984b:27). The population program's poor performance was but another indicator of the economic and political crisis faced by a country staggering from the effects of a negative economic growth rate, a deepening foreign debt and the assassination of Benigno Aquino, Jr..

A vigorous implementation of the program seemed called for. It appeared to be presaged by the following statement in the 1987-92 Development Plan:

> "The government strongly affirms that health is a fundamental human right and that adequate nutrition and well-spaced children are important prerequisites to good health...[Among its] three specific objectives...[is] to promote family planning as a means to improve family well-being" (NEDA, 1986).

The Plan aimed for a PGR of 2.32 per cent (NEDA, 1986), higher than Marcos' goal five years earlier. The CPR was expected to increase from 38 per cent in 1987 to 46 per cent in 1992 (NEDA 1986:22), almost similar to the actual percentage a decade before.

Even these modest targets ran into conflict with a renascent Catholic Church. President Aquino's inclination to adopt the Church's position was reenforced by her own special need for its support, with as many as seven coups threatening the government between 1986 and 1989. It seemed politic not to antagonize the Church with a population policy displeasing to it. Thus, the influence of the institutional church on government during this period was probably second only to that enjoyed by the Church during Spanish colonial days (1521-1898). That influence showed itself in this pro-natalist provision of the 1987 Constitution:

> Art. II. Sec. 12. The State...shall equally protect the life of the mother and the life of the unborn from

conception.

Against this background, the POPCOM Board prepared the Population Policy Statement of 1987:

> "The ultimate goal of the Population Program is the improvement of the quality of life in a just and humane society" (POPCOM, 1987).

The Statement recognized the close interrelationship among population, resources and the environment. Among its policy principles were: the linkage of FP with the broader issues of family welfare and the promotion of family solidarity and responsible parenthood, non-coercion, rejection of abortion, coordination and integration and public-private sector partnerships, which were restatements of the policies of the 1970s.

Herrin (1990:3-4) criticized the 1987 Policy Statement for its "explicit avoidance of policy advocacy for moderate fertility and population growth" and maintained that its policy thrusts suggested that FP was becoming only a health program.

The Statement indeed proved to herald the transformation of FP primarily into a health program. In August 1988, the DOH became the lead agency for FP. The FP strategy within health was defended as a means of invigorating an arrested program. Besides, even pro-natalists could not dispute the importance of MCH because, as then DOH Secretary Bengzon asserted, "family planning is a practical intervention mechanism [for MCH] ... for very good epidemiological and medical reasons".

Stressing MCH aspects of FP did not appease the Catholic hierarchy. In August 1990, the Catholic Bishops Conference of the Philippines (CBCP) and the government issued the following statement after a dialogue at President Aquino's invitation:

> "... The program will not be undertaken to reduce fertility or population growth."
>
> "The Church reiterates its objections to contraception and sterilization and expresses its reservations about the moral acceptability of certain aspects of the Program. But in a pluralistic society and recognizing the freedom of those who disagree with Church principles, the Church respects the government's toleration of other means that the conscience of others may not object to and that the law on abortion does not forbid" (Joint Government-CBCP Panels, 14 August 1990).

Despite Church resistance, other forces openly favored FP. The press printed news items favoring a stronger FP program (Raymundo, 1991:6). The NGOs seconded this stand. Moreover, three-fourths of the legislators and executives surveyed in 1989 wanted government to intervene in population matters. Two-thirds disagreed with the Church that only natural family planning should be promoted. The same proportion claimed they will support legislation contrary to the Church position (Raymundo, 1991:7).

That support may have been generated by the 1988 **Parliamentarians Conference on Human Survival: Population and Development** held in Manila which produced a plan of action on population, later adopted as a Congress resolution. It also convened a group of legislators who formed the Philippine Legislators' Committee on Population and Development (PLCPD) to keep the population issue alive. Funded by the United Nations Fund for Population Activities (UNFPA) and USAID, the PLCPD is co-chaired by Senator Leticia Ramos-Shahani and Representative Teresa Aquino-Oreta. The PLCPD has over 40 members from both Houses.

5. Family Planning and Sustainable Development

Fidel V. Ramos was the first Protestant to become president of this predominantly Catholic country. His strong support coupled with the commitment of donor agencies restored enthusiasm and confidence to POPCOM (POPCOM, 1993:1). The current program has two "new" features: (1) a shift from "population control" to "population management" (defined as improving the life of Filipinos through manageable population levels and human resource development balanced with available resources to facilitate the achievement of sustainable development); and (2) family planning embedded in a population-resources-environment framework. Also, a new Local Government Code devolved most public services, including health and FP functions, to local governments (RA 7169, October 1991).

Whether these features are really new is debatable. The DOH continues to be responsible for FP which is now undertaken in the context of reproductive health. The previous focus on demographic targets has shifted toward policies sanctioning use of FP information and services as a strategy to enable couples to achieve their reproductive choices.

Even Senate Bill 2012 entitled, **An Act Establishing a New Population Policy, Strengthening the Population Commission and For Other Purposes** echoes the thrusts of existing policy: (1) Access by all Filipinos to information and basic services essential to their free, fully informed, and responsible FP practice and on their desired family size, a principle since 1969; (2) Orientation towards the overall improvement of women and family welfare, the 1978 emphasis, except for the explicit reference to women; and (3) achievement of a desirable balance among population, resources and the environment, first articulated officially in 1987. It proposes to add to the present POPCOM Board membership, representatives of the women, youth and education sectors and the POPCOM Executive Director.

Specific Issues of Population Policy

Fertility and Family Planning - The Philippine Family Planning Program (PFPP) under the DOH aims to provide universal access to FP information and services in order to improve the health of women and children and to assist women in meeting their own reproductive goals. A new conceptual framework was devised in the light of devolution, the impending environmental threat, dwindling natural resources, increasing gender concern, changing health and disease patterns, and a reproductive health focus. The Philippine Family Planning Strategy (PFPS), 1996-2000, has for its objectives:

(1)Halving the unmet need for contraception;

(2)Reducing high-risk births to 56 per cent in 2000;

(3)Preventing abortion and reducing the percentage of reproductive age women who have had one abortion experience in their lifetime, by 7 per cent during 1996-2000;

(4)Moving towards sustainability by augmenting government financing and widening the role of NGOs and the commercial sector;

(5)Expanding the role of the private sector by implementing contraceptive social marketing in more areas, and raising the share of private/NGO hospitals and clinics as sources of modern

contraceptive methods, among others.

To meet these objectives, the DOH will utilize the following strategies:

(1)Broadening the range of available contraceptives to suit women's needs at every stage of the reproductive life cycle;

(2)Focusing on adolescents and the unmarried;

(3)Developing and implementing an urban strategy;

(4)Re-establishing the Outreach System;

(5)Segmenting the market;

(6)Improving collection and more systematic use of information for decision-making; and

(7)Increasing local-government units' capability to contribute to PFPP financing.

Mortality - The DOH's renewed commitment to FP is evident in the PFPP's explicit objective of improving mothers' and children's health. This was inspired by the 1989 empirical findings concerning the potential of reducing infant and maternal mortality by avoiding high-risk births (Casterline, 1989). It was estimated that if high-risk births (births to women under 18 and over 35, or women with four+ children or births spaced less than two years apart) were avoided, the infant mortality rate (IMR) could be reduced by a fifth. In the same vein, studies in countries with socio-economic settings similar to the Philippines estimated that the maternal mortality rate (MMR) could be diminished by 20-25 per cent through avoidance of high-risk pregnancies and births. While the FP program has emphasized IMR reduction, there are more direct interventions aimed at improving infant and child health also in place, like the immunization and breast-feeding programs. In addition, MCH programs such as nutrition classes, pre-pregnancy care are aimed at reducing maternal deaths.

Migration and distribution - As early as 1976, the Philippine Government had expressed its desire to decelerate the pace of urbanward migration. Two decades later, the concentrated pattern of urbanization still prevails and urban- ward migration continues despite the regional development efforts in the eighties. Even though the national population program had a stated goal of promoting a more balanced population distribution, the program has been almost entirely focused on meeting fertility reduction targets.

Among the policy instruments proposed to influence directly the individual search for alternative residential sites and the information channels aiding the selection of migration destinations was a bill establishing a public employment service office in every province, key cities and other strategic areas. Another attempt to legislate direct control of population movements proposed a migration registration system at the barangay (village) level coupled with such regulatory mechanisms as a migrant social guarantor at destination and police clearance at origin. These proposals proved unsuccessful. An improved migration-sensitive policy instrument that operates through urban development and housing needs is RA 7279 approved in 1992. The improvement lies in the explicit provision for inter-agency coordination among the NEDA, NSO and POPCOM to monitor population movements and to provide

advanced planning information such as population projections as embodied in Section 37, Article IX. What this provision has achieved is the interrelationship between population movements and urban development, focusing on its impact on housing services and the need to promote socio-economic growth in the countryside. However, what is lacking is a set of implementing rules and regulations for an effective inter-agency coordination to monitor population movements.

Population Structure - Although a sectoral representative of the elderly to the Philippine Congress has been appointed by the President, only two pieces of legislation have been passed that relate to the elderly. The first is the so-called Veterans Code and the other, an act granting discount privileges and other benefits to the elderly and the disabled. The meager legislative output has been attributed to the low level of awareness on the part of lawmakers of the problems of the elderly. Many legislators believe that NGOs are already susbtantively involved in implementing programs and projects for the elderly.

Although the Constitution gives "priority for the [health] needs of the underprivileged sick, elderly, disabled, women and children", no special programmes for the elderly have been instituted by the DOH. The services for this subgroup have been integrated into the package of services provided by the DOH.

Women - The Philippine Plan for Gender-Responsive Development (PPGD), 1995-2025, is the latest in a series of government initiatives meant to give Filipino women a more active and participatory role in the development process. It is the government's 30-year perspective framework for pursuing full equality and development for women and men, in compliance with RA 7192, known as the Women in Development and Nation-Building Act, and the Constitutional provision on gender equality (Article II, Section 14).

The PPGD takes over where the Philippine Development Plan for Women 1989-1992 (PDPW) left off after its mandate expired. Concentrating on promoting gender sensitivity in the government bureaucracy, the PDPW was able to: establish institutional mechanisms in various government agencies as focal points for women's integration in development; conduct Gender and Development (GAD) advocacy and training; set up gender-responsive data base systems; and institute a monitoring system to assess changes in women's status.

To ensure its relevance in the years to come, the PPGD is intended to be a "rolling plan" that will be updated every six years. The PPGD's extensive coverage also ensures that most, if not all, gender concerns are covered. Its formulation process considered the Long-Term Development Vision and Framework which will serve as the basis for the formulation of the country's long-term development plan.

In addition to RA 7192 and the General Appropriations Act of 1995 instructing government agencies to set aside a portion of their budgets for women/gender and development activities, the passage of the following laws is a testimony to the growing concern for the improvement in women's status:

* RA 7877 declares sexual harassment unlawful in the employment, education and training environment;
* RA 6972 mandates the establishment of day care centers in every barangay;
* RA 7322 increases the maternity benefits of women in the private sector;
* RA 7655 raises the minimum wage of domestic helpers;
* RA 6955 outlaws the practice of matching Filipino women for marriage to foreign nationals on a mail-order basis;
* RA 7688 gives representation to women in the Social Security Commission;
* RA 7600 provides incentives to all government and private health institutions with rooming-in and breastfeeding practices.
* RA 6949 declares 8 March of every year as a working holiday to be known as National Women's Day;

Stability and Change

The preceding overview manifests the continuities as well as changes in Philippine population policy over time. From its inception, the stable elements in population policy are the outright rejection of abortion, upholding the freedom of conscience in FP practice and encouraging the cafeteria approach, and forging a partnership between the government and private sectors. These continuing elements are consequences of the role of religion, the economic exigencies which have led to family size limitation and the historical role of NGOs in propagating responsible parenthood.

But there have been changes as well—changes in context and in organization. The modifications have been brought about by international conditions, local politics, political will, culture and personalities.

Changes in the context in which the FP program has been, and is located, have been frequent. The context of family welfare and more broadly development was introduced in 1978, MCH in 1987, environment and sustainable development in 1992, and reproductive health (RH) in 1995. The context which has most affected the program has been the incorporation of FP into MCH and now, RH.

Oganizational changes have been most noticeable. The POPCOM was transformed from a research body in 1969 to a coordinator in 1970, to an implementor/coordinator in 1975, and then to a coordinator divested of its FP responsibilities in 1987. It has been variously attached to the Office of the President (OP), the NEDA, the DOH, the Department of Social Welfare and Development (DSWD), and back to the OP and to the NEDA. Every attachment entailed a change in mandate from the parent organization, a new Chairperson and a different place in the government hierarchy. Sometimes, the move was conducive to a stronger support for FP as happened when POPCOM was transferred from NEDA to the DSWD. At other times, attaching the Commission to NEDA forced it to be more planning- and coordination-oriented. Its location under the Office of the President affirmed the Chief Executive's strong commitment to the population policy. Since 1969, POPCOM has had nine executive directors. As each new appointee presented his or her own agenda, discontinuities of policy arose.

The continuities in population policy are apparent, operationable and culturally acceptable. As such, they can form the bases of a successful program. The features which situate FP within the scope of RH, family welfare and sustainable development recognize that the policy cannot be formulated in isolation. Hence, their incorporation with other population policy elements would not pose a problem.

The absence of organizational continuity and the almost complete reliance on foreign assistance are factors detracting from success. That these factors continue to operate even after nearly 30 years of the program point to a lack of political will and strong commitment to enable the program to function properly. The continued opposition of the Catholic Church targeted at legislators and policy makers affects the program's implementation. Organizational stability, efforts at self-reliance or self-sufficiency and an acceptable accomodation with the Catholic Church are prerequisites to the attainment of Philippine population goals.

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Chapter VII

Population Problems and Policy of Singapore

Population Problems and Policy of Singapore

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I. Introduction

Singapore's population policy has often been cited as the success story of a developing country's effort to balance population growth with economic development. In the three phases of the policy's evolution thus far, changes were made to accommodate changing socioeconomic and demographic circumstances. These changes occur within the context of an island-state with a landmass of only 650 sq km, where over-population has always been an overriding concern. Yet, there was a swing in recent years from a concern for population control to an emphasis on population growth. In 1996, Singapore's total population growth was as high as 4.2%, much higher than other developing countries.

The central task of population planing in Singapore is to manage population growth and manpower resources to meet economic needs and improve the quality of life within the land resources available. It is akin to a multiple-optimization process - to achieve a balance between desired demographic objectives within the constraints of the environment and the economy. The following sections of this report give an overview and analysis of Singapore's population policy.

II. Evolution of Population Policy

Singapore was one of the first Asian countries to adopt a vigorous population control program as part of its socioeconomic development strategy. In 1966, when the Singapore Government established the Singapore Family Planning and Population Board (SFPPB) to spearhead the program, the population was growing at about 2% per year and the total fertility rate was about 4.5. The population was youthful, and the prospect of a population explosion on a small island loomed large in the minds of the planners. Having just separated from Malaysia, Singapore was trying hard to gain a firm political and economic footing. The need to curb population growth was obvious then, and population control was viewed as critical in balancing scarce economic and land resources with the demands of an expanding population.

The success of Singapore's population control program is well known. The combination of a vigorous family planning program with the judicious use of social incentives and disincentives had resulted in a dramatic fall in Singapore's fertility rate. Replacement fertility was attained in 1975, barely ten years after the establishment of SFPPB. The steady decline in fertility reached a historic low of 1.44

in 1986. By then, the demographic circumstances had clearly changed. Labour shortages were prevalent, and better town planning and public housing had enhanced the living conditions of the population and reduced overcrowding.

It had become clear in the 1980s that domestic labour supply was inadequate to meet the manpower needs of a rapidly growing economy. The persistent labour shortage had raised two concerns among the population planners : whether Singapore should increase its population at a faster pace to facilitate economic growth, and whether the recent cohort sizes were too small to provide the critical mass of people needed to run a diversified economy. The long-term implications of persistent fertility were also discussed : the aging of the workforce, the increasing welfare burden, and the reduced dynamism of the population.

In response to the prospect of a sustained fertility decline, the Government changed gear and announced the 'New Population Policy' in March 1987, which officially ended its anti-natalist population control policy. A package of policy measures and incentives was introduced to promote higher fertility and to arrest the continuing fertility decline. Replacement fertility and long-term population stabilization were stated as official demographic goals.

In the early 1990s, the continuing labour shortage and the rapidly expanding economy had prompted yet another review of the population situation. As Singapore progressed, it became less critical for the government to control population growth to meet resource constraints. It was also clear then that the expanding economy could support a larger population base. The influx of foreigners working in Singapore became larger. The 1990 Census enumerated over 300,000 foreigners residing in Singapore, the bulk of whom were foreign workers. The foreign population accounted for about 10% of the total population.

While the government recognized the importance of raising fertility to ensure population replacement, it realized that the inflow of foreign professionals from overseas would enable Singapore to achieve its economic objectives. Given the large presence of foreign unskilled workers, the government was keen to attract better-educated foreign talents. A program was established to attract talented Asians to come to Singapore to work and settle down. Suitable Asians such as Hong Kong residents were given permanent residence status as soon as they obtained a job in Singapore. In 1997, this program of talent recruitment for employment and possible permanent residence was extended to all nationalities. As a result of the relaxation of immigration regulations, Singapore's total population growth rose rapidly to about 4.2% in 1996.

III. Basic Concepts of Population Policy

Population planning in Singapore has taken on new dimensions, shifting from a narrow focus on family limitation with the aim to curb excessive population growth in the 1960s to a broader concern of meeting economic and social objectives in the 1990s. The key policy objectives are discussed below :

(1) Containing Population Pressure on Land Resource

The limited land supply of Singapore places a limit on the ultimate population size that the island can support. There is intense competition among the many users of land space. Population planning in Singapore, therefore, has to be well coordinated with efficient city planning and spatial management, particularly the vertical expansion of buildings, roads, and parks, to ensure that the population can be housed comfortably.

Population density in Singapore is one of the highest in the world, at 5,578 persons per sq km. However, in terms of land size, Singapore is one of the smallest countries in the world with a land area of only 650 sq km. This smallness in land size makes it critical for planners to ensure that, when planning for an eventual target population, the momentum of population growth does not lead to an overload situation, causing a deterioration of the quality of life. Although the supply of land in Singapore can be increased by land reclamation efforts, there is a limit to the expansion. Sheer physical limitations, including areas for housing, roads, parks and water-catchment, set a limit to the ultimate carrying capacity of the Singapore island.

(2) Arresting the Decline in Fertility Rates

Since 1975, Singapore's fertility rate has been below-replacement level. If the trend were to continue, the population would experience negative growth within the next 30-50 years. Once negative population growth sets in, it becomes difficult to reverse the downward momentum because of the 'top-heavy' age structure. It is therefore considered important to reverse the falling fertility rate and to keep it at about the replacement level.

Since the new policy was effected in 1987, the fertility decline has been halted. The fertility rate has rebounded from 1.4 in 1986 to 1.9 in 1990. Since 1990, the fertility rate has shown a slow decline to about 1.7 in 1996. Population projections show that if future fertility rates fall between 1.8 and 2.1, the population will start declining by the year 2020, after peaking at about 3.2 to 3.4 million. The number of elderly people will also increase significantly; about 25% of the population will be old people compared with 10% today. The negative impact of fertility decline on population structure will be compensated by gains made through immigration.

The concern facing policymakers and planners now is not only to ensure that we maintain this momentum of fertility increase, a task that is already difficult, but also to further increase the rate. Greater efforts are now being made to increase both the indigenous population growth rate and to bring foreign talents into Singapore. It has been argued that a larger population base for Singapore will provide many more opportunities for Singapore to grow and develop economically and socially. It will provide the critical mass of capable and talented people to develop and run future economic and social activities. A growing population will also age more slowly. The elderly will form a smaller proportion of the population and be less of a burden on the economy.

(3) Maintaining a Balanced Age Structure

Currently, the population age structure is at its optimum with the bulk of the population in youthful working ages. Persons aged 20-50 constitute over 50% of Singapore's population. But maintaining this balanced age structure will be a formidable challenge for Singapore as low fertility and mortality rates are likely to persist. If fertility rate does not increase, the elderly population is expected to reach 25% in forty years' time. The median age is likely to reach 40 years. The effects of an older population profile will be felt, especially in the economic, social welfare, and public health sectors.

Distortions in the age distribution of the population can be countered through modifications of a country's population policy. By raising fertility to replacement level and allowing a large population base, Singapore's population policy aims to stabilize the population structure with a more even age distribution, thereby moderating or controlling the inevitable aging process. In the long term, the proportion of the elderly is expected to stabilize at about 20%. This is an acceptable figure given a steady-state population structure.

(4) Maintaining Status Quo in Ethnic Balance

The population of Singapore is predominantly Chinese. They form about 77% of the population. The Malays and Indians form another 14% and 7% respectively. Any distinct shifts in the distribution may lead to changes in social and political expectations, resulting in adjustments in the social structure. It is therefore desirable that the population of Singapore should not deviate too much from the present ethnic distribution.

That the new policy encourages higher fertility from all, regardless of ethnicity, further emphasizes the government's long term plan to maintain the distribution as close as possible to the present ethnic composition. Although the new policy is not formulated across ethnic lines, policy-makers and planners have highlighted in their speeches the need to further increase the Chinese fertility because it is the only ethnic group in Singapore whose fertility rate remains below the replacement level. However, the differential is not large enough to cause major changes to the ethnic distribution.

(5) Attracting Talents from Overseas

The potential for Singapore's further development depends very much on the pool of capable and talented people in its population. The government has made explicit its intention to attract foreign talents to Singapore.

(6) Maintaining Family as the Core Institution

The family would continue to be the core institution of Singapore in the future. Social provisions have been planned with the family as the basic source of support and assistance to an individual. The new population policy encourages marriage and family formation. It is hoped that this would moderate, if not contain, the rise of individualism in Singapore. The government is concerned that increasing affluence and independence may erode the family as the basic social unit. Population planning in

Singapore therefore aims to keep the rate of voluntary childlessness as low as possible and to promote marriage and parenthood as desirable life goals.

IV. Current Population Policy

The thrust of the New Population Policy which is currently in place is to encourage marriage and childbearing. A new slogan "Have three, or more if you can afford it" is adopted to reflect the new direction. Generous incentives are given under the new policy, and some of the major ones are described below :

* *Income Tax Rebates*

A special tax rebate of S$20,000 is given to parents who have a newborn third or fourth child. The tax rebate is deducted against the tax payable by either or both parents. In addition, a tax deduction of 15% of the mother's earned income is allowed for working women who give birth to their third or fourth child. Tax incentive is also given if a mother has her second child before age 31.

* *Subsidy for Childcare Centre Fees*

A subsidy of S$150 is given for the first four children enrolled in government-approved childcare centres. Previously, the subsidy was given only to children whose parents were earning a combined monthly income of S$1,500 or less.

* *Subsidy for Delivery Fees*

The delivery and hospital costs arising from the delivery of the fourth child can be offset against the parents' earned income, up to a maximum of S$3,000. This incentive, focusing on the fourth child, is in line with the government's policy emphasis that only those who can afford to have more than three children should be encouraged to do so.

* *Special Leave Schemes for Married Female Civil Servants*

Married female civil servants are able to enjoy special unrecorded leave to look after their children who fall ill and are below 6 years old. A total of 5 days is allowed annually for each child. In addition, part-time employment and no-pay leave for childcare are allowed. The private sector is encouraged to establish similar schemes.

To support the New Population Policy, two programs have been implemented :

* *Strengthening the Marriage Program*

Since 1984, the government has established a Social Development Unit to promote

opportunities for interaction between male and female graduates. Besides organizing various social activities, the unit also offers a computerized matchmaking service. In 1985, another unit was established to organize similar activities for non-graduates (secondary and upper secondary graduates). More recently, in 1990, a unit was set up to promote interaction for those with primary education or less. The important role played by these three units is recognized and the range of activities has been significantly expanded.

* *Family Life Education Program*

A public education program on the three-child family norm was launched. Multi-media approaches are used and the program is expected to reach out to all sectors of the population.

V. Issues of Population Policy

1. Fertility and Related Issues

The fertility decline, which started in the late 1950s, reached its lowest level in 1986, in a period of less than 30 years. Table 1 shows the decline as measured by the Total Fertility Rate (TFR). The decline has been equally sharp for all ethnic groups. The TFR for the Chinese stood at 5.62 in 1960, which subsequently dropped to 1.25 in 1986. For the Malays, the decline was from 6.42 to 2.22 in the same period. The Indians had the sharpest decline, from 7.37 to 1.73.

Table 1: Crude Birth Rates and Total Fertility Rates, Selected Years, 1957-1996

Year	Crude Birth Rate (Per 1,000 Resident Population)	Total Fertility Rate (Per Woman Aged 15-44)			
		Total	Chinese	Malays	Indians
1957	42.7	6.41	6.48	6.22	7.20
1965	29.5	4.66	4.31	6.31	6.69
1970	22.1	3.07	3.00	3.45	3.15
1980	17.6	1.82	1.73	2.19	2.03
1985	16.6	1.61	1.46	2.28	1.79
1986	14.8	1.43	1.25	2.22	1.73
1990	18.4	1.87	1.68	2.71	1.95
1996	15.4	1.70	1.53	2.54	1.81

The particularly low fertility performance in 1986 of the Chinese was a result of two factors. Firstly, the year 1986 coincided with the year of the 'Tiger' in the lunar calendar, which was considered

as inauspicious for marriage and childbearing. Secondly, the economic recession, which started in 1984 and intensified in 1985-86, may have caused the postponement of births. The Indian community was also influenced by the recession and their fertility dropped appreciably in that year.

The long-term decline in fertility for all ethnic groups was halted in 1987 when fertility rebounded. In 1988, one year after the announcement of the New Population Policy, a significant rebound in fertility was seen. The TFR for the Chinese reached 1.84 in that year, and for the Malays and Indians, 2.51 and 1.90 respectively. After 1988, the fertility level started a slow decline for all ethnic groups. The decline was more noticeable among the Chinese than the other two groups.

The long-term decline in Singapore's fertility is due to two demographic factors : the decline in female marriage rates and the reduction in average family size (or marital fertility). As would be expected in an urban society, both factors are results of a way of life that is more suited for singlehood or small family size.

(1) Marriage Timing

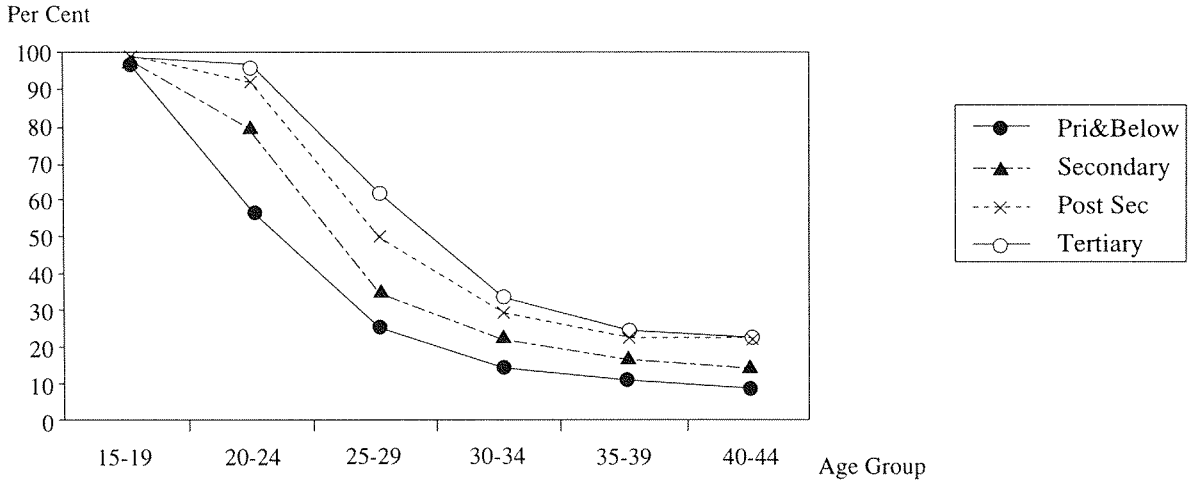
Changes in Singapore's marriage pattern have been swift in both the delay in marriage timing and the rise in celibacy. In both instances, the same effect occurs - the proportion of unmarried females by age increased rapidly over time. Table 2 shows the changes from 1970 to 1996. The share of the unmarried among the female population aged 30-34 increased from about 10% in 1970 to 21% 1996. For the next age group (35-39), the percentage increased from 5% to 15%. The average age at marriage in each year has also risen over time, from 23.7 in 1970 to 26.5 in 1996.

Table 2: Proportion Single Among Resident Females by Age Group, Selected Years, 1970-1996

Year	20-24	25-29	30-34	35-39	40-44
1970	64.6	22.6	9.6	5.1	3.3
1980	73.7	33.6	16.6	8.5	5.9
1990	78.5	39.3	20.9	14.8	11.5
1996	84.0	41.1	20.7	15.0	12.4

The delay in the entry to marriage is positively associated with educational attainment, with the higher educated having the longest delay. Figure 1 shows the educational differentials by age for 1996. It is noteworthy that for the tertiary educated, about 32% of women aged 30-34 remain unmarried. The future celibacy rate for this group is likely to stay at no less than 20%, taking into consideration the reduced marriage probabilities at older ages.

Figure 1: Proportion of Single Females by Educational Qualification, 1996



(2) Family Size

Delayed entry into marriage has resulted in a corresponding increase in the delay in the onset of childbearing. The mean age at first birth has risen steadily from 23.4 years in 1970 to 28.4 in 1996. The age of mothers at second birth has similarly risen from 25.4 to 30.8. The postponement of both marriage and childbearing has resulted in a smaller than desired family size.

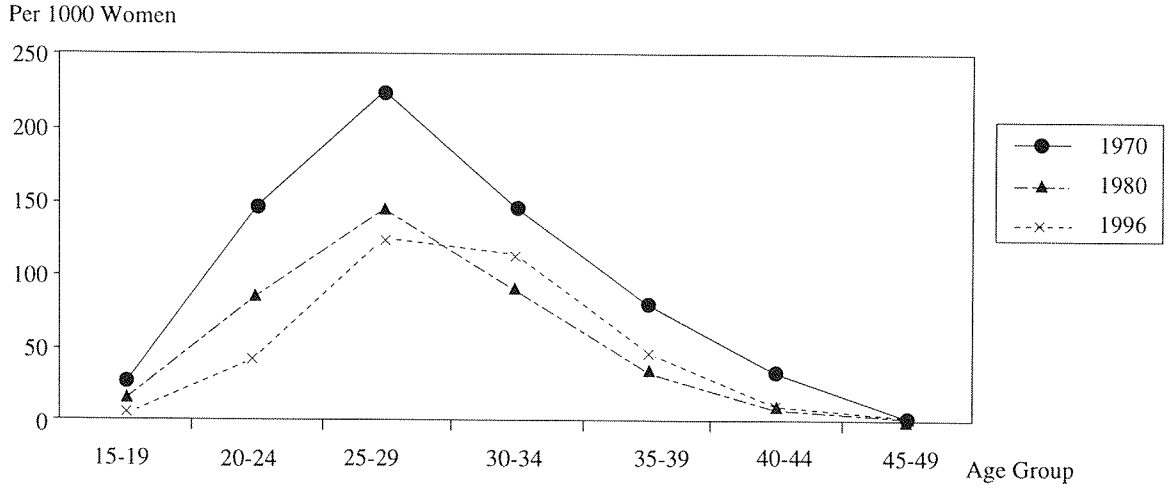
The decline in the family size has been slowed down somewhat by the new population policy which encourages third and higher order births. The number of such births increased rapidly, from a low 7,400 in 1986 to 11,300 in 1996. In terms of proportion of total babies born, the increase was from 19% in 1986 to 23% in 1996. It remains to be seen whether the increase in higher order births would increase the average family size appreciably. The 1990 population census showed that only 34% of ever-married women aged 35-39 have three or more children. This was much lower than the 1980 figure of 64%.

Table 3: Third and Higher Order Births

	Number	Per Cent of All Births
1986	7,367	19.2
1990	12,546	24.6
1996	11,254	23.2

The reduction in higher parity births has also been phenomenal, reflecting the early termination of childbearing. In 1970, about 33% of all births were of fourth or higher parity. By 1996, this proportion has dropped to 6%. Declining family size and early termination of childbearing means that the span of a woman's life course devoted to childbearing is considerably shortened. In Singapore, the reduction has occurred at both ends. Figure 2 shows the significant compression of the age-specific fertility rates over time.

Figure 2: Age-Specific Fertility Rates, 1970, 1980 and 1996



(3) Increasing fertility

If we look at the increase in higher order births, it may appear that the new population policy has been effective. However, the declining TFR suggests that the positive effect has diminished over time. This is largely due to the fact that marriage rates remain low, and delays in marriage and childbearing continue to hold down fertility.

How to motivate parents to have more children is a question that has received little attention in Asia where population control continues to be the key concern. Singapore is one of the few countries that has shifted its population planning paradigm. The government is aware that it may not be as successful with the new pro-natalist policy as it has been with the anti-natalist 'stop-at-two' policy of the past. As the country industrialized, a new way of life has emerged. For many women, work and career are now considered desired options along with marriage and procreation. To the extent that a small family size is rationally compatible with the demands of a modern society, any effort to promote larger family size can only be expected to bring modest results. It would be even harder to promote marriage among persons who no longer see marriage as an inevitable life event.

2. Mortality

Singapore, as a prosperous city-state, provides excellent health and medical services to its residents. Strict public health policies have ensured a high standard of environmental hygiene and minimal pollution. Although located in the tropics, Singapore is free from infectious diseases, except for some occasional imported cases. Proper manpower planning results in an adequate supply of health care professionals. The ratio of doctors to population, at 15 per 10,000 population, is among the highest in developing countries.

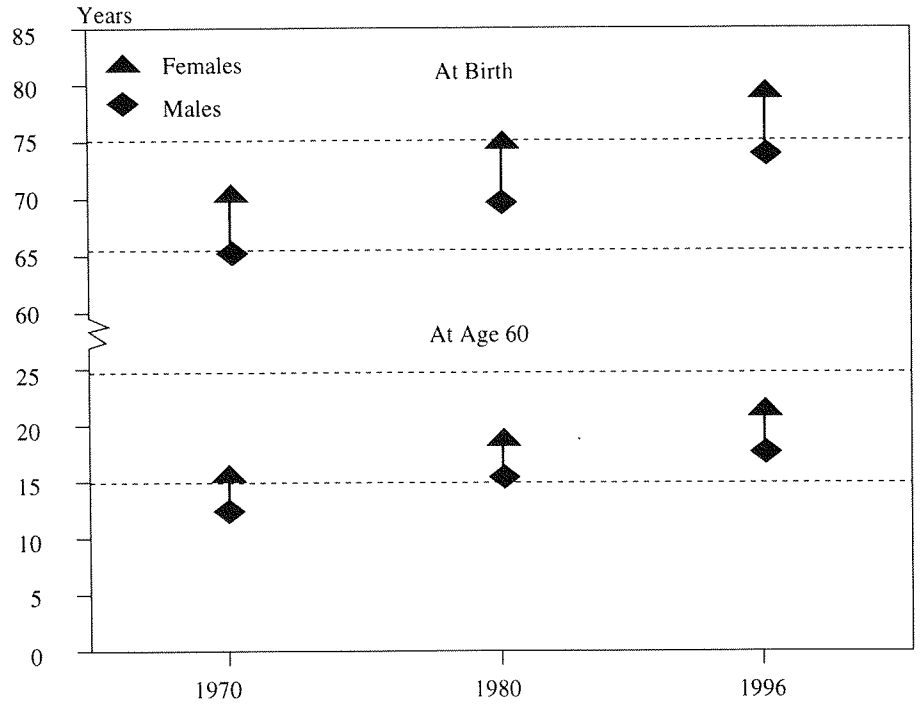
Medical facilities are new and well equipped. The government provides the bulk of hospital and outpatient services. Increasingly, private sector hospitals and clinics are becoming popular among local as well as overseas patients. A sound financial system has also been put in place to manage the rising

demand for medical services in an aging society. A nation-wide health education program to promote preventive medicine and health lifestyle is now on-going. It is not surprising, then, that the health and longevity of the Singapore population have improved significantly over the past three decades.

(1) Life Expectancy

Life expectancy for males has increased from 65.1 in 1970 to 74.4 in 1996 (Figure 3). For the females, the life expectancy at birth is higher than males and has increased from 70 to 78.9 years. Among the elderly, life expectancy for both sexes has also improved. The life expectancy at age 60 years was 18.4 among males in 1996, up from 12.9 in 1970. For elderly females, life expectancy has risen to 21.6 in 1996 from 15.6 in 1970.

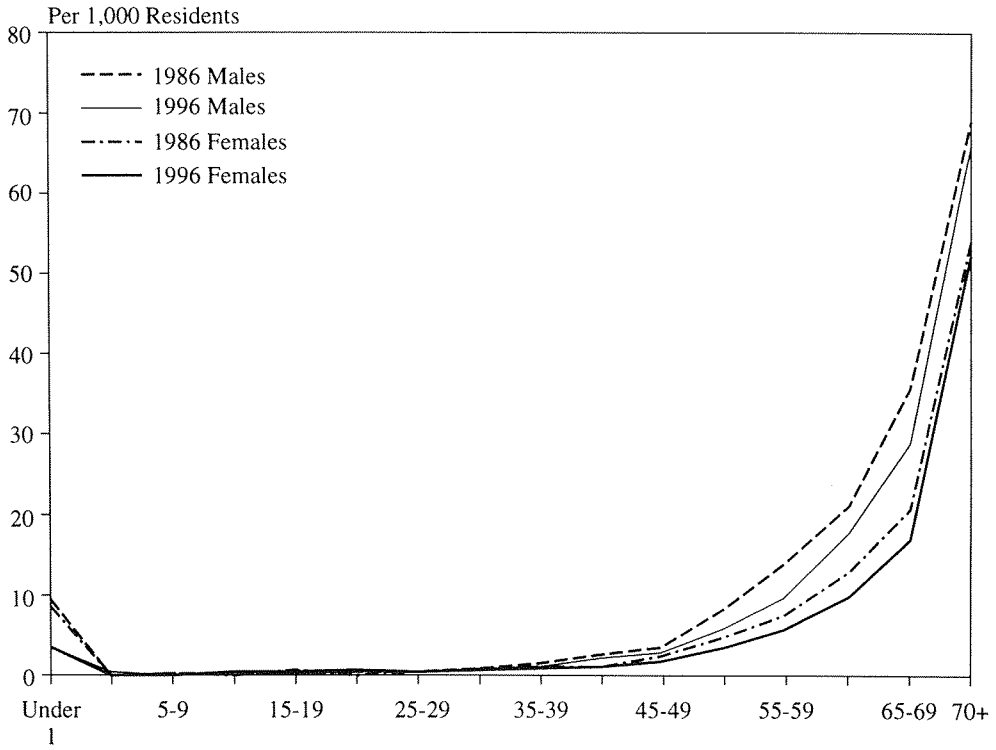
Figure 3: Life Expectancy



(2) Lower Mortality Rates

The trends in longevity correspond to the low level of mortality in Singapore. Mortality rates are low in the younger ages, even among infants below one year old. Singapore's infant mortality rate of 3.8 per 1,000 live-births in 1996 is low by international standards. As shown in Figure 4, the mortality curve is almost flat from the age 1 to 39 years and the rates are generally below 10 per 1,000 population up to age 60 years.

Figure 4: Age-Specific Death Rates



Compared with a decade ago, age specific death rates for both males and females have fallen. Increasing affluence and more effective medicine have resulted in the downward shift of the mortality curve. The decline in mortality occurs mainly among the very young and among the elderly. As shown in Table 4, neonatal and infant mortality rates have declined significantly while maternal mortality rates have remained at or close to zero value for most years. The rise in HIV/AIDS cases has been fairly rapid recently. Because of the small number of cases, it has yet to become a major public health issue.

Table 4: Selected Mortality Indicators

	1980	1990	1996
Number of Deaths	12,505	13,891	15,590
Crude Death Rate (Per 1,000 Resident Population)	4.9	4.8	4.7
Infant Mortality Rate (Per 1,000 Live-Births)	11.7	6.7	3.8
Maternal Mortality	0.0	0.0	0.0
Neonatal Mortality	8.9	4.3	2.3
Number of HIV/AIDS Cases	-	61	558
Life Expectancy at Births (Years)	72.1	75.3	76.6
Males	69.8	73.1	74.4
Females	74.7	77.6	78.9

The policy of emphasizing preventive health care is the cornerstone of Singapore's efforts to promote better health. The Ministry of Health and other non-government agencies regularly organize programs on health education, exercise, and health screening. These are held in easily accessible locations such as public housing estates, libraries and community centres. It is recognized that preventive health care is ultimately the most cost-effective measure to reduce health care cost.

To manage the demand on health services, the government has emphasized the co-payment of medical cost between the employees and the employers. In the past, medical costs were largely borne by the employers. The change in policy reflects the government's intention to emphasize individual responsibility in the purchase of medical services. In addition, the government has established a 'Medisave Account' within the Central Provident Fund to ensure that individuals' savings are preserved to cover medical expenses. To address the inadequacy of Medisave and the risk of its depletion by catastrophic illnesses, the government has also introduced an insurance-based scheme to provide support for major illnesses.

3. Migration

Singapore was founded in 1819 as a free port and trade settlement by the British. An open door migration policy was maintained up till 1933 with the migratory flows and the size of the settlement fluctuating with the market forces. Since 1933, selective migratory control was introduced. To address the problem of sex-ratio imbalance, the Aliens Ordinance of 1933 allowed for easy inflow and outflow of females while regulating the inflow of males. Following self-government in 1959, complete control over immigration was put into effect with the enactment of a comprehensive Immigration Ordinance in the same year.

Since independence in 1965, immigration into Singapore had been brought under strict administrative control, and was allowed only for family reunions. However, as the economy developed, and the demand for labour outstripped local labour supply, immigration policy was relaxed to allow entry of temporary foreign workers to alleviate sectoral labour shortages. In addition, Singapore also openly welcomed skilled and professional workers, as well as entrepreneurs with industrial experience and capital to settle in Singapore. Moreover, economic linkages with the world and the establishment of multi-national corporations have led to a growing number of expatriate managers and professionals residing in Singapore.

Table 5: Foreign Population and Permanent Residents

	Foreign Population	Per Cent of Total Population	New Permanent Residents
1980	131,800	5.5	9,000
1990	311,300	10.3	22,000
1996	567,700	15.7	30,000

The magnitude of these streams is largely governed by domestic market conditions. In recent years, along side with the rapid growth of the economy, there has been an increase in foreign population in Singapore. In 1996, as many as 567,700 foreigners, or 16% of the total population, were residing in Singapore. The bulk of this group would be the unskilled workers. Table 5 shows the growth of the foreign population over time in Singapore. In addition to the foreign population, Singapore also takes in foreigners as permanent residents. In 1996, as many as 30,000 persons were granted permanent residence. Thus, there are three main streams of inflow into Singapore :

Unskilled Workers

They are allowed temporary stay in Singapore upon successful application for a work permit. The permit is usually valid for two years and renewable for two years. Upon expiry of the permit, the workers would have to return to their home countries.

Skilled Workers and Professionals

This group is allowed temporary stay in Singapore by means of an employment pass which is readily granted if local employment is secured. Most are encouraged to apply for permanent residence.

Expatriates

This group consists of managerial personnel in multi-national corporations with operations in Singapore or in the region. Most enter Singapore by means of an employment pass and would remain so throughout the duration of their stay.

The relative benefits and costs of having a sizable foreign workforce has been the subject of much debate. Some have argued that the availability of foreign labour has imposed an economic cost by slowing down Singapore's economic restructuring process. Social costs such as increased congestion and demand for public services are also mentioned. However, the economic benefits of foreign labour cannot be denied. Their easy availability enables the smooth functioning of the labour market without excessive wage escalation. To prevent their cheap wage from pulling down the wage of local workers, the government has introduced a monthly levy for bringing in foreign workers. The current level is about $330 per worker per month for the manufacturing sector. How to manage a growing pool of foreign workers in a compact society like Singapore is an important concern. By all standards, Singapore has managed the present large pool of workers very well. Adequately housed and cared for, the workers generally do not pose any particular welfare or security problems.

4. Population Structure

Singapore's population structure has grown older over the last three decades. In 1970, the median age was only 19.7 years. It increased to 32.2 years in 1996 and is now projected to increase to 40 years in 2030. The percentage of people aged 60 and above has risen corresponding. Now, this group accounts for 10% of the total population, rising steadily from the 5.7% registered in 1970. The share of

the elderly is expected to rise to about 25% in 2030 (Table 6). The elderly population has also grown in absolute size. From 1980 to 1996, the elderly population has grown by an annual growth rate of 3.7%. Table 6 also shows the decline in the youth population, as the population structure becomes top-heavy.

Table 6: Population Ageing Indicators

		1970	1980	1990	1996	2030
Age 60 & Over	(%)	5.7	7.5	9.1	10.0	24.8
Average Annual Growth Rate	(%)	. .	. .	3.8	3.6	3.8
% of Population						
Aged Less Than 15		39.1	27.6	23.2	22.8	17.7
Aged 15 - 59		55.1	64.9	67.7	67.2	57.5
Aged 60 - 74		4.9	6.1	6.9	7.5	18.1
Aged 75 & Over		0.8	1.3	2.2	2.6	6.7
Median Age	(Years)	19.7	24.4	29.8	32.2	40.5
Old-Age Dependency Ratio	(Per 100)	10.3	11.5	13.5	14.9	43.1
Child Dependency Ratio	(Per 100)	69.9	42.6	34.2	34.0	30.7

The rapid increase in the elderly population relative to the younger cohorts will cause a surge in the old age dependency ratio. In 1970, there were 10 elderly persons for every 100 working adults. This ratio increased to 15 in 1996, and is expected to triple by 2030. Correspondingly, the child dependency ratio has declined by half from 69.9 in 1970 to 34 in 1996. Projections show that it is likely to drop to 31 per 100 in 2030.

Policies to deal with the increase in vulnerable groups because of shifts in age structure are concentrated mostly on the elderly. The policies are multi-faceted and comprehensive. The key policies are briefly mentioned below :

(1) Income Security

The Central Provident Fund (CPF) was established in 1955 to provide for workers' financial security after retirement. At present, the employee contributes 20% of his salary to the CPF, and the employer contributes another 20%. The government guarantees the savings and a modest interest is added to the principal sum every year. Upon age 55, the account holder will be able to withdraw the bulk of his savings, except for a minimum sum to provide for his remaining years. This minimum sum is to prevent an elderly person from squandering his savings and becoming a burden to the state. The minimum sum is set at an initial amount of S$50,000 which will be increased by S$5,000 annually to S$80,000 in 2003.

In 1996, the CPF has some 2.7 million contributors, and a total deposit of S$73 billion. The number of withdrawals in 1996 was 121,422, amounting to a total of S$1.6 billion. For the same year, the interest rate for the deposits was 3.48%.

(2) Retirement Age

With longer life expectancy and labour shortages, the elderly are encouraged to stay in the workforce for as long as possible. The government will raise the retirement age to 62 by 1999 and review it regularly. The retirement age is expected to rise to 67 in the near future. To encourage employers to retain their older workers, the CPF contributions by employers for older workers are much lower. For workers aged 55 to 65, the employers' contribution rate is only 7.5%, as compared with 20% for the younger workers. For workers above 65, the contribution rate is only 5%.

(3) Housing

A host of policies have been introduced to promote greater co-residence among the generations. The government's housing policy for the elderly is premised on the fact that the elderly should be encouraged to lead an independent life, through the assistance of their families, for as long as possible. Retirement homes are viewed as the last resort, and institutional care is not encouraged. The latest policy to promote independent living includes building specially designed studio flats for the elderly and locating such flats near residential estates. Priority allocation will be granted to those elderly with children living in those estates.

5. Women Issues

Women have an advantageous position in Singapore compared with many developing countries, being in an egalitarian society where men and women enjoy equal social status. Since 1961, the enactment of the Women's Charter has assured women of their rights in marriage and provided them with due protection. There are no discriminatory policies or practices that restrict the women in achieving their full potential in economic and social activities. There are therefore no critical issues for women here, whether in terms of access to education, employment, health or family planning.

(1) Education and Employment

In Singapore, women have enjoyed equal opportunities in education and employment for the last three decades. Among the younger generation below 40 years, 70.6% of women had at least a secondary qualification, compared with 67.8% of the men. The women have made dramatic progress in polytechnic and university enrolment, narrowing the gap with men. With their improving educational profile, the literacy rate of the women has improved and more women are now participating in the labour force. The labour force participation rate increased for women from 46% in 1986 to 52% in 1996.

Table 7: Key Indicators on Women

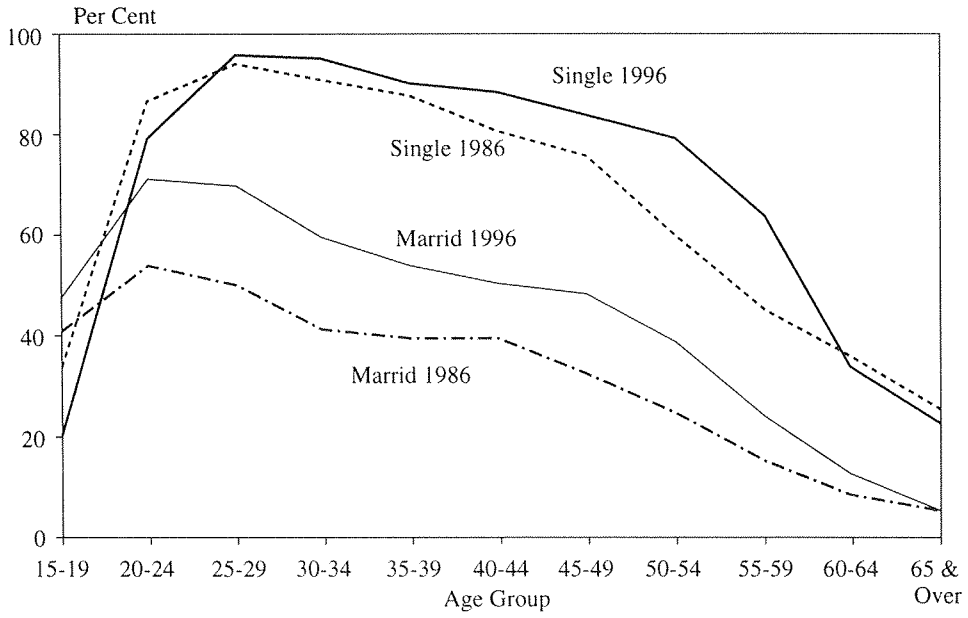
Year	Literacy Rate[1]		Enrolment Ratio [2]				Working Persons		Labour Force Participation Rate	
			Participation		University					
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
	Per Cent						Per Cent of Total		Per Cent	
1986	93.6	78.9	12.9	5.2	7.6	6.7	62.6	37.4	79.4	45.6
1990	95.1	83.0	17.0	9.6	11.4	10.6	59.6	40.4	78.3	53.0
1996	96.4	87.8	27.9	20.8	19.2	16.7	58.6	41.4	78.7	51.5

1 Refer to residents aged 15 years and over.

2 Defined as students divided by residents aged 18-22 years.

The increased female labour force participation has been a major contributory factor for the continuing trend of below-replacement fertility. Among married women, the rate has risen significantly in the prime child-bearing ages 20-44 during the last ten years (Figure 5). That many women are able to remain in the workforce even after the onset of child-bearing is due to Singapore's labour market policy and childcare programmes. These include the legislative provision on paid maternity leave, payment of child care subsidy by the government, and easy availability of creches and child care centres.

Figure 5: Age-Specific Labour Force Participation Rates Among Women



(2) Health and Family Planning

Good primary health care is readily available to women in Singapore. Such primary health care focus on prevention of ill health through immunization and early detection and treatment, and provides affordable outpatient medical care. Within the government health system, the Family Health Service provides comprehensive and cost-effective primary health care to women and their children. This is carried out through a network of 14 polyclinics, 4 outpatient dispensaries and 2 maternal & child health clinics.

Almost half of the attendances of women at the maternal & child health clinics are for family planning reasons and one-fifth is for antenatal visits. The remaining attendances are part of the 'well women' clinic programme, whereby cervical and breast cancer screening are carried out. Most of the attendances of infants and pre-school children are mainly for immunization and health development and screening.

Table 8: Maternal and Child Health Attendances

		1980	1990	1996
Attendances by Women	(No.)	389,656	210,582	115,895
of which :	(%)			
Family Planning		66.5	48.4	45.9
Antenatal		27.4	16.9	19.9
Well Women Clinic		..	18.2	25.8
Others*		6.1	16.6	8.5
Attendances by Children	(No.)	635,695	581,283	515,876
of which :	(%)			
Immunization		32.0	41.6	41.0
Health & Development Screening		24.7	24.4	33.9
Sick		43.3	34.0	25.2

* Includes postnatal care, immunization and breast examination.

Since 1969, induced abortion has been legalized in Singapore to complement the convention contraceptive methods, in line with the policy on population control and family planning. In addition, voluntary sterilization was also legalized in 1969 as a complement to family planning for women who had completed family formation. With the introduction of the New Population Policy in 1987 to encourage Singaporeans to have three or more children, legalized abortion and sterilization have been reviewed. There is now compulsory pre- and post-abortion counseling for women with less than three children as well as pre-sterilization counseling for those with less than two living children.

Chapter VIII

Population Policy in Thailand: Progress and Perspectives

Population Policy in Thailand: Progress and Perspectives

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I. Introduction

Over the past three decades and due to progmatic industrial and export-oriented development policies, Thailand has made impressive gains in both economic and social development. Despite this progress, however, Thailand's development is at a critical juncture; certain national development challenges persist, while rapid social changes related to industrialization have led to the emergence of new ones. For instance, the Thai government recognizes that the daily activities of all individuals, communities and countries are inter-related with population change, patterns and levels of environmental use, as well as the pace and quality of economic and social development. Yet, there is also general agreement that unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and environmental degradation as well as the reinforcement of social inequities and poverty.

The nation's economy is also becoming increasingly internationalized, requiring constant upgrading of the nation and its population production capacity in order to stay competitive within the international arena. Consequently, to increase the people's role in determining and bringing about growth and social developemnt, the government fully realizes the vitalness of raising their capabilities and developing human potential in the fullest harmony with the rapid changing environment. Moreover, since human resource development is a leading priority for national growth, it is inter-related with other aspects of socio-economic development, some of which are determinants of successful development while others represent positive and negative ramifications of the development process.

Over the years, the wide ranging vision of process in the Thai government has brought to the population development process, a new understanding of the fundamental issues and problems facing the nations as it strives to attain the industrialized status. All, moreover, have worked especially diligently at establishing and strengthening mechanisms within government and in Thai society to reach lasting sustainable development solutions.

Thailand performance on the population policy front has been highly satisfactory. The rate of population growth had declined significantly together with declines in mortality rates, and much improvement in basic health indicators. One of the most enduring and significant contributions made for the success on the population front by the Thai government, is in its ongoing role in strengthening the

National Family Planning Programme (NFPP). At present, it is a dynamic programme for change aim not only at family planning but also at reproductive health improvement, gender, environment and other development issues in a holistic manner (Heyn, 1991).

II. Population Policy : Achievements and Challanges

This part of paper gives an overview of demographic changes, basic concept and the history of population policy in Thailand. Achievements and challenges will be discussed.

1. Current Population Situation

Thailand's fertility has fallen from average completed family size to 6.6 per couple in 1960 to roughly 3.0 in 1985, a reduction of over 50 percent in one generation (Knodel 1978; Robinson and Rachapaetayakom, 1988). The decline in fertility occurred everywhere in Thailand. It had begun firstly in urban areas and then pervaded into the rural areas. However, regional disparities still persisted. The total fertility rate (TFR) the average number of childbirths during women's life time, has declined from 6.3 in 1964-65 to about 2.6 in 1985-90. It is estimated that the TFR will continue to decline at the replacement level during 1995-2000.

According to the preliminary 1990 Census Report, the nation's population size has increased to 54.5 million. The Northeast region, which is the largest area of the country, accounted for about 35 percent of the total population; the Central region, 33 percent; the North, 19 percent; and the South, 13 percent. The country's population growth rate decreased to 1.4 percent by 1991. The Seventh National Economic and Social Development Plan (1992-1996) targeted at reducing the population growth rate further to 1.2 percent by the end of the plan. In 1997, Thailand's populaiton size has reached 60.6 million with 30.4 million for men and 30.2 million for women. As mentioned, Thailand's drastic decline in fertility continues and the TFR will be at the replacement level very soon, the population growth rate will not be emphasized in the Eighth Plan (1997-01). Target related to population context in the present Plan are that Thai families will have an appropriat size and the population will be geographically distributed in concerted with the development potential and opportunities available (NESDB, 1996).

The Survey of Population Change Report in 1991 indicates that the TFR dropped from about 2.4 in 1989 to 2.2 in 1991. However, a fertility differential clearly exists between regions. While the fertility rate of women in the Northern and Central regions as well as the Bangkok Metropolitan Area (BMA) in 1991 was below replacement level, those of the Northeast, the South and among minority groups were still high, between 2.7 and 2.9.

In addition, mortality levels are quite low due to vast improvement in public health and education. By 1997, the crude death rate was at 5.0 per 1,000 population, while the infant mortality rate was 25.0 per 1,000 live births. A decrease in the mortality rate, was reflected an increase in life expectancy: It is estimated that the expectation of life at birth will be 66.6 years for males and 71.7 years for females by 1997 (Table 1).

Table 1: Population in Thailand, 1997

1) Total Population (,000)	60,440
Male	30,202
Female	30,238
2) Urban Population (,000)	19,087
3) Rural Population (,000)	41,353
4) Regional Population (,000)	
North	12,141
Northeast	19,678
South	7,566
Contral (Exclude BMA)	13,112
BMA	7,943
5) Age Structure (,000)	
0 - 14	16,288
15 - 59	39,073
60 +	5,079
Women 15 - 44	15,558
6) Crude Birth Rate (per thousand)	15.6
7) Crode Death Rate (per thousand)	5.0
8) Infant Mortality Rate (per thousand live births)	25.0
9) Expectation of Life at Birth (years)	
Male	66.6
Female	71.7
10) Total Fertility Rate (average number of live births over a women's life)	1.98
11) Contraception Pre valence Rate (per 100 married women)	72.2
12) Population in 2020 (,000)	70,503

Source : 1. IPSR, "Mahidol Population Gazette", No.1, July 1997. (1-11).
2. Human Resource Planning Division, NESDB, *Thailand Population Projection During the Eighth Plan (1997-2001).*

For population distribution, Thailand is still largely rural but this has been changing rapidly in the last several decades and will continue to in the future. Regional differences in net growth also seem likely to persist due to migration. But the effect of these differences will be positive since they should help eliminate some of the most striking economic disparities presently found among regions.

The urban population also grew at about 3.5 percent annually during 1975-1984. This was due mainly to internal migraion from the rural areas to the BMA where residents suffer severe shortages of public utilities, facilities and housing, increases in unemployment, crime, environmental deterioration and pollution. The urban population was estimated to be about 19.1 million or 32 percent of the population in 1997, and is expected to increase to about 25 million or 39 percent in 2000 and one half of them are living in the BMA. Consequently, the BMA has become the primate city of the country

(Rachapaetayakom, 1997).

It is expected that the basic demographic trends displayed in the last twenty years will continue in the near future. Mortality will continue to fall and by the year 2001 will approach the levels of developed nations. Fertility will also continue to fall although the rate of decline is less certain. Migration in or out of the country is not expected to play a major role. 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. By the year 2010, Thailand will be facing an urban-dominated population situation.

The official projection for Thailand during 1990-2020 based on the medium ferfility assumption, which is thought to be the most likely phenomenon, is that the population, which numbers around 60.6 million in 1997, will increase to 67.2 million by the year 2010 and increase to 70.5 million by the year 2020. The projection by age distribution indicates that 30.6 percent will be in the 0-14 age cohort in 1990 which will reduce to 25.6 percent in 2000. The population in the 60+ age cohort, however, will increase from 7.2 percent in 1990 to about 9.2 percent by 2000. Regional fertility differentials will continue to exist with the highest fertility being in the South. The urban population is estimated to increase to be about 25 million or 39 percent to total population in 2000. Estimates of population and selected demographic rates during 1990-2020 are shown in Table 2.

Table 2: Number of Population and Selected Rates 1990-2020

Year	Total Population (million)	Natural Increase (%)	Total Fertility Rates	Net Reproduction Rates	CBR	CDR	IMR
1990	55.84	1.34	2.26	1.05	20.26	6.82	30.08
1995	59.40	1.08	2.07	0.96	18.36	7.52	32.04
2000	62.41	0.88	1.93	0.89	16.76	7.92	29.17
2005	65.03	0.72	1.85	0.86	15.48	8.24	26.64
2010	67.23	0.59	1.81	0.85	14.40	8.52	24.41
2015	69.08	0.46	1.78	0.84	13.52	8.90	22.41
2020	70.50	0.33	1.76	0.83	12.72	9.40	20.50

Remarks : 1. CBR and CDR rates per thousand population.
2. IMR rate per thousand live births.

Source : Human Resource Planning Division, Population Projection for Thailand, 1990 - 2020.

The results of these projections suggest a need of more concern about specific groups and ares-based strategies, in particular sub-target groups and a regional approach to successfully reduce the population growth rate. There is also a need to increase the availability of contraceptive devices and to analyze various socio-economic variables that can act as an incentive for population control by affecting the demand for children. Table 3 shows selected social indicators which are related to population and development in Thailand. Relying on family planning alone to deal with these target groups may not achieve ambitious national goals.

Table 3: Selected social indicators for 1978, 1982, 1987, 1991 and 1994

Indicators	1978[1]	1982[1]	1987[2]	1991[2]	1994
Population					
birth rate per 1,000	24.6	22.7	16.1	16.9	16.5
death rate per 1,000	5.2	4.7	4.2	4.9	4.2
Health					
maternal death rate per 1,000	1.2	0.7	0.4	0.2	0.0*
Education					
% students in primary school	93.3	99.2	94.7	100.4	94.03
% students completing higher than compulsory education	8.8	11.4	16.5	18.6	22.8
% illiterate	11.9	9.6	8.1	7.4	6.3
Socio-economic					
Per capita GDP	10,571 (US$423)	16,824 (S673)	24,332 (S973)	44,307 (S1764)	61,909 (S2064)
Employment					
Labour force (million)	22.9	26.3	29.6	32.1	32.5
% opened unemployment	0.58	1.20	5.86	0.48	0.43
% in agriculture	73.7	68.4	64.4	60.3	56.0

Remark : * Less than 0.1

Sources : 1 Social Indicators in 10 years and Social Indicators : 1987, National Economic and Social Development Board (NESDB)

2 Social Indicators 1991, NESDB

2. Basic Concept of Population Policy

During the first half of the present century, Thailand's official stance on population was undustandably pro-natal. The populaiton at the beginning of the century was around 8 million and was growing slowly owing to high death rates. In the context of the need to develop and defend the country, the population was considered to be inadequate. In late 1942, when Thailand's population was estimated at about 18 million, the Prime Minister at the inauguration of the Ministry of Public Health declared that the country's population was not sufficient to achieve national greatness and that *at least a 100 million people were needed to make the country a real power.* During the Second World War, the Minister of

Public Health appointed a Wedding Promotion Committee to encourage an increase early marriages. The slogan was "Get married young and make the nation prosper" (Suwannavej, 1976).

During the 1947-1960 intercensal period, the average annual growth rate 3.2 percent was one of the highest in the world. The World Bank report in 1959 pointed out that Thailand's rapid increasing population was creating "many alarming problems, such as a shortage of schools and public services as well as a shortage of living accommodation" (IBRD, 1959). In 1961, the Cabinet made the dicision that birth control should be a matter of voluntary action on the part of the people, who should be aware of their own status and how many children they should have (Rachapaetayakom,1997:9). During 1963-1968, three national seminars on population policy issues were held, each of which submitted recommendations to the Government and warned for the dangers of a very rapidly growing population and urged the wider adoption of birth control practices. In 1969, the Cabinet requested the National Economic and Social Development Board, the Ministry of Public Health and the Institute of Population Studies to submit policy recommendations to the Cabinet concerning basic concept policy for suitable measures to be taken regarding population growth. A comprehensive report with basic concept on policy was prepared and *pointed out on the difficulities cause by a high rate of population growth to the nation's socio-economic development efforts and strongly recommended the adoption of a population policy.*

In March 1970, the Cabinet declared that "the Thai Government has the policy to support voluntary family planning in order to resolve various problems concerned with very high rate of population growth which constitutes an important obstacle to the economic and social development of the nation" (NESDB, 1972).

3. Population Pocicies : Evoluation and Current Status

As mentioned, the first policy to reduce the national population growth was officially adopted in March, 1970 with population programmes being subsequently included in the Third National Economic and Social Development Plan (1972-1976). The realization that rapid population growth was a major impediment to development made it a key target area for national population planning in Thailand. Consequently, since the early 1970s all development plans have specified target rates for population growth to be attained by each plan completion.

The Third Plan called for the creation of a National Family Planning Project (NFPP) in the Ministry of Public Health (MOPH) to provide contraceptive services to the populace and to promote the use thereof (Robinson and Rachapaetayakom, 1988 : 13). The Plan also called for cooperation with this MOPH programme by all other Ministries and assigned a cooperative role for the already existing private sector activities in the field. The Plan target was to reduce the population growth rate from over 3.0 percent per year by the end of the Plan. The implementations were satisfied and reached the target.

The Fourth Plan (1977-1981) was undertaken when it was already clear that the earlier efforts to curb population growth had begun to bear fruit. It called for a reduction in the population growth rate from 2.5 to 2.1, and the implementations were successful. The Fouth Plan came out more strongly than ever for policies aimed at showing the rapid rate of rural to urban migration and called for promoting

industrial growth outside Bangkok for improving infrastructure in the rural areas.

Since the Fifth Plan (1982-1986) to the Seventh Plan (1992-1996), the government has continuously set a policy to further reduce the population growth rate from 2.1 percent in 1981 to 1.5 percent in 1986, 1.3 percent in 1991 and 1.2 percent in 1996 (see next page). The emphasis has been on remote and underdeveloped areas, the South and the Northeast, and among population groups that pose problems and need accelerated development, namely those in slum areas, urban-rural poor, the hilltribes, and the Thai muslims. The present Eighth Plan does not set the target of population growth rate but emphasizes on the appropriate family size, instead. It is desirable that Thailand have a population of appropriate size and structure, distributes evenly in accordance with the development potential and availability of opportunities in the various regions of the nation (NESDB, 1996 : 49).

Family Planning Targets and Implementations

National Development Plan	Targets	Implementations
Third Plan (1972-1976)	2.5	2.5
Fourth Plan (1977-1981)	2.1	2.1
Fifth Plan (1982-1986)	1.5	1.7
Sixth Plan (1987-1991)	1.3	1.4
Seventh Plan (1992-1996)	1.2	1.2
Eight Plan (1997-2001)	appropriate family size	-na-

Source : NESDB, National Economic and Social Development Plans : 1971, 1976. 1981, 1986, 1991 and 1996

III. Specific Issues of Population Policy

A key part of Thailand's success in population and development is the multi-sectoral component approach. It has taken in planning and implementing policies, plans and programmes aimed at rectifying the nation's most urgent problems. This part of the paper will describe population components and immediate target areas that the government is now embracing using this multi-sectoral component approach.

1. Fertility and Contraceptive Prevalence

Thailand's reproductive revolution has accomparried an economic revolution. This and the other trends of modernization have transformed Thai society so much that within one or two generations parents' attitudes toward childbearing and childrearing have changed almost completely, from desiring a high quantity of children to desiring a high quality of children. As Thailand's drastic decline in fertility continues, *the total fertility rate is projected to fall below the replacement level in the near future* (Wongboonsin et al., 1993:1).

Many characteristics of Thailand's fertility transition are unique, mainly because of unique

aspects of Thai culture and because the government has taken an active role in promoting a fertility dicline. These unique aspects make the Thai fertility situation an interesting subject for demographic studies. The success of Thailand's population programme has been mainly due to popular demand and to a clear recognition of the problem that rapid population growth poses a great hindrance to the country's development. The decline in fertility is primarily attribute to reduce reproductive rates among married couples, with a rising age at marriage contributing to the change. A decline in fertility was accompanied by a massive increase in the practice of modern methods of birth control.

(1) Pattern of Fertility

Fertility has fallen from an average completed family size of 6.6 per couple in 1960 to roughly 2.4 in 1990. It is estimated that total fertility rates will be approximately 1.9 during 2000-2005 (Table 4). During 1960s, the populaiton growth rate was the highest, reaching 3.0 to 3.3 percent. In 1970, after the Government launched the National Population Policy, it decreased to about 1.5 in 1991 (Robinson and Rachapaetayakom, 1988:7). The Seventh Plan called for reducing the population growth rate further to 1.2 percent by the Plan's end, a rate which is reported to be already achieved. The Eighth Plan, which set human resource development as the leading development issue, states the appropriate size of family for the demographic target.

The age-specific fertility rates at national level is shown in Table 5. The decline in fertility occur among married women 15-49 age groups. during 1990-95 to 2005-20 periods but not for women in age groups 40-44 and 45-49 which their fertility remain the same for 2010-15 and 2015-20 periods. Total fertility rates are estimated to be below replacement level after 1990-1995. The population's fertility rate has constantly declined with some remaining problem in selected areas. Regional rates of fertility are differ from region to region with the highest for the South and the lowest for the Bangkok Metropolition Area (BMA). The fertility rates remain high, particularly in the Northeast, the South, among some hilltribes and Thai nationals of distinctive cultures who are in the low-income groups. Several studies indicate that the high fertility in the South might be due to the high reproduction pattern of the Southern Thai Muslim. Fertility of the Southern Thai Muslims remains high and contraceptive prevalence rate is low.

Table 4: Total Fertility Rate (TFR) from Selected Sources

Periods	TFR
1960 (Census) [1]	6.63
1964-65 (SPC1) [2]	6.25
1970 (Census) [1]	6.09
1970-74 (SOFT) [2]	5.09
1974-76 (SPC2) [2]	4.90
1978-79 (CPS1) [3]	3.77
1980 (Census) [1]	3.84
1981 (CPS2) [4]	3.68[a]
1984 (CPS3) [4]	3.47[a] 3.36[b] 3.33[c]
1980-85 [5]	3.46[d] 3.61[c]
1985-90 [5]	2.84[d] 2.93[c]
1990-95 [6]	2.81[d]
1995-2000 [6]	2.00[d]
2000-2005 [6]	1.89[d]

Notes : a TFR based on Preceding 12 months
b TFR based on Preceding 24 months
c TFR Calculated from past trend
d TFR from past trend adjusted by NESDB Working Group on Population Projection, 1985.

Sources : 1 National Statistical Office, 1960, 1970, 1980 Census of Population and Housing : Whole Kingdom.
2 National Statistical Office, the Survey of Population Change 1964/65 and the Survey of Population Change 1974-76.
3 Titaya Suvansjate and Peerasit Kamnuansilpa, Thailand Contraceptive Prevelence Survey : Country Report 1979, National Institute of Development Information, Bangkok 1980, Table 3.4, p.20.
4 Institute for Population and Social Research, Mahidol University, Research Center, National Institute of Development Administration and National Family Planning and Ministry of Public Health. Third Contraceptive Prevalence Survey : Summary Report, Bangkok, Table 6, p.24
5 NESDB, Working Group on Population Projections, Population Projections for Thailand Whole Kingdom 1980-2015.
6 NESDB, Population Projection for Thailand 1990-2020, Bangkok 1995 : Table 1, p.6

Table 5: Estimates of Fertility at National Level : 1990 - 2020 (Medium Level)

Age Group	1990-95	1995-00	2000-05	2005-10	2010-15	2015-20
15-19	0.0620	0.0592	0.0572	0.0562	0.0552	0.0545
20-24	0.1403	0.1315	0.1285	0.1262	0.1251	0.1248
25-29	0.1135	0.1025	0.0971	0.0952	0.0941	0.0928
30-34	0.0663	0.0576	0.0522	0.0487	0.0472	0.0457
35-39	0.0350	0.0315	0.0275	0.0245	0.0225	0.0215
40-44	0.0140	0.0115	0.0115	0.0113	0.0112	0.0112
45-49	0.0060	0.0056	0.0045	0.0037	0.0035	0.0035
TFR	2.1855	1.9970	1.8925	1.8288	1.7940	1.7700
%	-	-8.63	-5.23	-3.37	-1.90	-134

Source : Human Resource Planning Division, NESDB, Population Projection for Thailand, 1990-2020 : Bangkok, 1995.

(2) Contraceptive Prevalence

Throughout the last two decades, the National Family Planning Programme (NFPP) has achieved the targets set. The success of the NFPP in recruiting family planning acceptors was due to two main activities implemented by the Ministry of Public Health (MOPH): a) increasing the availability and accessibility of contraceptive supplies and services; and b) increasing demand for contraceptive methods by supplying information, education and communication. To meet the ulimate goal of reducing the growth rate and increasing contraceptive acceptors, the two strategies were launched in a series of activities in each Five Year National Development Plan.

Thailand's contraceptive prevalence rate of 75 percent now surpasses the cumulative averages for developing nations. Unmet need for contraception in Thailand is also very low at less than 5 percent. The current high level of contraceptive use in Thailand is associated with almost universal knowledge and general approval of contraception. Consequently, Thailand's "reproductive revolution" is well documented and known as one of the world's most prominent success stories in population and family planning.

According to the estimates in 1995, there were about 8.8 million married women of reproductive age (MWRA) still living with their spouses which constitutes about 15 percent of total population. Results from Contraceptive Prevalence Surveys conducted by various sources indicated that Thai women of reproductive age have an increased tendency towards contraceptive use from a low contraceptive prevalence rate (CPR) of 14.4 percent in 1970 to 66.2 percent in 1989 and to a much higher rate of 75 percent in 1995. Pills were still be the most favourite method, followed by female sterilization. In 1995, the vasectomy was only 1.9 percent and the norplant was 1.3 percent (Table 6).

Table 6: Married Women Practicing Contraception by Methods in 1989, 1991 and 1995

Methods	1989			1991			1995		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Merried Women (15-44)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Practice	66.2	65.8	66.6	69.3	67.8	69.4	75.2	71.1	76.1
Pill	24.2	24.7	23.7	24.0	25.6	23.7	28.4	31.9	27.5
IUD	4.2	2.8	5.3	4.7	2.7	5.1	3.5	2.0	3.9
Injection	9.3	5.8	12.3	12.3	6.7	13.4	14.3	7.3	15.9
Female Sterilization	22.0	24.5	21.1	22.5	24.2	23.4	23.9	23.0	24.0
Vasectomy	3.4	3.8	3.2	2.8	3.5	2.6	1.9	2.2	1.8
Others	2.5	4.2	1.0	1.9	5.1	1.2	3.2	4.4	3.0
Condom	-	-	-	-	-	-	0.5	1.1	0.4
Norplant	-	-	-	-	-	-	1.3	0.3	1.6
Others	-	-	-	-	-	-	1.4	3.0	1.0
Not Proctice	33.8	34.2	33.4	30.8	32.2	30.6	24.8	28.6	23.9

Remark : Other methods data in 1989 and 1991 did not classify type of methods
Source : National Statistical Office, Population Change Surveys in 1989, 1991 and 1995.

It is clear that the focus on quantitative targets has given successful results in terms of number, but there is very scanty invormation on the quality of services being provided to explain. It is known that there is some shift from one method to another but the reasons are not documented. The service programme is not supported by appropriate research. Discontinuity in the supplies of contraceptive might be a part that leads the providers to advise the use of another method.

Target related to reproductive context in the Eighth Plan is that Thai families will have an appropriate size. The advocacy for an appropriate family size is to adjust the intensity of family planning promotion activities in accordance with the local situation, give priority to increase such activities in areas where fertility remains significantly higher than the target; expedite family planning areas where birth rates remain high, e.g., certain areas of the South and the Northeast; heighten the efficacy of family planning service delivery and encourage gender equality in sharing the responsibility for family planning; to campaign continually and promote public awareness of the benefits of an appropriate famity size; and to promote the private sector involvement in social projects.

2. Mortality

Mortality has historically played an important role in determining population growth in Thailand. The rapid decline in mortality over the past 30 years has led to a high population growth rate with serious consequences. An examination of mortality trends estimated from various sources indicates that the mortality transition in Thailand began around 1950, with a decline in crude death rates from 27 in 1948

to 18 in 1955 (Rachapaetayakom, 1976).

Mortality continued to fall steadily after 1960 although, in more recent years, this decline has started to level off. During the same periods, infant mortalit, one of the most revealing health indicators, declined substantially. Based on direct and indirect measures of infant mortality, the estimated rate in 1992 was 35.5 per thousand live births. The current crude death rate is 5.0 per 1,000 population and the life expectancy at birth for males and females in 1997 are 67 years and 72 years respectively. From 1980 to 1997 male and female life expectancy increased by about 4 years. Socio-economic, regional and rural/urban differentials in mortality remain, however, Important differentials can also be found for education, occupation, housing characteristics, and environmental factors. Mortality assumption of the country is shown in Table 7.

Table 7: Mortality Assumption at National : 1990-2020

Life Expectancy	1990-95	1995-00	2000-05	2005-10	2010-15	2015-20
Life Expectancy at Birth						
Male	66.48	67.36	68.15	68.86	69.50	70.07
Female	71.04	71.74	72.39	73.00	75.58	74.11
Change in 5 years						
Male	-	0.88	0.79	0.71	0.64	0.57
Female	-	0.70	0.65	0.61	0.58	0.53
Sex Difference						
Female-Male	4.56	4.38	4.24	4.14	4.08	4.04

Source : Human Resource Planning Division, NESDB,
Population Projection for Thailand, 1990-2020 : Bankok : 1995

Results from several studies which have investigated sources of death reveal changes in the leading causes of deaths in Thailand since the 1970s. 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 under five year old population groups. Regional differences in causes of death among the general population are correlated with the degree of social and health development of each region. *A new factor in mortality patterns is the growth in the AIDS epidemic.* Based on the summary report of AIDS situation as of January 1997, there were 55,443 AIDS cases in Thailand. About one half of these were found in te Upper North. The Human Resources Planning Division of the NESDB (1995) has estimated the regional life expectancy at birth and found regional differences due to the level of socio-economic development of each region. Men and Women in BMA have longer life than men and women in other regions. During 1995-2000, BMA's men and women could live, on the average, till 73.1 and 77.5 years respectively (Table 8). As indicated, a new factor in mortality is the AIDS epedimic and the estimates of AIDS deaths is shown in

Table 9. Men and women in the North are facing with serious AIDS problem and the highest AIDS deaths is occured in this region (Table 10).

Table 8: Estimates of Mortality by Region 1990 - 2010

Region	Life Expectancy at Birth			
	1991-95	1995-00	2000-05	2005-10
BMA				
Female	76.68	77.48	77.98	78.24
Male	72.07	73.07	73.57	74.02
Vicinity Provinces				
Female	76.02	76.96	77.66	77.89
Male	70.59	71.59	72.57	73.48
Sub-Central				
Female	76.06	76.86	77.41	77.71
Male	70.68	71.68	72.43	72.93
East				
Female	73.57	74.87	75.91	76.79
Male	69.06	70.63	71.68	72.73
West				
Female	73.67	74.98	76.02	76.91
Male	69.06	70.52	71.57	72.61
North				
Female	68.93	70.16	71.23	72.27
Male	64.19	65.65	66.83	67.95
Northeast				
Female	67.10	68.29	69.24	70.16
Male	62.53	63.95	65.10	66.15
South				
Female	69.15	70.73	71.56	72.29
Male	64.41	65.88	66.96	68.03

Source : Human Resource Planning Division, Population Projections for Thailand 1990-2020, NESDB 1995, T.5.

Table 9: AIDS Deaths Assumption at National Level, 1991 - 2020 (Medium Intervention)

	1991-95	1996-00	2001-05	2006-10	2011-15	2016-20
Female	28,946	105,298	131,476	133,531	103,829	74,453
Male	86,866	206,085	180,369	176,861	100,872	84,969
Total	115,812	311,383	311,845	310,392	204,698	159,422

Source : The NESDB Working Group, "Projections for HIV/AIDS in Thailand : 1987-2020", November 1994.

Table 10: AID Deaths Assumption by Region 1991-2010

Region	Life Expectancy at Birth			
	1991-95	1996-00	2001-05	2006-10
BMA				
Female	1289	4919	6304	6784
Male	7149	20448	21241	23492
Vicinity Provinces				
Female	614	1304	1173	1080
Male	3249	7596	6642	6616
Sub-Central				
Female	379	1712	2684	3932
Male	2195	5245	4474	4466
East				
Female	1688	8183	11384	10967
Male	6043	14434	12281	10931
West				
Female	1246	4587	6218	6235
Male	4683	10535	8751	83085
North				
Female	19819	69358	82944	80850
Male	49726	116975	101541	98412
Northeast				
Female	2488	8634	10290	9390
Male	9562	20548	16745	17001
South				
Female	1423	6602	10478	14293
Male	4210	10303	8693	7558

Source : The NESDB Working Group, "Projections for HIV/AIDS in Thailand: 1987-2020", November 1994..

(1) Meternal and Infant Mortality

Thailand's maternal mortality rate (MMR) over the last 20 years has declined eleven-fold. Better coverage of care and increases in deliveries by medical personnel have contributed to the decline. Causes of MMR show a similar pattern to that of the developing nations where most maternal deaths are related to pregnancy, working and postpartum periods. The 1993 statistics of the MOPH revealed that

the majority of deaths directly resulted from obsterical causes. Most maternal deaths occurred among women aged 20-34 years (Vuthipongse, 1996). For infant mortality, the rates have also declined from 84.3 infant deaths per 1,000 live births in 1960 to 28.0 and 25.0 in 1994 and 1997 respectively. The major cause of deaths was certain conditions originating in the perinatal period and other causes included congenital anomalies and diseases of reproductive system.

The national health policy of the country is based on ensuring the quality of life of the population, with both physical and mental health policies directed towards the attainment of the long term goal of HFA/2000. These targets are to be achieved through a basic minimum needs approach and under the principle of social justice and self-reliance of the individual, family and community.

The government also took on a target-specific approach where specific poverty-stricken districts were identified, and then needed services and resources were funneled to them. Social programmes were introduced into these areas such as primary health care, nutrition development, clean water supplies, and community hospital construction. A special government budget was allocated to this programme of rural development, with coordinating efforts among the four main ministries (Health, Education, Agriculture and Interior).

To ensure that the Thai population's quality of life and health (both physical and mental) is continually developed in order to attain the global goal of HFA/2000, the Seventh National HealthDevelopment Plan (1992-1996) was based on coverage and quality, integrated development, relevancy to local needs, and self-reliance.

The main targets of the Seventh Five-Year Health Development Plan (1992-1996) were : 1) reduce the infant mortality rate to 23 per 1,000 live birth; 2) reduce the maternal mortality rate to 0.3 per 1,000 live births; and 3) reduce the mortality rate of children aged below 5 years to 35 per 1,000 live births.

(2) HIV/AIDS Infected

AIDS is a disease plaguing all countries of the world at no matter what stage of development or technological advancement. Like many other nations the HIV/AIDS situation in Thailand is an extremely complicated and well-publicized issue. Fortunately though, according to leading international AIDS organizations, Thailand has one of the most aggressive HIV prevention programmes in the world. The Prime Minister, for example, chairs the National AIDS Committee, the government provides ten millions of dollars each year for prevention communication, an array of international donors provide direct resource transfers for HIV prevention, 45 NGOs have programmes on AIDS prevention and care. After the first AIDS case was reported in 1984, the nation was quick to set up Thailand's National AIDS Committee in 1985.

Based on the summary report AIDS situation as in 1997, toward the end of 1995, there were 750,000 HIV infected cases which will gradually fall sick of HIV related symptoms. Existing government hospitals are obliged to cater for increasing number of the AIDS cases and symptomatic HIV infected cases. This situation has a tendency to occur in the Central of Thailand in the near and further

experiences in other regions of the country.

First National AIDS Prevention Plan (1992-1996) : The Cabinet approved the launching of Thailand's AIDS Prevention and Control Programme (1988-1991), as developed and proposed by the Ministry of Public Health in 1987, and the following year the World Health Organization and the Ministry formulated a "Short Term Programme" with an initial funding of US.$500.000. The "Medium Term Programme" for the Prevention and Control of AIDS began in 1989. The programme, implemented and directed by the Ministry of Public Health, was a three-year plan with detailed work plans developed annually. It contained many activities in programme management, health education, counselling, training, surveillance, monitoring, medical and social care, laboratory and blood safety initiatives. The National AIDS Committee assigned by the NESDB drafted the "National AIDS Prevention Plan (1992-1996)" which was approved by the Cabinet in September 1992 (Rachapaetayakom, 1997).

Second National Plan for Prevention and Alleviation of the HIV/AIDS Problems : In prevention and alleviation of AIDS problems during the period 1997-2001, the underlying concept and approaches have been reoriented in pursuant of the changing conditions of the disease as well as the socio-economic and cultural changes which followed the advent of globalization. To ensure full success in solving the problem, it is envisaged that the concept and approaches should pinpoint the followings : 1) focus on human development so that each individual has potential in preventing AIDS and other social problems, and in solving their own problems; 2) focus on enabling environment of the individual to be conducive to AIDS prevention and problem alleviation.

The salient features of the Plan appear as follows : *General objectives* are to prevent and reduce the problem of AIDS epidemic and to reduce the impacts brought about by the spread of the diseases. *Strategic objectives* are to generate the social environment which is conducive to the prevention and control of AIDS and to strengthen the potential of the people, the family and the community. The targets are reduction of new cases of HIV infection and reduction of the impacts brought about by the spread of AIDS upon the socio-economic and health statuses of the population.

Development strategies are as follows : 1) strategies for developing the potential of the people, their families and communities. 2) Developing the potential of the society; 3) Developing social psychological measures enabling AIDS patients and HIV infected persons; 4) Developing the basic services inherent in the socio-economic system; 5) Developing health promotion and medical care services; 6) Developing wisdom and related research; 7) Enhancing international cooperation; and 8) Reinventing the managerial process and mechanism for preventing and alleviating the AIDS problems (Rachapaetayakom, 1997 : 40).

3. Population Distribution and Migration

Thailand's population is not evenly distributed. The Central region, excluding Bangkok, is the most densely populated, while the Northeast has the largest number of people, and the South has the least population. Either as a city or a province, Bangkok has the largest population number and it is the most populated area in Thailand. As a city, it is can be classified a mega-city with a population that is 22 times larger than the second largest city of Nonthaburi Municipality. As a province, Bangkok's population is more than twice that of Nakhonratchasima, the second largest province.

(1) Policies Related to Population Distribution

Government policies concerning population distribution were first mentioned in the Third Plan. It dealt with the high rate of in-migration from rural to urban areas which caused problems in the receiving areas such as unemployment, housing, crime, etc. Since then, population distribution policies have been explicitly stated in the Fourth, Fifth and Sixth Plans. These policies were designed to slow down the high population growth of Bangkok due to in-migration. The policies ranged from setting up growth poles in every region in order to absorb labour within the region, developing these growth poles as the centres for economic and social development as well as administrative centres of the regions, promoting satellite cities around Bangkok to absorb labour from other parts of the country, developing the Eastern Seaboard and areas of the South as new development zones, accelerating rural development, discouraging industry or industrial expansion in Bangkok, and providing incentives for industries who locate outside of Bangkok. In total, these policies were successful in reducing Bangkok's population growth rate but the rate of reduction was not large enough to bridge the gap between Bangkok and other areas.

The Seventh Plan does not explicitly state any population distribution programme. However, many population distribution policies are continued from the previous Sixth Plan but under the banner of economic and social development. These policies include developing linkages between the Eastern Seaboard and Bangkok including its peripheral areas, restructuring agricultural production and decentralizing industry and services, and developing growth poles as the centres for economic development and employment of the regions. Certainly even under other programmes, these policies would have a direct impact on population distribution.

Recently, the Government announced a new industrial decentralization scheme of investment promotion zones: Zone 1 (Bangkok), Zone 2 (provinces surrounding Bangkok), and Zone 3 (remaining provinces). These zones encourage industrial development outside Bangkok *by granting higher tax and duty privileges for promoted industrial zones.* Zone 3 is given the highest tax privileges, while Zone 2 receives half of these privileges, and Zone 1 receives none. A recent increase in the number of Zone 3 industrial investment applications to the Office of Board of investment indicates that the country's population distribution will improve in the future.

(2) Internal and International Migration

The role that internal migration plays in undesirable patterns of population distribution is fully recognized by the government. 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, primarity aimed at affecting the location and development of economic activities, have been instituted with the aim of affecting internal migration. All Five-Year National Development Plans, since the Fourth Plan have included polices designed to promote economic growth outside of Bangkok, to discourage the expansion of industry within Bangkok, and to decentralize government services.

These policies, have as a major aim the redirection of migration away from Bangkok to regional centres. By building infrastructure and providing investment incentives to industries that locate in provincial areas, new employment opportunities will be generated and this will reduce the need for the rural population to migrate to Bangkok in search of jobs. There are some indications that these policies are having an effect, with growth rates of regional growth centres exceeding those of Bangkok, although levels of migration to Bangkok remain high (Commitee for ICPD, 1994 : 18).

Many of the government's social and economic policies will have an affect on levels of internal migration. In particular, one of the main objectives of the Seventh Plan is to increase the quality of the population. Human resource development is also associated, in most contexts, with increased geographical mobility. For example, the current policy to increase the transition rate from primary to secondary school from 46 percent to at least 73 percent by the end of the Seventh Plan will create a more mobile labor force and a more highly educated one in search of more suitable work opportunities. The government recognizes the need to support regional development so that the expected higher levels of mobility of the Thai population will not be directed towards Bangkok as in the past.

Policies designed to improve the quality of life of the poor, while not in most cases targeted at migrants, often affect this group because of their geographical concentration. For example, policies aimed at improving living conditions of slum dwellers by increasing access to health and educational services cater to large groups of migrants. However, it is also recognized that many of these services do not reach the large numbers of temporary migrants who spend part of the year living in large cities. For specific services, such as the provision of family planning and AIDS information, some attempts have been made to reach these groups by targeting workplaces in which temporary migrants can be found (Committee for ICPD, 1994 : 18).

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, the need to resettle persons who have encroached on land set aside as national parks, watershed areas or designated forest reserves has been recognized. In the Sixth and Seventh Plans, the adverse environmental consequences of this encroachment are recognized and policies designed to move

people from these areas to other areas where they are provided with land are proposed. Several projects which are designed to provide land to the poor and landless who are currently living in these areas have been initiated. This has resulted in large numbers of the rural population being moved. The main resettlement scheme is currently being reformulated. Table 11 shows the net Inter-Regional Migration Estimate during 1990-2010.

Table 11: Net Inter-Regional Migration Estimate : 1990-2010

Region	1991-95	1996-00	2001-05	2006-10
BMA				
Female	45873	48764	51304	53560
Male	30830	32525	33965	35230
Vicinity Provinces				
Female	26769	27795	29677	31730
Male	22929	23591	25130	26809
Sub-Central				
Female	-6230	-7278	-7572	-7952
Male	-4623	-5528	-5665	-5884
East				
Female	1316	3012	3334	3584
Male	3192	4966	5344	5637
West				
Female	-3215	-3647	-3844	-4085
Male	-2041	-2327	-2386	-2496
North				
Female	-10416	-11927	-12910	-13856
Male	-5148	-6193	-6726	-7255
Northeast				
Female	-45259	-47479	-49390	-51218
Male	-38460	-40290	-41850	-43341
South				
Female	-8837	-9240	-10599	-117763
Male	-6679	-6745	-7811	-8702

Source : TDRI/NESDB/UNFPA, Working Paper No.4, November 1994.

International migration from Thailand not regulated and hence data concerning the international movement of Thais is difficult to obtain. Most persons who leave do so on the basis of short-term contracts for employment in foreign countries. There are also large flows of illegal migration, especially to countries in East Asia and neighboring countries. The government recognizes the benefits at macro and micro levels of the legal international employment of Thai labor and has initiated a number of policies designed to encourage the extent and direction of movement, to protect the interests of workers both before and during migration, and to assist in the reintegration of workers upon their return. The

benefits from migration include foreign exchange remittances by workers, the learning of new skills by workers overseas, and reductions of pressures on the local labour market. The specific policies adopted by the government include implementation of bilateral negotiations between Thailand and other countries in order to encourage the use of Thai labour. Since the Sixth Plan, the policy has been to diversify the markets for Thai labor from the Middle East to other regions. Recent negotiations have concentrated on improving access to East Asian labour markets. Efforts have also been made to improve monitoring systems of workers in foreign countries so that problems can be quickly responded to and information on changes in labour market demands can be communicated effectively to Thai workers. The government has also attempted to set minimum conditions for employment, including wage levels and benefits, so that Thai workers will be protected. Skilled labour is to be tested and the level of skills certified. Policies for the establishment of registrars of skilled labour have been adopted. The aim of this policy is to ensure that receiving countries are aware of the availability of skilled labour in Thailand and can be sure that the labour that is provided meets acceptable standards.

Another area of governmental concern is the protection of workers' interests before they leave Thailand. The government has an active policy of reducing the recruitment costs that workers have to pay agencies. These costs are fixed by law, and policies have been implemented to help workers obtain the money to meet the costs. Labour recruiting agencies are licensed and are regularly monitored in order to ensure that they are meeting the required standards. The government has a policy of providing information at the village level to potential job seekers about the opportunities available, costs of and procedures for recruitment.

In the Sixth Plan, the importance of providing workers with language and other work skills necessary to compete in the international labour market was recognized. In the Seventh Plan, the need to upgrade the labour skills of Thai workers seeking to work overseas was also stated. It is anticipated that some of the traditional markets for Thai labour, especially in the Middle East, would become smaller, and therefore to maintain the level of remittances, it would be necessary to provide higher quality workers.

Migration of foreign migrant workers from neighburing countries to migrate and work in Thailand is another problem. 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 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 the other countries. However, the reliable data of foreign workers is still lacking. 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 the last few years, although there still exists refugee groups from Myanmar and Laos. The estimated numbers of foreign workers was about 750,000 to one million in 1996. The implication on socio-economic, culture and national securety should be reconsidered (Rachapaetayakom, 1997 : 6).

In the Eighth Plan, it is desirable that Thailand have a population of appropriate size and structure, distributed evenly in accordance with the development potential and availability of

opportunities in the various regions of the country. *The encouragement of population distribution in accordance with development potential* and opportunities are to increase the efficacy of social services delivery system; to provide rural people with occupational skills in concerted with the market demand in each area; to develop, update and widely disseminat the labour and product market information system; and to develop a more valid and complete data base on urban population to be used for systematic city planning. In summary, forces affecting internal movements within Thailand and international movements from Thailand are largely determined by market mechanisms and are not directly regulated by the government. For both types of movement, the government has preferred outcomes. For internal migration, the preferred outcome is a slowing of movement to large urban centers while encouraging international labour migration. To achieve these outcomes, however, mainly indirect policies are pursued. For internal migration, this involves attempting to influence the location of economic activities, while for international migration the government primarily plays a facilitating and protective role.

4. The Elderly

The decline in fertility has had a substantial impact on the age structure of the population. The proportion of population under age 15 has fallen. Despite these proportional declines, the absolute number of children in the youngest age group still increase. A decline in the absolute number of persons in this age group will, however, occur in the near future. The corollary to these changes is that population aged 60 years and over has been, and will continue, to increase in both relative size and absolute number (Robinson and Rachapaetayakom, 1988). *It seems that Thai society will change from a children society to an elderly society in the near future.*

While the decline in fertility and consequent slowing of the population growth rate is generally seen as a possitive development, *the resultant ageing of the population is frequently viewed more negatively*, particularly when considered in the context of the rapid socio-economic development within which it is taking place. Key areas of concern include the potential erosion of the existing familia support system, increase in demand for health care, and the persistence of poverty among broad segments of the elderly population. Within this context, occasional calls are made to halt the fertility decline and to return to somewhat high fertility levels (Knodel, 1994 : 277). There can be no doubt that the altered age structure that is emerging as a consequence of fertility decline and particularly the associated population ageing and future rapid growth of the elderly in Thailand has important demographic and socio-economic implications for the intermediate and long term future well-being of Thai society. Not all these implications need be seen as negative, however, especially if appropriate planning and policies are implemented in a time fasion to help in the adjustment process (Havanon, 1994).

(1) Trends of the Elderly

As of 1980, Thailand's age structure resembled fairly closely that of the world's less developed regions taken as a whole where 6 per cent of the total population was aged 60 and over in 1980. Thailand is experiencing unusually fast growth of the elderly population, however, in comparison to other less

developed countries. During the 1970-80 decade, the 3.9 per cent annual growth rate of the population aged 60 and over in Thailand exceeded considerably the 2.7 per cent rate for the elderly population of the world's less developed regions as a whole.

It is of interest that the results of the 1990 Census suggest that the elderly Thai population is growing fast and the population ageing is taken place rapidly. Previous studies have documented that future Thai elderly will differ significantly from elderly today in terms of their characteristics, needs, preferences and expectations. Because of rapid social and demographic change in the past, the characteristics of the elderly in the future is likely to differ considerably from that in the present and recent past. This is particularly clear in the case of education. (Chayovan, 1992 : 113).

Not only will the future elderly be better educated, they will also have fewer children. Hence their needs and preferences for living arrangements, and support are likely to be different from the present elderly (Knodel and et al., 1992). Estimates indicate that the present day elderly have on average 5.1 living children (including step and adopted children) while under current low fertility, the future elderly will average only 2.2 living children.

(2) Policies for the Elderly

Thailand has first launched the Long Term Plan for the elderly in 1982 in response to the United Nations resolution. In this long Term Plan (1982-2001), the major concerns are on the acceptance of elderly as part of the society, awareness of population ageing problems; and developement of quality of life for the elderly. However, the economic and social situations have changed and the Plan has not been effectively implemented. Most of the elderly especially in the rural areas have still been neglected. The government has formulated a new Long Term Plan for the Elderly (1992-2011) which has been approved and implemented during the Seventh Plan (1992-1996). This Plan is slightly different from the former one by emphasizing the development of the elderly themselves through caring of their health, participation in family and community activities and enabling to adapt themselves to the economic and social changes. Major policies have been formulated inclulding the policy of health and nutrition for the elderly. Ministry of Public Health has assigned to take responsibility. For the policy of life long education, Ministry of Education has taken charge of implementation. For policy of social welfare, Ministry of Labour and Social Welfare has been assigned to take responsibility. Furthermore, families and communities have to assist the elderly in living happily in the society (Watana, 1996).

The steady of increasing trend in the size and proportion of the population aged 60 years and over is being recognized. The proportion of elderly in 1990 was 7.2 percent and is estimated to be 15.5 percent in 2020. A National Survey on the Socio-Economic Consequences of the Ageing of the Population in Thailand conducted by the Institute of Population Studies at Chulalongkorn University indicates that the elderly have faced with two main problems - *a poor economic situation and poor health status*. In addition, there are other problems such as maintaining satisfactory living arrangements and changes in roles and statuses. Old people living in rural areas are in a worse financial situation than their urban counterparts. More than half of the surveyed people over the aged of 60 indicated that they prefer

to work. (Chayovan and Wongsith, 1987). A self-support policy to promote work participation of the elderly have to be supported to supplement incomes, to reduce government contributions, as well as for psychological benefits.

(3) Recent Programme for the Elderly

The Department of Public Welfare has the responsibilities to provide major welfare services to the elderly, namely residental care in Homes for the Elderly, non-institutional care at Social Service Centres for the Elderly, and monthly subsistent allowance to the needy elderly in communities. Due to the problems of less family care and support for the elderly, Department of Public Welfare has implemented a pilot Project of Establishing Elderly Social Service Centres in Communities. Main objectives of the project are motivating communities to realize the importance of elderly population and provide services for elderly in communities. The project has been funded by UNFPA with duration of 2 years from September 1995 - August 1997. After the project ended, the Department will allocate budget to subsidize the operation of the centres. (Watana, 1996 : 12).

Department of Medical Service in the Ministry of Public Health is responsible for health care programmes for elderly. In every general hospital and medical centre has set up a clinic for elderly where preventive and curative services, and physical and mental rehabilitation are provided. Many elderly club are also established and supported by hospital. Training practitioners, nurses, related personnel for elderly have bee implemented.

Elderly health promotion has been implemented by Department of Health. Health care for the elderly has been promoted throughout the country. Training of health personnel about care for elderly has been done. Campaigns of elderly health promotion have been implemented occasionally in every province.

In Thailand, the main institution responsible for care of the elderly is the family. Most elderly live with their children. In the traditional family, authority was based on respect for those senior to oneself, a seniority based on age and/or gender. This respect was buttressed by the elderly's control of resources, especially land. As the family systems have changed, they lost power that they formerly enjoyed to the young because it is the young who, through activities outside the family, increasing earn most of the family's income (ESCAP 1993; Watana, 1996 : 9).

Apart from the government, the non-governmental organizations (NGOs) have played an important role in the elderly issue. There are two main types of NGOs for the elderly. The first one is those NGOs that established by the elderly, for instance, the Senior Citizen Council of Thailand which has been organized by the elderly themselves and has objectives of encouraging the elderly to join together, being the representative in claiming the legal rights in many aspects and being the place that elderly are able to come and have participated in many activities. Other NGOs that have all over the country and are also members of the Senior Citizen Council of Thailand are the elderly clubs in many provinces. And another type of NGOs are those organizations that have delivered services for the elderly. They have operated home cares, medical services, recreation and home visit (Chayovan and

Wongsith, 1987 : 21; Watana, 1996 : 13).

Since problems of the elderly are new phenomena for Thailand and both the government, NGOs and the people themselves are not familiar with the situation, there is a need to plan for future activities (Government of Thailand, 1995 : 38). Since the Thai people generally do not make preparation for life in old age, future elderly will have to be encouraged and stimulated to plan and prepare for later years. Social security schemes to provide old age labour financial assistance are scheduled to be implemented by 1998 fiscal year and details of such schemes are under preparation. It is essential also to provide old-age saving accounts through tax exemption.

5. Women, Population and Development

The important issue related to fertility is women and development. Thailand's rapid economic development since the mid-1980s has opened the country to a full range of international influences on the economy, society and culture. The phenomenon of openness to globalizing trends, in combination with government policies, have created opportunities for women to overcome poverty, gained access to education, participated in new and expanding labour markets, decided family size and improve their own and their families reproductive health and general health, ventured into public life and higher levels of decision making. (GDRI and APWIP, 1994) But rapid socio-economic changes have also led to more imbalances and contradictions in the everyday lives of Thai women and their families.

Development has generally been associated with a slow but steady trend towards increasing women's participation in socio-economic and demographic life. Low fertility has significantly reduced Thai women's reproductive role, freeing them for labour force participation outside the households (Rachapaetayakom, 1995). Rising living standards and modernization also tend to push women into the labour market to meet household needs. Women in poor households, particularly in urban areas, are being forced into the labour market, even an economy still at the early stages of development, regardless of their reproductive role.

In the area of education, illiteracy had been greatly reduced although a slight male-female gap remained. There were no overt constraints for women with respect to education (NCWA, 1995). But it was found that women's access and enrolment at various levels and in formal and non-formal programmes of study were still limited by stereotypes, informal restrictive practices and apparent necessity and/or preference for entering the labour force as opposed to continue education. In the area of employment, Thai women are among the most economically active in Asia, second only to the women in China (UNFPA, 1991). Out of the 32.6 million persons in the labour force in 1995, about 50 percent were women, about 60 percent of whom were concentrated in rural areas. Although there was no rigid gender-based division of labour in agriculture, women were by and large unpaid family workers. The success of Thailand's export-oriented industrialization clearly relied on women working in labour-intensive manufacturing. Such success, including rural industrialization and employment resulted in the expansion of the informal sector both in the urban and rural areas where most women were engaged.

Thailand has made great progress and women have been major beneficiaries so that the maternal

mortality rate has been greatly reduced. Access to improve health services, safe water and sanitation has become more widespread and the health of Thai women generally improved. Serious health problems were found to be of direct concern for women, including venereal were considered to have an effect on women's health, essentially in terms of health hazards and dangers in the work place and mental stress.

In the present Eighth Plan, women will be developed as well as men. One of the development guideline of the disadvantage population is the development aimed at the problem of children and women engaged in commercial sex and/or subject to violence, and eliminating the sexist suppression of women (NESDB, 1996 : 40). For the action programmes, networking among governmental as well as non-governmental agencies and communities, etc., should be strengthened. Distribution and dissemination of information are essential.

6. Other Issues Ralated to Population and Development

There are some important issues related to population and development in Thailand. For example, population and environment, and adolscent and youth. The government has recognized the inter-relationship of these issues that may create severe impacts on people living conditions and human development. Policy guidelines and measures have been set to solve the problems.

(1) Population and Environment

Past development has involved wasteful and uneconomical exploitation of national resources, including land, forestry, water, fisheries and mineral resources, resulting in rapid resource and environmental deterioration. The rural population whose principal livelihood relies on these resources, have been negatively affected, making a more complex and the consuming to solve rural poverty problems. Furthermore, forest encroachment has also led to the extinction of valuable species of plants and animals.

Moreover, the rapid economic expansion in the past, along with the changing economic structure which has become more industrialization and service oriented, and the transformation of rural societies to urban communities, have led to more serious pollution problems, including water, air, solid wastes and toxic chemicals (NESDB, 1991 : 7). These problems have severe impacts on people living conditions.

Rapid economic growth associated with unbanization and industrialization has had serious implications for natural resource and urban environmental situations. Urban environment problems are concentrated in the Bangkok Metropolitan Area. With economic and population growth, the number of moter vehicles has increased and Bangkok's traffic congestion has caused air and noise pollution determental to people's physical and mental health (Government of Thailand, 1995 : 32).

Population and environment problems in Thailand shoud be attacked at different levels. One approach would focus or underly structural causes. Often the appropriate response is to address immediate causes in the short run and set actions to remedy underlying structural causes for medium - or long run benefits. There should be close collaborations among the government, NGOs and the Community Based Organization (CBOs) which operate indigenously at the neighbourhood level to

manage and work together in order to take effective action to improve the quality of the environment (Committee for ICDP, 1994 : 26 and Government of Thailand, 1995 : 33).

Targets of management on natural resources and environment in the Eighth Plan are to develop better quality of life of the people and communities; and to improve economic production base. The three strategies are to develop and stress the conservation of natural resources and environment; to build up people and communities participation : and to improve administration mechanism and environmental management of natural resource and environment (NESDB, 1996 : 136).

(2) Adolescents and Youth

Adolescents and youth in Thailand are people aged between 13-25 years. According to the 1990 Population and Housing Census, the number of youth (age 15-25 years) was 11,459.8 thousand people. An adolescent and youth development plan for Thailand was first integrated into the Fourth National Economic and Social Development Plan (1977-1981) as a manpower planning effort. After that, a long-term Policy and Plan (1982-2001) and the Five-Year Plans on Children and Youth Development were formulated and became parts of National Economic and Social Development Plans (1982-2001). These plans addressed six developmental areas : 1) youth and health; 2) youth and education; 3) youth and employment; 4) youth and morals; 5) youth, government and politics; and 6) youth and resources.

Population changes and the nation's social and economic situation impact greatly upon adolescent and youth development. The decline in youth segments of the populaiton, an increase in urban youth numbers, the country's transitioning from an agricultural to an industrial society, and the rapid economic growth rate have significantly influenced the youth situation in terms of illness and death associated with industrialization and urbanization, increasing demands for a specialized and well-educated work force, people's values and lifestyles tend to move towards greater individualism, materialism, consumerism and self-interest. Five major problem and need dimensions now exist with respect to adolescents and youth. They are as follows : physical, mental, health and nutritional well-being; in tellectual capacities; occupational preparations; social, cultural, moral and political problems; and children in especially difficult circumstances (Committee for ICPD, 1994; 26-27).

Four main approaches are being used to address the problems of adolescents and youth in the Thai society ; 1) social mobilization to motivate people, institutions and organizations responsible for adolescents and youth to be well aware of the current situation and taken an active role in youth development activities; 2) pooling of resources from Gos and NGOs for adolescent and youth development; 3) creating and increased awareness of their rights, duties and obligations towards self development in society; and 4) implementing policies and measures for the benifit of adolescent and youth development. The four approaches are in line with the adolescents and youth main objectives : accelerate pre-school education; extend basic education from 6 to 9 years; expedite quantity and quality of vocational training; develop young people's attitudes, values culture; increase rapid prevention and control for AIDS/HIV; increase rapid protection, prevention, cure and development for children in especially circumstance, and promote intelligent and gifted them to achieve their fullest potential.

IV. Conclusions

Thailand has long recognized the importance of population issues, which are closely interrelated with almost every aspect of national development. In a very real sense, Thailand is already attempting to improve its population programmes in line with the recommendations of the World Population Plan of Action (WPPA) the ICPD Declaration and many of the points called for in the Bali Declaration.

Thailand experienced rapid population growth after the Second World War. The Thai Government has long recognized the importance of population issues, which are closely interrelated with almost every aspect of national development. The policy of inducing the population growth rate was first adopted in 1970 and officially announced in March of 1970. Population reduction programmes were subsequently included in the Third Development Plan (1972-1976). Consequently, since the early 1970s, all development plans have specified target rates of population growth for their terminal years. To achieve fertility reduction, Thailand has relied on a government sponsored and implemented national family planning programme. More recently, the inequitable population distribution among regions and among urban and rural locations came to be seen as a problem to be addressed by the national population policy.

The broad definition of population policies includes improvements in quality of life, education, health and environment. A reduction in the infant mortality rate and a decline in second and third degree malnutrition for children aged 0-5 years to less than 1 percent are major targets for health development. In order to improve family planning and maternal and child health services for the population, regular monitoring of programme performance at local and national level through improved FP/MCH programme management information systems and periodic demographic surveys are required.

The decline in fertility has been astonishing. Fertility has fallen from an average completed family size of 6.6 per couple in 1960 to approximately 2.0 in 1997. The growth rate has fallen from over 3.0 percent in 1970 to about 1.2 percent in 1996. A replacement level of fertility is almost certain to eventuate in this year. Regional rates of natural increase still differ but show signs of convergence towards the emerging low overall of population increase.

Policies on population distribution are aimed at promoting population distribution and settlement patterns according to socio-economic development and the employment situation. The population distribution strategies are urban-oriented ones, including development of regional cities, special area developments such as the Eastern and Southern Seaboards, and promotion of industrial estates in the provinces.

Due to a rapid reduction in fertility during the last 20 years, the age structure of the population is changing to one with a higher proportion of older people. The government must prepare for problems related the elderly such as social security, the involvement of families in caregiving, morbidity, chronic diseases, and well-being for the aged. In addition, fertility reduction has brought about changes in the family pattern. The proportion of single-child families becoming larger and will exacerbate the seriousness of ageing problems.

Environmental deterioration is also a very serious issues and may cause major delay in development efforts. This has been partly due to mismanagement of natural resources and the environment. There seems to be a general lack of proper understanding about the dangers posed by environmental deterioration, and thus there is a pressing need to raise national awareness of these issues.

Targets ralated to demographic context in the Eighth Plan are that Thai families will have an appropriate size. It is desirable that Thailand have also appropriate population structure, distributed evenly in accordance with the development potential and availability of opportunities in various regions of the country. The reproductive health which has recently emerged as a more holistic concept of health will be developed. It is essential that measures and programmes to achieve the target must be strengthened.

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Chapter IX

Population Policy in Vietnam

Population Policy in Vietnam

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I. Introduction—Last Runner in "Demographic Transition Race"

December 1986 was dramatic for Vietnam, when Doi Moi policy was adopted. The year 1986 was memorable divide for Vietnam to achieve transition from political, economic disturbance in the years before 1986 to embark on new ambitious era. The Doi Moi was not only revolutionary in economic and political fields, but also demographic field.

Importantly here, policy makers and politicians in Vietnam have maintained consistent idea to regulate fertility and population growth on the basis of clear understanding of adverse effects of high fertility and rapid population growth.

Doi Moi policy triggered economic development on the one hand, and population policy on the other. Rising level of living and rising expectation for better life and comprehensive, exhaustive population policy have reinforced each other to bring down fertility rate and population growth rate.

Vietnam is the last runner in the race of demographic transition in East and South-eastern Asia. That suggests favorable position for Vietnam, because she can learn and apply predecessors' successful experiences, and consequently catch up with those countries in much shorter period of time.

However, some attention should be given to unequal distribution of population, regional economic disparity, and also very low level of urbanization, which are serious questions, and must be tackled in the context of economic, social and demographic policy.

Population variables and socio-economic variables are mutually interrelated, Theoretically, population policies may be distinguished into two types. The first aims at qualitative or quantitative change of population through general development efforts. In other words, these policies are actually economic and social policies, but basic objective is to modify population variables. Such policies may be called "population-responsive" policies. The second attempts to influence directly one or more of the almographic variables. It is termed "population-influencing" policies. The former may be called population policies defined broadly, and the latter defined narrowly.

II. Demographic Profile of Vietnam

(1) Vital events of Vietnam population

Major events affecting population in Vietnam are examined. They are tentatively shown by crude birth rate, crude death rate, population change rate per year, total fertility rate, infant mortality rate per 1,000 births, and life expectancy at birth (years), in Table 1 and Figure 1.

Table 1: Several Indicators of Fertility and Mortality of Vietnamese Population, 1550 ~ 55 — 1990 ~ 95

Period	CBR	CDR	NIR	TFR	IMR	Average longevity		
						Total	Males	Females
1950 ~ 55	41.8	28.5	13.3	6.05	180	40.4	39.1	41.8
1955 ~ 60	42.0	25.6	16.4	6.05	163	42.9	41.3	44.6
1960 ~ 65	40.9	21.2	19.7	6.05	130	45.4	43.5	47.4
1965 ~ 70	38.3	16.6	21.7	5.94	118	47.9	45.7	50.2
1970 ~ 75	37.6	14.3	23.3	5.85	106	50.3	47.7	53.1
1975 ~ 80	38.3	11.4	26.9	5.59	82	55.8	53.7	58.1
1980 ~ 85	34.7	11.1	23.6	4.69	63	58.8	56.7	61.1
1985 ~ 90	31.8	9.5	22.3	4.22	47	62.6	60.6	64.8
1990 ~ 95	28.9	7.9	21.0	3.40	42	65.2	62.9	67.3

Source: United Nations: World Population Prospects The 1996 Revision Annex II & III: Demographic indicators by major area, region and country

Remarks: CBR = Crude birth rate, CDR = Crude death rate, TFR = Total fertility rate, IMR = Infant mortality rate, Average longevity = Average life expectancy at birth

Figure 1: Crudl Birth and Death Rate in Vitnam, 1950 to 1995

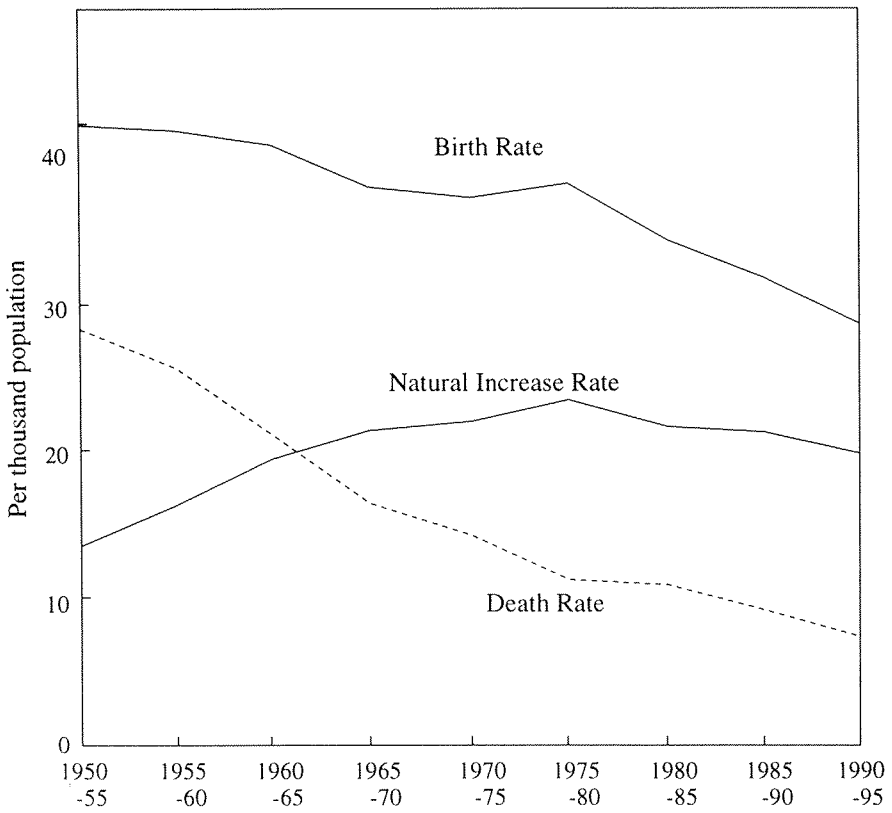
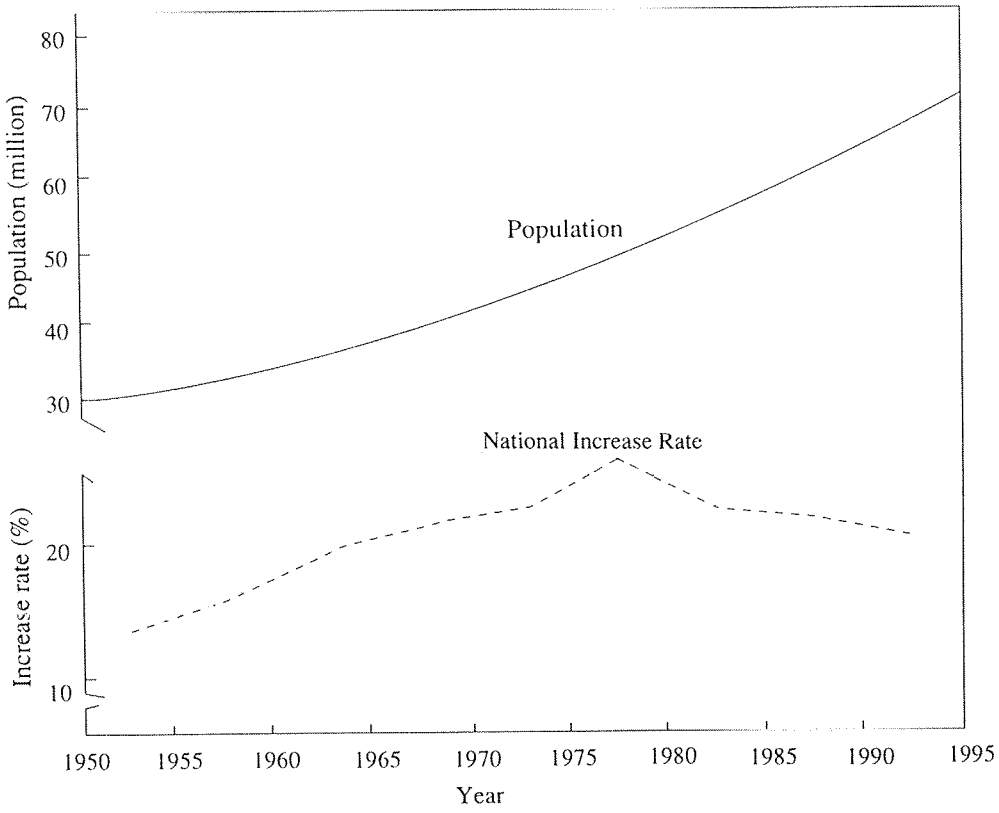


Figure 2: Population and Increase Rate in Vietnam, 1950-1995



Both crude birth and crude death rate are showing interesting trends. Both trends indicate continuous declining pace. However, more rapid declining pace of crude death rate than that of crude birth rate resulted in higher natural increase rates since 1965-1970, in particular as high as 2.7 percent in 1975-1980. Taking into account net out-international migration, population growth rate per year exceeds two percent since 1965-1970, up to the 1990-1995. That of the period 1970-1975 was as high as 2.34 percent (See Table 2 and Figure 2).

Crude death rate is at low level combarable to those in advanced countries. However, of course, much younger population of Vietnam than those of advanced countries where populations are heavily aged should be considered. It will be sufficiently expected that recent quicker declining fertility than mortality improvement would contribute to lower natural increase rate which is also demonstrated by quick reduction of total fertility rate.

Mortality improvement in Vietnam has been remarkable not only in terms of crude death rate, but also in infant mortality rate. Table 1 indicates that it has dropped to 42 per thousand births in recent ten years, which is lower than that of Indonesia and equal to the Philippines (See Table 6). Drastic reduction of mortality is also reflected in rapid extension of average life expectancy at birth. During the period of 1970-1975, it was only 50.3 years for both sexes combined, but recently (1990-1995) attained 65.2 years for both sexes combined. Extension of 15 years of average expectancy of life took only 15 years. However, in Japan where extension of average expectancy of life was remarkably rapid, extension of about 15 years from 63.9 in the period, 1950-1955, to 78.3 in the period, 1985-1990, took 35 years. How

rapid was the extension of average expectancy of life in Vietnam can be easily understood.

(2) Population structure and change

Table 2 shows a few indicators of population structure in Vietnam. Vietnamese population made remarkable increase in the post-World War II. During the period of 45 years, 1950-1995, they increased from about 30 to 74 millions, approximately 2.5 times. In particular, population growth rate has sharply risen up to higher than two percent per year since the second half of the 1960s. In the first half of the 1970s it reached peak of 2.3 percent per year, and then rapidly slowed down, but still a little higher than 2 percent per year in the first half of the 1990s. It indicates that population control would be serious issue facing the government of Vietnam. In this connection attention should be paid to much higher natural increase rates than population growth rates mentioned here. Natural increase rates have been much higher than population growth rate since 1975, which are shown below.

Table 2: Population Structure and Change in Vietnam, 1950-1995

Year	Population (,000)	Growth rate (%)	Sex ratio	Age distribution (%)			Dependency ratio	Density (per km²)
				0~14	15~64	65+		
1950	29,954	-	99.1	34.3	61.8	3.9	61.7	90
1955	32,009	1.33	97.0	36.0	60.0	4.0	66.9	97
1960	34,743	1.64	95.5	38.7	57.1	4.2	75.1	105
1965	38,341	1.97	94.7	42.1	53.6	4.3	86.3	116
1970	42,729	2.17	94.5	43.8	51.9	4.3	92.8	129
1975	48,030	2.34	94.9	43.7	52.3	4.0	91.2	145
1980	53,711	2.24	94.2	42.5	52.7	4.8	89.9	162
1985	59,898	2.18	95.1	40.5	55.0	4.5	82.0	181
1990	66,689	2.15	95.9	38.8	56.4	4.8	77.4	201
1995	73,793	2.02	96.9	37.0	58.1	4.9	72.0	222

Source: United Nations: World Population Prospects The 1996 Revision Annex II & III. Dependency ratio is based on World Population Prospects the 1996 Revision Annex I.

Remarks: Proportion of population aged 15-64 is calculated by deducting the proportions of 0~14 and 65+ combined (which are given in The 1996 Revision Annex II & III) from 100.

	Natural increase rate	Population growth rate
1975-1980	2.69% per year	2.24% per year
1980-1985	2.36	2.18
1985-1990	2.23	2.15
1990-1995	2.10	2.02

Difference between higher natural increase rate and lower population growth rate is caused by excess of emigration over immigration. Tremendous emigration including refugees and so called boat people occurred due to unusual political and economic conditions in the second half of the 1970s. It is estimated that more than 574,000 left Vietnam by boat in the period, 1975-1985, not including emigrants by land.

Sex ratio of Vietnamese population is shown in Table 2. Number of males per 100 females is usually less than 100 because of higher mortality of male than female, although young age group is characterized by more males than females usually due to higher sex ratio at birth. It is needless to say that sex ratio is often disturbed by war or other accidents and social gender discrimination affecting specifically male or female. In Vietnam, six ratio indicates rapid decline from 99 in 1950 to 94 in 1980, extending 15 years up to 1980, and then is steadily rising up to 97 in 1995.

Significant drop of sex ratio in these years reflect serious political, social and economic disturbances. Comparison with sex ratio of Thailand that has maintained very stable level of 100 for entire postwar period is helpful for understanding Vietnam situation.

Profile of Vietnam population is characterized by very young one, and just now in the initial stage of demographic transition. However, age profile of Vietnam population has already shown steady changing process of population structure. Proportion of young population, aged 0~14, is undergoing quick reduction from peak level of 44% in 1970 and 1975 down to less than 40% in 1990 and 37 % in 1995 primarily due to rapid decline is fertility. Secondly, working age population aged 15~64, after decreasing trend in the period 1950-1970, 62 to 52 percent, restoring trend has started, and finally reached 58 percent in 1995 which is approximately similar high level in the second half of the 1950s. Thirdly, elderly population aged 65 and over is still maintaining very low level of 4%. However, it is noticed that aging process is going on slowly but steadily in the last ten years, 4.5 in 1985 to 4.8 in 1990 and 4.9 percent in 1995. Reflecting quite diversified trends of major are groups, dependency ratio continues to decrease since 1970, inducting highest percent of 93 percent, and reached low level of 72%. Increasing working age population associated with declining dependency ratio is extremely favorable for economic and social development in Vietnam. Structural change of population and dependency ratio are shown in Table 2 and Figure 3. They suggest roughly that dependency ratio is correlated positively with young age population and negatively with working population. In case of Vietnam, old age population does not have any effective contribution to dependency ratio, because its share of population is very small, and consequently size of young population and its change is major element to determine size of dependency ratio. Share of young are population and old age population constituting dependency ratio is shown in Table 3.

It can be easily understood that age dependency ratio of Vietnam population is overwhelmingly occupied by young population. However, since 1980 steady declining trend is taking place. Dependency ratio of elderly population is showing very slow increasing trend. It should be noticed on the other hand that total dependency ratio is rapidly declining particularly since 1980, which is favorable sign for economic and social development.

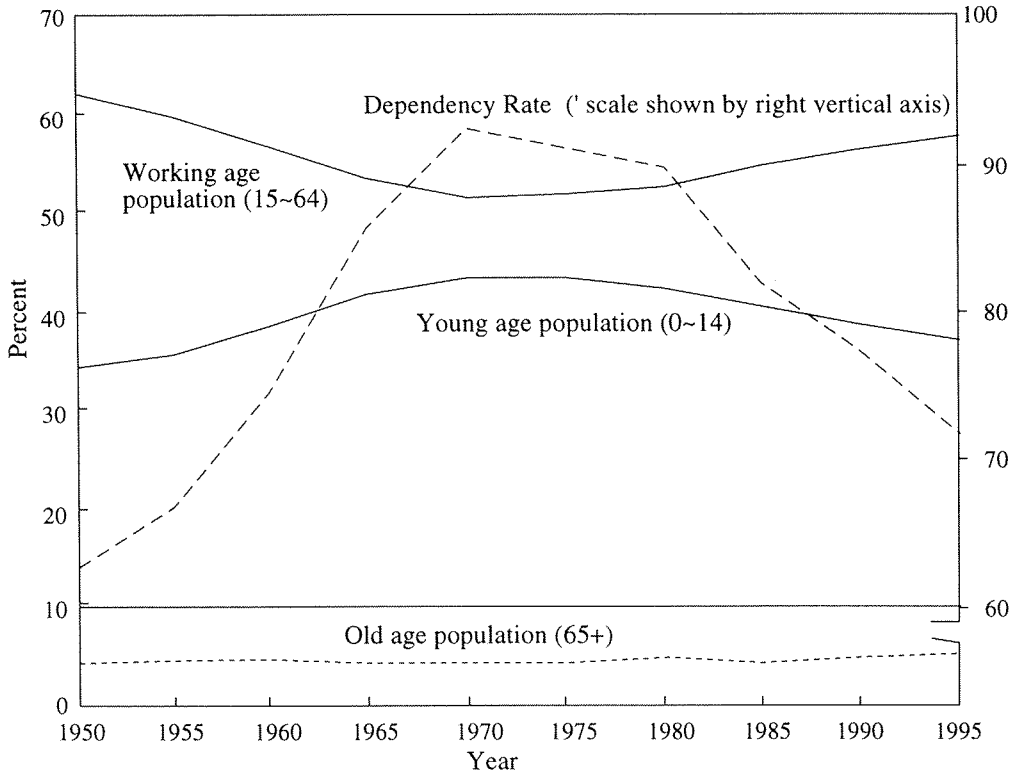
Table 3: Components of Dependency ratio

Year	Dependency ratio, total	Young population	Old population
1950	100.0 (61.7)	90.0 (55.5)	10.2 (6.3)
1955	100.0 (66.9)	89.7 (60.0)	10.0 (6.7)
1960	100.0 (75.1)	90.3 (67.8)	9.7 (7.3)
1965	100.0 (86.3)	91.0 (78.5)	9.3 (18.0)
1970	100.0 (92.8)	90.9 (84.4)	9.0 (8.3)
1975	100.0 (91.2)	91.7 (83.6)	8.3 (7.6)
1980	100.0 (89.9)	89.7 (80.6)	10.1 (9.1)
1985	100.0 (82.0)	89.7 (73.6)	10.0 (8.2)
1990	100.0 (77.4)	88.9 (68.8)	11.0 (8.5)
1995	100.0 (72.0)	88.6 (63.7)	11.7 (8.4)

Source: Based on Table 2

Remarks: Figures shown in parentheses are dependency ratio, total, young and elderly. Dependency ratio total is not necessarily equal to the sum of "young" and "old" dependency ratio because of rounding.

Figure 3: Age Distribution and Dependency Ratio in Vietnam, 1950-1995



III. Fertility Decline delayed in Vietnam

Fertility in selected South East Asian countries to compare with Vietnam is shown in terms of total fertility rate and crude birth rate in Table 4 and Figures 4, 5. It is interesting to see that fertility trend in Vietnam has shown different pattern of fertility decline in terms of time lag of initiation compared with three other countries surrounding Vietnam, with exception of the Philippines to some extent.

Second half of the 1960s was starting period of fertility decline in Indonesia and Thailand where official family planning program were adopted, and total fertility showed clear declining trend from more than 5 to lower level, and crude birth rate also declining trend from more than 40 per thousand live births to below 40. The case of the Philippines was interesting to see that fertility was very high, and to show declining trend from more than 7 children to 6 children in the second half of the 1960 when Thailand and Indonesia began to decline. However, fertility decline in the Philippines started earlier but was much slower than those of Indonesia and Thailand.

Table 4: Fertility Rates in Selected Countries in South-eastern Asia

Period	Indonesia		Philippines		Thailand		Vietnam	
	TFR	CBR	TFR	CBR	TFR	CBR	TFR	CBR
1950-55	5.49	43.0	7.29	49.3	6.59	46.6	6.05	41.8
1955-60	5.67	45.4	7.09	47.4	6.39	44.3	6.05	42.0
1960-65	5.42	42.9	6.61	43.6	6.39	43.5	6.05	40.9
1965-70	5.57	42.6	6.04	40.2	6.11	41.8	5.94	38.3
1970-75	5.10	38.2	5.50	38.4	4.99	35.1	5.85	37.6
1975-80	4.68	35.4	4.96	35.9	4.25	31.6	5.59	38.3
1980-85	4.06	32.4	4.74	35.8	2.96	25.1	4.69	34.7
1985-90	3.31	28.4	4.30	32.8	2.57	23.1	4.22	31.8
1990-95	2.90	24.6	4.00	31.2	1.94	18.1	3.40	28.9

Source: United Nations: World Population Prospects The 1996 Revision Annex II & III: Demographic indicators by major area, region and country

Remarks: TFR = total fertility rate per woman, CBR = Crude birth rate per 1000 live births.

Figure 4: Total Fertility Rate in Selected Countries in South-eastern Asia

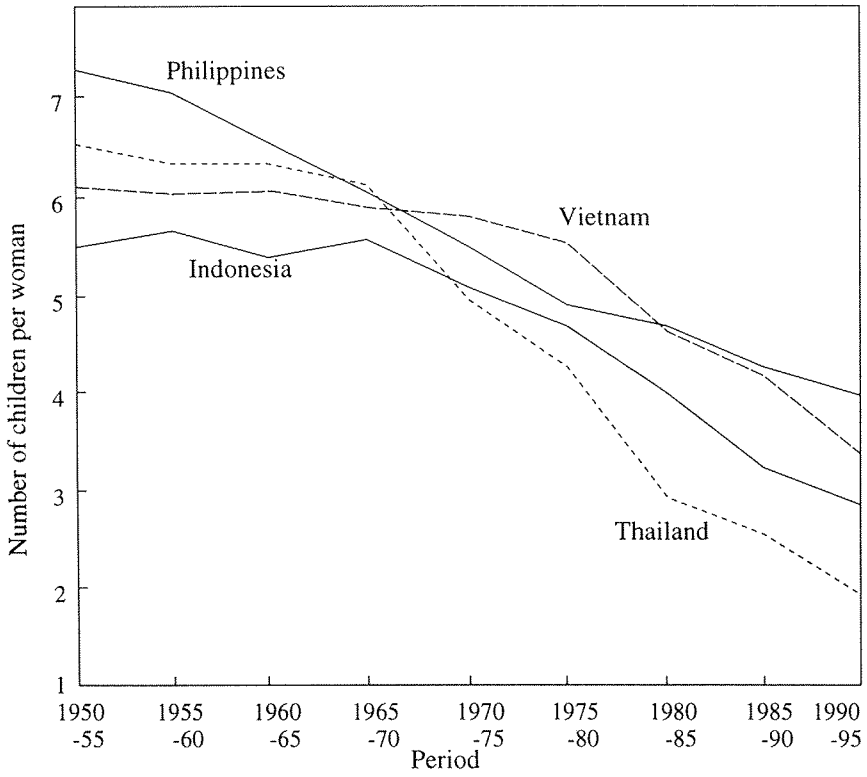


Figure 5: Crude Birth Rate in Selected Countries in South-eastern Asia

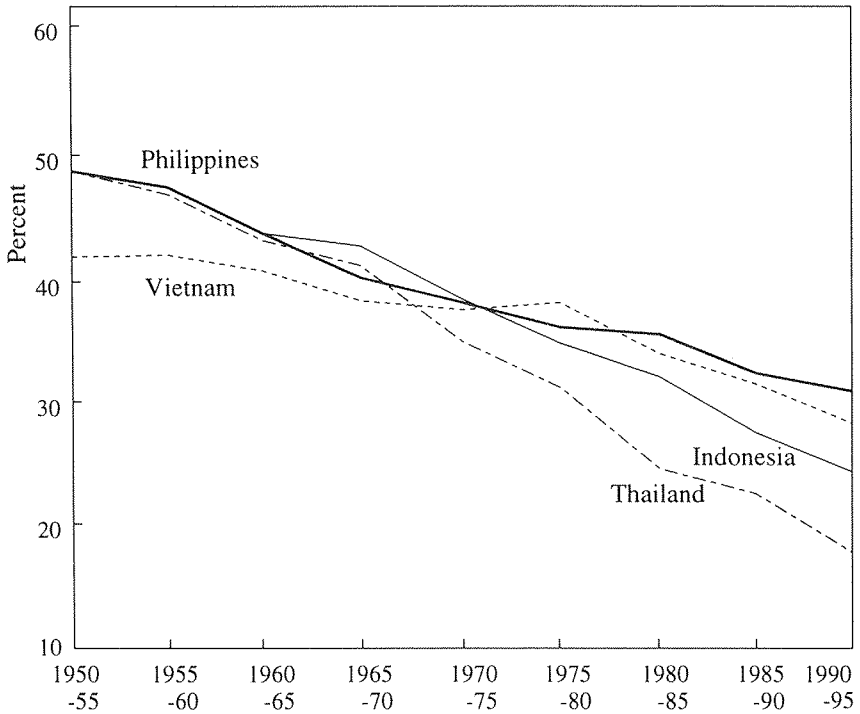


Table 5: Fertility Decline before and after 1970 in four countries in South– eastern Asia

Country	Total fertility rate			Crude birth rate		
	1950-55 ~ 1965-70	1965-70 ~ 1990-95	1950-55 ~ 1990-95	1950-55 ~ 1965-70	1965-70 ~ 1990-95	1950-55 ~ 1990-95
Indonesia	+1.5%	47.9%	47.2%	0.9%	42.3%	42.8
Philippines	17.1	33.8	45.1	18.5	22.4	36.7
Thailand	7.3	68.2	70.6	10.3	56.7	61.2
Vietnam	3.5	42.8	43.8	8.4	24.5	30.7

Source: Calculation is based on Table 4

Vietnamese fertility decline started only after second half of the 1970s, later than the Philippines. However, it should be noticed that fertility decline in Vietnam is so rapid. It was very high during the last 20 years, 1975-80 ~ 1990~95, total fertility rate in Vietnam declined by 39.2 %, but 38.0 % in Indonesia, only 19.4% in the Philippines. Thailand showed spectacular decline, from 4.25 to 1.94, below replacement level, namely decline by 54.3 percent.

Table 5 shows fertility decline in four countries in terms of total fertility rate and crude births rate in two periods before and after 1970, and total period of after the World War II. It is commonly recognized that fertility decline took place during the last 20 to 25 years. With the exceptionally remarkable decline in Thailand, about 70%, Vietnam could decline comparable decline with Indonesia and the Philippines. Total fertility rate in Vietnam declined by 44% in the whole period from 1950-1995, which is comparable to 45% of the Philippines and 47% of Indonesia. Decline of Crude birth rate is also same.

Comparative examination of fertility transition in from selected countries in the South-eastern Asia provides us diversified patterns of demographic evolution. Thailand represents the most advanced pattern, characterized by below replacement level of total fertility rate and very low crude birth rate less than 20 per thousand live births. Second pattern is reflected in the case of Indonesia where total fertility rate came down from 5 to 3 in about 20years or so and recently 2.9 children. Although, still high fertility is kept, but it is expected that rapid declining trend will follow Thai experience. Third one is exemplified by the Philippine pattern. Extremely high total fertility rate of more than 7 children started to decrease, but still at the present time 4 children. Crude birth rate is higher than 30 per thousand population. It is surely claimed that fertility transition to lower regime has started in the Philippines, but would be called initial stage of transition characterized by explosive population for the time being.

Vietnamese case seems to be in different pattern from other three examined here. Firstly, three countries, Indonesia, Philippines and Thailand, maintained high total fertility rate as high as 5 children up to 1970-75, and has began to reduce their fertility after 1975, but the starting point for Vietnam to reduce it was five years later after 1980.

Secondly, fertility decline was very rapid in Vietnam. Already in the period, 1980-85, Vietnam showed lower total fertility rate than that of the Philippines, and is continuing to maintain remarkably

lower level than Philippines. There is high probability that fertility transition in Vietnam will accelerate. It is usual that late-comers tend to catch up more quickly with predecessors. In case of Vietnam there is another additional factors to accelerate fertility transition. Rapid economic growth, high literacy rate, high female labor force participation rate and peoples industriousness are basic supporting factors to drive fertility control.

IV. Mortality Trends among Four Countries

Three indicators of mortality, namely crude death rate, infant mortality rate, and expectation life at birth for both sexes combined, including Vietnam are shown in Table 6. It is generally recognized the overall decline of mortality has been achieved rapidly among all countries concerned. Crude death rate is now commonly very low, in particular, only 6.1 in Thailand and 6.5 in the Philippines.

How rapidly mortality was improved in the postwar period of 45 years in four countries is shown in Table 6. It is noticeable that Vietnam showed most remarkable improvement of mortality. Decrease rates of crude birth rate and infant mortality rate was 72.3 percent, and 76.7 percent in this half a century respectively, both of them highest compared with other three countries. Increase rate of expectation of life at birth in Vietnam is second to Indonesia. Expectation of life at birth in Vietnam extended by 24.8 years which was very close to 25.2 years of Indonesia.

Table 6: Some Indicators of Mortality in Four Countries
- Crude Death Rate, Infant Mortality Rate and Expectation of Life at Birth -

Period	Indonesia			Philippines			Thailand			Vietnam		
	CDR	IMR	ELB	CDR	IMR	ELB	CDR	IMR	ELB	CDR	IMR	ELB
1950-55	26.1	160	37.5	19.5	100	47.5	19.2	132	47.0	28.5	180	40.4
1955-60	24.3	145	39.9	16.1	83	51.1	15.9	111	50.6	25.6	163	42.9
1960-65	21.5	133	42.5	13.1	76	54.5	13.4	95	53.9	21.2	130	45.4
1965-70	19.3	124	46.0	10.7	72	56.2	11.4	84	56.7	16.6	118	47.9
1970-75	17.3	114	49.3	10.2	71	57.8	9.3	65	59.6	14.3	106	50.3
1975-80	15.1	105	52.8	9.0	62	59.9	8.3	56	61.2	11.4	82	55.8
1980-85	11.2	90	56.2	8.1	60	61.9	7.0	44	65.0	4.1	63	58.8
1985-90	9.4	75	60.2	7.2	53	64.0	6.4	39	67.5	9.5	47	62.6
1990-95	8.4	58	62.7	6.5	40	68.3	6.1	32	69.0	7.9	42	65.2

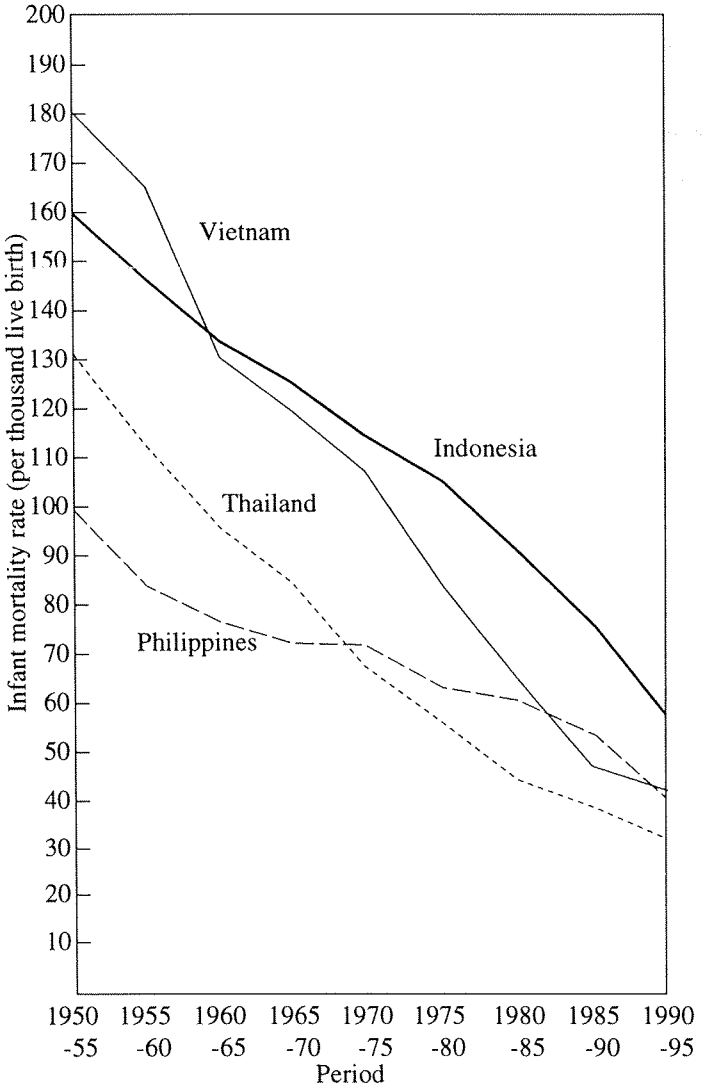
Source: United Nations: World Population Prospects: The 1996 Revision Annex I: Demographic indicators
Remarks: CDR = Crude death rate, IMR = Infant mortality rate, ELB = Expectancy of life at birth

Table 7: Decrease Rates of CDR and IMR, and Increase rates of ELB in Four Countries, 1950-55 -1990-95

	Indonesia	Philippines	Thailand	Vietnam
Decrease rate (%)				
Crude death rate	67.8	66.7	68.2	72.3
Infant mortality rate	63.8	60.0	75.8	76.7
Increase rate (%)				
Expectation of life at birth	67.2	39.6	46.8	61.4
Increase of expectation of lie at birth (years)	25.2	18.8	22.0	24.8

Source: Based on Table 6

Figure 6: Infant Mortality Rate in Four Countries, 1950～55 — 1990～95



Vietnam and the Philippines indicated remarkable contrast. Initial stage of mortality decline shows that mortality levels of the Philippines were much lower than those of Vietnam. However, declining pace of mortality in Vietnam was much more rapid than that of the Philippines, catched up with the same level of the Philippines in terms of infant mortality (see Figure 6)

It is surprising to find that Vietnam challenged with success to reduce mortality during extremely severe disaster of war extending over many years and economic difficulties.

Remarkable reduction of mortality and in particular, that of infant mortality rate is crucial factor to introduce new value system toward small family norm. Fertility control and also mortality improvement are basically associated with population policy.

V. Population Policy in Vietnam

(1) Fertility Transition

Vietnam is the last runner of demographic transition "race" in South-eastern Asia. She is energetically catching up with her predessors in Asia. Vietnam has experienced quite serious difficulties different from other three countries of South-eastern Asia, Indonesia, the Philippines and Thailand. More than 70 million people and land were heavily damaged due to terrible wars, military trouble and economic hardships and privations for many years from the second half of the 1960s to the second half of the 1970s.

Fertility in Vietnam had been characterized by very high level. Total fertility rate was around 6 up to the period, 1970-75. Declining trend started only after 1975-80, particularly from 1980-85. Population increase rate in terms of natural increase rate had been high, continuing to rise up at 27 per thousand in 1975-80, which was peak, and then initiated decline.

However, it is interesting to know that the Government in the Northern Vietnam started with the government's regulation numbered 216/CP dated on 22nd December 1961, which are concerned with population policy. During 1960-1975, three regulations and one decision related with population policy were promulgated by Northern Vietnam Government. In 1970, the Steering Committee of Family Planning Activities was established in order to coordinate family planning matters which were taken care by the Committee of Mother and Children Protection, Vietnam Women Union and Vietnam Trade Union.

It seems to me that population policies taken by the government at least up to 1972, when the Vietnam war ended, were strongly concerned with health aspect of mother and children.

The 10year period,1975-1984 can be characterized by second stage of population policy, transition from wartime to peace time. The year 1984 marked an important Milestone in the populations policy of Vietnam, because the National Committees of Population and Family Planning (NCPFP) was established. A series of regulations and decisions related to the family planning programs have been promulgated during the period between 1984 and the present.

The last stage of population policy focussed on family planning is demonstrated by rapid decline of fertility rates shown below.

	Crude birth rate	Total fertility rate
1975-1980	38.3	5.59
1980-1985	34.7	4.69
1985-1990	31.8	4.22
1990-1995	28.9	3.40

In Vietnam, significance of population policy, particularly awareness of importance to reduce rapid population growth and fertility control was recognized by policy makers. However, positive and effective implementation of family planning programs were not given priority because of emergencies of war and economic distress.

Restoration of peace became active motivation to accelerate family planning practice among people, strongly supported by the government. For example, contraceptive prevalence of 65 percent, higher than those of Indonesia and the Philippines with the exception of Thailand (see Table 7).

Value system toward children is also drastically changing. Desired number of children was more than 4 expressed by majority of married females in 1988, but only two or three children in 1991 (Information based on field survey in Vietnam given by Ms. Sumie Ishii, Director of International Programs Division, Japanese Organization for International Cooperation in Family Planning.).

There are several favorable factors to accelerate fertility reduction in Vietnam.

First, strong recognition of necessity of fertility control of the government in order to catch up with surrounding countries.

Table 7: Illiteracy and Contraceptive Prevalence in Vietnam and Selected Countries in South-eastern Asia

Country	% Illiterate (15 and over)		Contraceptive prevalence		% Knowing
	M	F	any method	modern method	FP method
Vietnam	4	9	65	44	95
Indonesia	10	22	55	52	95
Philippines	5	6	48	40	97
Thailand	4	8	74	72	100

Source: UNFPA: The State of World Population, 1997

Remarks: 1989 Vietnam Population census indicated percent literate of population aged 10 years and over, which shows 93 for male and 84 percent for female. Overall literacy is 88 percent. It is interesting to see literacy rate by sex and age which has shown rapid improvement in Vietnam (See Tables 8 and 9).

Second, percent illiteracy is very low comparable with that of Thailand (See Table 8 and 9). It is remarkable that age groups 10-44 years old are highly literate of more than 90 percent for both sexes. In particular, males aged 10-54 show literacy of 94-96 percent (See Table 8). Of course, some difference between urban and rural exists, but not so much differences between urban male and rural male. Only rural female show significantly lower literacy (82 percent) compared with 92 percent of urban female (see Table 9).

Table 8: Literacy Rate by Age Group and Sex in Vietnam, 1989

Age group	Percent literate		Total
	Male	Female	
10-14	94	93	94
15-24	94	93	94
25-34	96	93	94
35-44	96	90	92
45-54	94	79	86
55-64	89	61	74
65+	73	31	48
Total	93	84	88

Source: Central Census Steering Committee: Vietnam Population Census-1989, Sample Results, Hanoi, 1990, p.45

Table 9: Literacy Rate by Sex and Urban/Rural Residence in Vietnam 1989

Urban, Rural	Percent literate		Total
	Male	Female	
Urban	97	92	94
Rural	92	82	87
Total	93	84	88

Source: Central Census Steering Committee: Vietnam Population Census-1989, Sample Results, Hanoi,1990, p.46

Thirdly, high level of female labor force participation rate in Vietnam should be mentioned in connection with fertility behavior. According to sample results of Vietnam Population census 1989, economically active population was 81.6 percent for male and 73.6 percent for females, who are aged 15 years and other, including employed more than 6 month (73.9% for males, and 67.5 % for females), employed less than 6 months (3.2 for males, and 2.6 for females) and unemployed (4.5 and 3.5 respectively).

A very high labor force participation rate for females comparable to that of Thailand, which is widely well-known and achieved dramatic decline of fertility, is surely favorable factor to promote

fertility control.

Fourthly, rapid economic development is another important factor to stimulate fertility control, in particular family planning practice. Since "Doi Moi" reform adopted in 1986, economic and social conditions quickly returned to prosperity. Average increase rate of GDP in the four year period, 1990-93 jumped up to 7.6 percent from low level of 3.5 percent in the period, 1986-88: growth rate of GDP is still continuing, 9.3 percent in 1996, and 8.6 expected in 1997 (Data from the Institute of Developing Economies), Asahi newspapers, December 10, 1997).

Lastly, extremely important is the government policy for population control. Vietnam Government was aware of high population growth rate and its serious effect on economic and social development since as early as 1960. However, it was strengthened only after 1975 when unification of Vietnam was realized. Official statements of fertility control were based on so-called "three late" slogan, - late marriage, late first birth and late second birth -. It is recommended that each family should not have more than three children. But due to long time of war as well as babyboom after war, fertility control policy was not successful in the decade of 1970s.

In the decade of 1980s, legal arrangements and financial increase to promote family planning programs have been made. A 65 percent of married couple in reproductive age is practicing contraception. The contraceptives are provided free of charge to all people who want to use it. IUD is most popular, 50 percent of all contraceptives. Age at first marriage is defined by the Law on Family and Marriage (1986) at 18 years old for female, and 20 years old for male. The government encourage people to have spasing of 3-5 years and also to have one or two children. First birth should be desirable to have after 19 (for rural) and 22 (for urban).

It should be emphasized that very strong, comprehensive programs to deal with rapid population increase by the government, coordinated by the National Committee for Population and Family Planning established in 1984, with determined objective to achieve replacement level of fertility in the decade of 1990s, has been successful in reducing fertility level rapidly, that is demonstrated in the recent achievements.

(2) Family Planning and Abortion

It is extremely interesting to find that abortion has been available on request since at least 1971 only in the Democratic Republic of Vietnam, and in the entire country since its unification in 1975. The Law on the Protection of Public Health (30 June 1989) clearly states that "woman shall be entitled to have an abortion if they so desire". According to decision No. 162 of the Council of Ministers in January 1989, the State will supply, free of charge, birth control devices and public-health services, including induced abortion, to eligible persons that register to practice family planning.

Emphasis on family planning varied greatly between northern and southern provinces of Vietnam before unification. Beginning in 1962, in the northern province, the government policy was directed to reducing the rate of population growth. Relatively permanent contraceptive methods, such as the intrauterine device (IUD) was promoted. Abortion on request (with the husband's consent) was

available.

In contrast, family planning programme in the southern province began in the late 1960s largely in response to concern over maternal and infant mortality and the increasing number of illegal abortions. Family planning clinics offered services only to women with at least five living children up until the early 1970s. Family planning services were later expanded to include women with one living child. In the mid-1970s, the government of the Republic of South Vietnam stated that family planning had been adopted as an official policy.

Since the unification of Vietnam, family planning has been considered a major national priority. In 1982, various family planning measures were adopted, including the use of abortion. After 1983, limiting families to two children became obligatory. The target is a total fertility rate of 3.1 births per woman by the year 2000 and 2.1 by 2010.

The Demographic and Health Survey conducted in 1988 provided important information of family planning. For example, predominant used method of IUD; almost 70 percent of the woman mentioned pregnancy termination, or menstrual regulation as contraceptive method; 38 percent of married women aged 15-44 using a modern method of contraception. Of these women, 89 percent used IUD, 6 percent sterilized, 3 percent using condom and 1 percent relied upon oral contraceptive.

Following figures on abortion indicate a substantial unmet demand for family planning.

Table 10: Incidence of Abortion

Coverage	Year	Measurement	
National	1987	58.5	abortions/1,000 women aged 15-44
National	1988	71.3	abortions/1,000 women aged 15-44
National	1989	70.0	abortions/1,000 women aged 15-44

Source: United Nations: Abortion Policies A Global Review Volume III Oman to Zimbabue, 1995.

(3) Mortality Transition

Mortality improvement policies and measures taken by the governments are their intrinsic responsibility and may not be objective of population policy. However, in view of the important role of mortality affecting population growth, age structure of population and also reproductive behavior, mortality issue should be considered a component of population policy.

Mortality component is unique, however, in the sense that reduction of mortality is a universal objective of any governments. Essential difference of mortality from fertility is that policy is directed to the reduction only which is socially acceptable. Any policy to rising mortality is rejected in this context, therefore, mortality policy is health and welfare policy of the governments, but may not be appropriate to include mortality issue as a component of population policy.

How to deal with mortality component from the standpoint of population policy is still controversial question. However, theoretically and practically, two points should be taken into account

concerning significant role of mortality in population policy. One point is concerned with qualitative improvement of population through mortality reduction. In this sense, mortality reduction can be designated as "population-responsive" policies, and aiming at qualitative improvement through general development efforts. So, mortality reduction may not be able to claim directly the term "population-influencing" policy. Second point is demographic role in various ways: population growth, age structure of population, expectation of life at birth, close relationship with fertility behavior and so on. From practical standpoint, since mortality issue is closely and mutually linked with population change, population policy has to take mortality component into policy program.

In Vietnam, remarkable reduction of mortality has been achieved, and also expected to be improved in the future (See II and IV). With substantial decline of fertility and more rapid decline of mortality, population growth rate is now declining. Demographic transition is going on steadily.

(4) Migration

Migration is a critical issue affecting population distribution within a country and consequently creating regional disparity of age and sex distribution between urban and rural in particular. Migratory movement usually is motivated by regional economic and social conditions and also different population growth level. In terms of policy standpoint, migration policy is quite different from fertility policy, because migratory behavior is greatly affected by economic reasons. Regional economic development policy becomes major policy to solve problems.

However, from the standpoint of the public administration, national or local, two aspects of policy are necessary. One is adequate provision of daily life assistance, including shelter and job opportunity, to new-comers in receiving areas like city. On the other hand, sending areas like rural have to take policies to assist elderly people who are left behind, to create job opportunity to be provided to potential new comers.

Second aspect of policy is related with incentive or disincentive policies depending on the actual situation.

Scope and intensity of migration are different according to the stage of economic development and also country to country. Migratory movement in Vietnam is characterized by three major streams. One is traditional stream of rural-urban migration which is very common in the stage of industrialization and urbanization. Typical case was that of Ho Chi Minh city where about 0.6 million people are estimated to be migrants from rural areas.

Second pattern is rural to rural migration. For example, a lot of people migrated from the North Mountainous areas to Central highland (Tay Nguyen). In the last 4-5 years, it is estimated that approximately 400,000~500,000 people migrated. Majority of them are minority people.

They are occupied in cultivation of rice through "slash and burn" method which attracts governmental concern from the standpoint of environmental issue.

Last one is migratory stream from the North Vietnam to South Vietnam that had been encouraged by the Vietnam government since unification of Vietnam (1975).

Industrialization has contributed to structural change of distribution of labor force population among several sectors of industries. However, agriculture is still dominant compared with industries and services in terms of distribution of working population and output among them.

Urbanization is rapidly going on, but percentage of urban population in the total population is still very low at 19%, just comparable to that of Thailand, 20%. Percentage of urban population in Indonesia and the Philippines are 36% and 55% respectively (United Nations: World Urbanization Prospects The 1996 Revision).

It will be surely expected that industrialization and urbanization will continue to accelerate in near future, and migration issue will be more important policy for the Government.

International migration is also subject of migration study. Vietnam experienced serious problems of emigration during the period of 1975-1988). However, unusual issue such as refugees is now completely replaced by normal international patters.

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