“The publication attempts to reflect the regional situation by examining the views and policies of each country in the South-East Asia Region from 1975 to 2005 with respect to population size and growth, population age structure, fertility and family planning, health and mortality, spatial distribution and international migration within the context of demographic, social and economic change. The material is amply illustrated with graphs demonstrating trends in countries of the Region and over time.”
POPULATION SITUATION AND POLICIES IN THE SOUTH-EAST ASIA REGION

World Health Organization
Regional Office for South-East Asia
# Content

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Foreword

The South-East Asia Region of WHO with its 11 Member countries is home to approximately a quarter of the world’s population and represents various cultures and levels of social and economic development. Its Member countries also differ in terms of population dynamics and policies.

The current publication analyses population policies and dynamics in the Region drawing on the date included in the World Population Policies 2005. The core information included in the monitoring of population policies encompasses two basic components: (i) government perceptions of population size and growth, population age structure and spatial distribution, and of the demographic components of fertility, mortality and migration which affect them; and (ii) government policies with respect to each variable and plans to influence each variable.

The publication attempts to reflect the regional situation by examining the views and policies of each country in the South-East Asia Region from 1975 to 2005 with respect to population size and growth, population age structure, fertility and family planning, health and mortality, spatial distribution and international migration within the context of demographic, social and economic change. The material is amply illustrated with graphs demonstrating trends in countries of the Region over time.

This review contains full range of information on the population situation in the countries of the South-East Asia Region and is a useful source for addressing population and reproductive health issues at the national and regional levels.

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Regional Director
1. Introduction

The South-East Asia Region (SEA) represents various cultures and levels of social and economic development. Its member countries also differ in terms of population dynamics and policies. A review of the population situation and policies in the Region would be useful for addressing population and reproductive health issues.

The United Nations Department of Economic and Social Affairs, through its Population Division, provides regular monitoring on population policies of countries all over the world. The work was initiated in 1974 at the World Population Conference held at Bucharest through the adoption of the World Population Plan of Action, which uses major population variables in its framework to define population policies. The World Population Plan of Action was elaborated further through the Programme of Action of the International Conference on Population and Development held at Cairo in 1994.

The *World Population Policies 2005* was published as a part of the effort to disseminate information resulting from the population monitoring activities. It provides an overview of population policies and dynamics for countries that utilized data from the mid-decade of the 1970s, 1980s, 1990s, as well as of 2005. There are three basic components included in the monitoring of population policies: i) government perceptions of population size and growth, population age structure and spatial distribution, and of the demographic components of fertility, mortality and migration that affect them; ii) government objectives with respect to each variable; and iii) government policies concerning interventions to influence each variable.

It was acknowledged that the monitoring exercise had helped to increase awareness of population issues globally as well as the need for appropriate policy responses. This had contributed to the evolution of government views on population issues and in formulating population policies. Such awareness would be beneficial to countries in the South-East Asia Region as well. For this reason, information on population policies in the South-East Asia Region (SEAR) countries – using the information and data provided in the *World Population Policies 2005* – is presented. Table 1 shows the population size in 11 countries of the Region.
Table 1: Population size of countries in SEAR, 1975-2005 (in thousands)

<table>
<thead>
<tr>
<th>Countries</th>
<th>1975</th>
<th>1985</th>
<th>1995</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bangladesh</td>
<td>73,178</td>
<td>92,818</td>
<td>116,455</td>
<td>141,822</td>
</tr>
<tr>
<td>2. Bhutan*</td>
<td>358</td>
<td>480</td>
<td>507</td>
<td>637</td>
</tr>
<tr>
<td>3. DPR Korea</td>
<td>16,018</td>
<td>18,438</td>
<td>30,918</td>
<td>22,488</td>
</tr>
<tr>
<td>4. India</td>
<td>620,701</td>
<td>766,053</td>
<td>935,572</td>
<td>1,103,371</td>
</tr>
<tr>
<td>5. Indonesia</td>
<td>134,395</td>
<td>166,180</td>
<td>195,649</td>
<td>222,781</td>
</tr>
<tr>
<td>6. Maldives</td>
<td>137</td>
<td>184</td>
<td>252</td>
<td>329</td>
</tr>
<tr>
<td>7. Myanmar</td>
<td>30,138</td>
<td>37,237</td>
<td>44,500</td>
<td>50,519</td>
</tr>
<tr>
<td>8. Nepal</td>
<td>13,548</td>
<td>17,003</td>
<td>21,682</td>
<td>27,133</td>
</tr>
<tr>
<td>9. Sri Lanka</td>
<td>14,042</td>
<td>16,437</td>
<td>18,872</td>
<td>20,743</td>
</tr>
<tr>
<td>10. Thailand</td>
<td>41,292</td>
<td>50,612</td>
<td>58,336</td>
<td>64,233</td>
</tr>
<tr>
<td>11. Timor-Leste</td>
<td>672</td>
<td>659</td>
<td>848</td>
<td>947</td>
</tr>
<tr>
<td>Total</td>
<td>944,479</td>
<td>1,166,101</td>
<td>1,423,591</td>
<td>1,655,003</td>
</tr>
</tbody>
</table>

Source: World Population Policies, 2005
* Source: World Population Prospects 2006 Revision


The increasing problem of HIV infection is considered as the most significant issue in both developed and developing countries. The high maternal, infant and child mortality rates are the next most important issues in the developing countries, besides the large size of the working-age population, high adolescent fertility, low life expectancy, high fertility and high population growth. In contrast, the developed countries face concerns related to low fertility, population ageing and the small size of the working-age population.

Population size and growth

Many developing countries have realized the importance of reducing the high rates of population growth in order to ease the pressure on resources, environmental pollution and degradation, food insufficiency, provision of employment and basic social services. In countries of the South-East Asia Region, these concerns have been mostly translated into policy interventions.
DPR Korea and Thailand view their population growth rate as too low, while Myanmar views it as satisfactory. DPR Korea and Thailand have decided to maintain their current situation, while Myanmar has not made significant interventions for population growth. Figure 1 shows the trends of population growth rate during the period 1975-2005.

The other countries in the Region view their population growth as being too high in 2005 and aim to make lower their population growth rate. As a new emerging country with the highest population growth rate at 5.4%, Timor-Leste – with the highest TFR of 7.8 children per woman and contraceptive prevalence rate as low as 9% in 2005 – has just developed a strategy for improving access to modern methods of contraception.

**Population age structure**

The shift from high to low mortality and fertility is known as the *demographic transition*. In the classic transition, the trend of high birth and death rates – and minimal population growth – is disrupted by a long-term decline in mortality.
Mortality rates eventually stabilize at low levels, followed by a decline in birth rates to about the same level as the mortality rates. This would create the equilibrium of slow population growth from *natural increase* (birth rate minus death rate). To maintain *replacement level* fertility, the TFR must be slightly above 2.0 (i.e. 2.1).

One of the consequences of the demographic transition is the evolution in the age structure. Many developing countries in the midst of the transition have experienced rapid shifts in the relative numbers of children, working-age population (15-59 years) and older persons (60 years or older). Almost all the countries in the South-East Asia Region have worried concerns regarding the population age structure, except DPR Korea and Sri Lanka. While DPR Korea is not concerned, Sri Lanka is mildly concerned at the size of working-age population and ageing of the population. Figure 2 shows the trends in the percentage of the population below 15 years and 60 years or older in 1975-2005 in the SEA Region.

![Figure 2a. Trends in percentage of population under 15 years, SEAR, 1975-2005](image)

The nature of the concern related to size of working-age population differs between developed and developing countries: too small number that poses problems of labour shortages versus too large number that poses problems
of high unemployment. The concerns related to the increasing size of ageing population included decrease of the working-age population, pension system viability and provision of care for the growing older population. In dealing with the challenge, developed countries implemented possible interventions, such as increasing the retirement age and encouraging more women to enter the workforce.

**Fertility and family planning**

As shown in Figure 3, all countries in the Region have shown a significant decline in total fertility rate (TFR, average number of births per woman) during the period 1975-2005, except for Timor-Leste which has the highest TFR in the world. The global total fertility declined from an average of 4.5 births per woman in 1970-1975 to 2.6 births in 2000-2005. In the Region, six countries had a TFR higher than 2.6 in 2005, despite the significant decline they achieved during the last three decades, i.e. Bangladesh (3.2), Bhutan (4.4), India (3.1), Maldives (4.3), Nepal (3.7) and Timor-Leste (7.8). While seven countries in the Region viewed their TFR as too high, DPR Korea viewed it as too low and Myanmar, Sri Lanka and Thailand viewed as satisfactory.
The governments’ responses were consistent with their views on their TFR: seven countries wanted to lower their TFR, no intervention was planned in DPR Korea while Myanmar, Sri Lanka and Thailand wanted to maintain the current level.

Governments have implemented a variety of measures to directly and indirectly affect fertility levels, i.e. the integration of family planning and safe motherhood into the primary health care system; improving access to other reproductive health services; enhancing the role of men in reproductive health; raising the legal age at marriage; improving female education and employment opportunities; discouraging son preference and provision of low-cost, safe and effective contraceptives.

Most countries in the Region have improved access to modern contraceptive methods by providing direct support through government-run facilities, i.e. hospitals, health centres, clinics and health posts and through government field workers. Indirect support through nongovernmental activities has been provided. Figure 4 shows the percentage of married women using modern contraception in the SEA countries. The use of traditional contraceptive
methods was significant in some countries, i.e. Bangladesh and Sri Lanka, accounting to 11% using traditional methods out of 58% of all contraceptive users in 2005 in the former and 20% out of 70% of all contraceptive users in 2005 in the latter.

Adolescent fertility (women younger than 20 years of age bearing children) was a concern for governments in developing countries. Early childbearing entails a much greater risk of maternal, neonatal and infant morbidity and mortality. Seven countries of the Region viewed adolescent fertility as a major concern and have developed policies and programmes to overcome the problem. DPR Korea and Sri Lanka considered that this issue is a minor concern; however, Sri Lanka has developed some policies and programmes on adolescent fertility. No data are available for Bhutan and Timor-Leste. Figure 5 shows teenage fertility rate (per 1,000 women aged 15-19 years) in countries of the Region, while Figure 6 shows the percentage of births to women under 20 years.
Health and mortality

The pursuit of health and longevity are among the fundamental pillars of development. Life expectancy at birth has improved substantially in the last few decades, mainly as a result of more attention given to health concerns and reduction of infant and child mortality. However, most countries in the Region
feel that their level of life expectancy is not acceptable. Only Sri Lanka and Thailand view it as acceptable.

Some countries in the Region have not met the goal of life expectancy at birth higher than 70 years by 2000-2005 as stated in the Programme of Action. Many factors have contributed to the situation, including political and economic crises, socio-economic restructuring, unhealthy life-styles, re-emergence of diseases, such as tuberculosis and malaria and the impact of the HIV/AIDS epidemic, besides inability to provide a minimal package of cost-effective public health and clinical services because of too low government expenditure on health. Figure 7 shows the trends in life expectancy at birth for both sexes combined – the South-East Asia Region.

All countries view their infant and under-five mortality rates and maternal mortality ratio as being unacceptable. Although dissatisfaction with the level of infant and child mortality has been decreasing since the early 2000s, concern on the level of maternal and neonatal mortality remains high. Many countries with high maternal and neonatal mortality have problems in improving access to essential maternal and newborn health services. Lack of skilled health personnel at the primary health care level is a major contributor among other problems. Lack of progress in achieving health objectives, i.e. those cited in the Millennium Development Goals and other international development goals may have been due to wide inequalities
within countries: wealthy and poor populations, urban and rural, male and female, as well as due to inequalities between countries. Figures 8, 9 and 10 show infant mortality and under-five mortality rates and maternal mortality ratio respectively during the period 1975-2005.

Figure 8. Infant mortality rate, SEAR, 1975-2005

Source: World Population Data, 2005

Figure 9. Under-five mortality rate, SEAR, 1975-2005

Source: World Population Data, 2005
As stated above, the AIDS epidemic has been one of the greatest challenges confronting the international community. All countries in the Region, except DPR Korea, view HIV infection as a major concern, especially from 1995 onwards. The Region contributed a significant number of HIV/AIDS cases. As of the end of 2005, in India alone there were an estimated 5.7 million people living with HIV/AIDS. Among those aged 15-49, there were an estimated 5.2 million living with the disease at the same point in time\(^1\). While still India’s prevalence rate is relatively low, there are large scale prevention and other interventions today undertaken to contain a risk of a more serious epidemic in the future. With 20% of the global population in India, even a small increase in its HIV/AIDS prevalence rate would represent a significant component of the world’s HIV/AIDS burden. Governments have pursued a multi-pronged strategy to combat HIV/AIDS by focusing on: i) prevention; ii) care and treatment; iii) protection from discrimination and stigmatization; iv) development of multi-sectoral strategies; v) creation of HIV/AIDS coordination bodies and vi) establishment of partnerships with civil society, people living with HIV/AIDS, community-based groups, nongovernmental organizations and the private sector. Figure 11 shows the number of infected adults in some countries of the Region.

In countries of the Region, prevention is an important aspect for response to the HIV/AIDS epidemic, besides care, support and treatment programmes. Public awareness programmes have been carried out in countries with the involvement of all stakeholders. While the condom use programme is widespread, supply shortages and poor quality of services persist. Although antiretroviral treatment can significantly prolong lives and alleviate suffering of people living with HIV/AIDS, access to such treatment is extremely low.

Policies on abortion vary widely in countries of the Region. The grounds on which abortion is permitted include: i) to save a woman’s life; ii) to preserve physical health; iii) to preserve mental health; iv) rape or incest; v) foetal impairment; vi) economic or social reasons; vii) on request. Abortion is legally available on request in DPR Korea, India and Nepal, while in most other SEA countries abortion is permitted only to save a woman’s life and for preserving physical and/or mental health. Abortion is permitted in Thailand on the first four grounds stated above. Bangladesh permits menstrual regulation up to 8-10 weeks of gestation.

**Spatial distribution and internal migration**

Another significant demographic trend during 1950-2000 was the large movement of persons from rural to urban areas. Countries with a large population, such as Bangladesh, India, Indonesia and Thailand desired a major change during the period 1995 onwards; however, the Government of
Bangladesh viewed that the situation was satisfactory in 2005. Countries with a smaller population, such as Bhutan, Maldives, Myanmar, Nepal, Sri Lanka and Timor-Leste, desired minor change, while DPR Korea viewed the situation as satisfactory. Figure 12 shows the percentage of the urban population in the Region.

Most governments feared that rapid urban growth would hamper their ability to provide basic urban services, such as safe drinking water, sanitation, affordable housing, public transportation and employment. They carried out some interventions to modify the undesired spatial distribution patterns to lower or maintain the level of internal migration, although they were not always successful in meeting their objectives. These included redirecting growth from large urban agglomerations to small and medium-sized cities, establishing sustainable rural development, undertaking land redistribution schemes, creating regional development zones, imposing internal migration controls and moving the national capital.

In the early 1980s, the Indonesian Government had implemented a large transmigration programme (involving approximately 2.5 million people in 5 years) to move landless people from densely populated areas in Java to less populous areas of the country. While the purpose of the programme was to reduce the considerable poverty and overpopulation on Java, it was controversial.
and even led to conflict between settlers and indigenous populations. Some adjustments were made to the programme and currently there is a slower annual rate of resettlement involving approximately 15,000-20,000 families.

**International migration**

More attention is being paid to international migration, as governments, both of the countries of origin and destination, are confronted with competing priorities that relate to employment, trade, development and national security. Two important initiatives have been taken in this regard: i) establishment of the Global Commission on International Migration in 2003, with a mandate to provide the framework for the formulation of a coherent, comprehensive and global response to the issue of international migration. Its report published in 2005 focused on concerns related to the economic, social, human rights and governance dimensions of international migration, which led to the establishment of a broader and more formal coordination mechanism; ii) the decision by the UN General Assembly to have a high-level dialogue on international migration and development during its sixty-first session in 2006 to discuss its multidimensional aspects in order to identify appropriate ways and means to maximize its development benefits and minimize its negative impact.

Most countries in the Region view the level of international immigration as satisfactory, except Indonesia which considers it to be too low and Nepal which

![Figure 13. Percentage of international migrant stock in SEAR, 1975-2005](source: World Population Data, 2005)
considers it to be too high in 2005. Most countries wanted to maintain the current level, while Myanmar desired to lower. Figure 13 shows the trends of proportion of international migrant stock in the Region between 1975-2005. Since the mid-1990s, governments have moved away from policies to restrict migration by focusing on the better management of migration flows. This significant shift was attributable to factors including improved understanding of the consequences of international migration; the growing recognition of the need to better manage migration; the persistence of labour shortages in some sectors; regional harmonization of migration policies; an expanding global economy and long-term trends in population ageing.

Labour migration has become more complex, as it often depends on the skills that migrants possess. Many developed countries have provided fiscal incentives for highly-skilled migrants, i.e. income tax-free status or large tax deductions. In SEAR, only Bhutan wanted to reduce the entry of highly-skilled foreign workers in 2005 with the aim to improve the employment prospects of its nationals.

On the contrary, most developing countries want to reduce emigration, especially of highly-skilled workers. However, 11 countries – nine of which were in Asia, including Bangladesh, India, Indonesia and Thailand – have policies to increase emigration. These countries have a young population age structure and high unemployment, particularly among young people. A sharp rise in the emigration of skilled workers has prompted some countries to address the brain drain through initiatives to encourage the return of skilled workers.

Population ageing and rising job expectations have also produced labour shortages in low-skilled sectors, such as agriculture, construction and domestic services. Some countries have devised bilateral agreements in this area covering seasonal, contract, guest and cross-border workers for temporary migration without an expectation of obtaining permanent residence status.

Most countries of destination have some basic provision for family reunification, which allows individuals to join family members already in the country. While it ensures the integrity of the family unit, it is a type of migration that is difficult to manage. It is open to potential abuse through marriages that use family reunification provisions as a means of trafficking. To avoid such practice, some countries have tightened requirements for the immigration of spouses,
i.e. by raising the minimum age requirement for reunification of spouses or after successful integration for a specified period.

Policies on the integration of migrants have mostly used assimilation as a means of integration; however, many developed countries have recognized and promoted the benefits that diversity brings to their society. To ensure that minimal human rights standards are respected, many countries have adopted non-discrimination provisions to protect religious freedom and the use of other languages. To improve migrants’ access to labour markets, some countries have introduced education and employment training programmes.

3. Summary and Conclusion

The *World Population Policies 2005* tracks the evolution of governments’ views and policies on population and development that have taken place since the convening of the World Population Conference in 1974. It shows that governments, including those in countries of the South-East Asia Region, have become increasingly concerned with the consequences of population trends, which have facilitated their actions in addressing major population issues.

Population policies and programmes in many countries have been reoriented towards the Programme of Action of the International Conference on Population and Development (ICPD) in 1994, the goals of ICPD+5 year review undertaken in 1999 and the ICPD+10 year review undertaken in 2004. For example, in the area of family planning, policies focusing on women of reproductive age have given way to a life-cycle oriented reproductive health approach encompassing both sexes. Targets to reduce the unmet need for contraception have replaced fertility reduction and contraceptive-use targets. Improving choice and availability of methods and the quality of care have also become priorities.

Most countries in the Region are in the midst of a demographic transition, with major concerns on many aspects of population issues as elaborated above. However, a few countries in the Region seem to have completed the demographic transition period and have achieved replacement-level fertility, such as DPR Korea, Sri Lanka and Thailand. These countries can provide lessons learnt on how to successfully respond to the increasing challenges of population development. Collaboration and networking within the Region, as well as with other countries outside the Region would be useful for sustainable population development.
References


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