Social Policy and Population Growth in South-East Asia

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The socio-economic setting and the population problem

SOUTH-EAST ASIA comprises Burma, Indonesia, the Khmer Republic, Laos, Malaysia, the Philippines, Singapore, Thailand, the Democratic Republic of Viet-Nam and the Republic of Viet-Nam (hereinafter referred to respectively as North and South Viet-Nam). In 1971, 294 million people lived in these ten countries. From table 1, it will be seen that with the exception of Malaysia and Singapore which have a relatively high gross national product per head of US$380 and US$920 respectively, the bulk of the population of south-east Asia has a low annual income per head ranging from US$80 in Burma and Indonesia to US$210 in the Philippines. In most of these countries about 80 per cent of the inhabitants live in rural areas, the exceptions being Malaysia, the Philippines and Singapore.

If one excludes the city State of Singapore with its 2.2 million inhabitants, practically the entire south-east Asian region is in the " high fertility zone ", with a crude birth rate of around or over 40 per thousand in most countries.[2] Nearly one-third of the entire south-east Asian population, that is to say, the populations of Burma, Indonesia, the Khmer Republic, Laos and North and South Viet-Nam are also in the " high mortality zone ", with relatively high crude death rates. Table 2, showing the average number of inhabitants per physician and nurse in eight countries gives an idea of the progress which still remains to be made by the majority of south-east Asian countries in reducing mortality.

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[2] The temporal trends in crude birth rate are not available for most of the south-east Asian countries. The countries in the high fertility zone, we may conjecture, have not experienced any reduction in fertility in the past. In West Malaysia, on the other hand, the crude birth rate declined from 44 in 1950 to 37 in 1968, and in Singapore it has fallen sharply from 46 in 1950 to 22 in 1970; however, West Malaysia and Singapore together account for less than 4 per cent of the south-east Asian population.

TABLE 1. GROSS NATIONAL PRODUCT PER HEAD, TOTAL AND URBAN POPULATION CRUDE BIRTH AND DEATH RATES

Country	(1) GNP per head, 1970 (US$)	(2) Average annual growth rate of population, 1960-70 (%)	(3) Population [1] (millions)	(4) Crude birth rate [1] (per 1,000)	(5) Crude death rate [1] (per 1,000)	(6) Urban as % of total population, 1970
Burma	80	2.1	28.4	40	17	19
Indonesia	80	2.0	124.9	47	19	17
Khmer Republic	130	3.2	7.3	45	16	12
Laos	120	2.4	3.1	42	17	15
Malaysia	380	3.1	11.1	37	8	45
Philippines	210	3.0	39.4	46	12	34
Singapore	920	2.4	2.2	22	5	100
Thailand	200	3.1	37.4	42	10	15
Viet-Nam (North)	100	2.8	21.6	.	.	18
Viet-Nam (South)	200	2.6	18.3	44	15	24

[1] Estimates for 1971.

Sources: Columns 1 and 2: IBRD: *World Bank atlas* (Washington, 1972). Columns 3, 4 and 5: Population Reference Bureau: *1971 world population data sheet*; You Poh Seng and Stephen Yeh: "Aspects of population growth and population policy", in Asian Development Bank: *Southeast Asia's economy in the 1970s* (London, Longman, 1971); and *Yearbook of statistics, Singapore, 1972/73.* Column 6: Dorothy Nortman: "Population and family planning programs: a factbook", in *Reports on population/family planning* (New York, Population Council, 1973).

It shows clearly the relationship between the relatively low levels of mortality noted in Singapore and Malaysia (cf. table 1) and the progress achieved there in the medical and health fields.

The majority of south-east Asian nations are thus faced with the urgent and challenging task of simultaneously reducing the levels of fertility as well as of mortality, since a reduction in mortality alone may cause the rate of population growth to rise to 3 per cent or more and aggravate such social problems as poverty, illiteracy, unemployment and urban slums.

To illustrate just one aspect of the current level of social development, educational development is considered here in simple quantitative terms. From table 3, it will be noted that the situation in regard to secondary education is by no means bright in nearly two-thirds of south-east Asia. The secondary school (crude) enrolment percentages are very low in Burma, Indonesia, Laos, Thailand and South Viet-Nam. The situation is worse in respect of females than of males.

The south-east Asian nations are generally aware of the necessity to increase the educational levels of their populations. In fact the spreading

TABLE 2. AVAILABILITY OF HEALTH PERSONNEL

Country and year	Population ('000)	
	Per physician	Per nurse
Burma, 1971	9	7
Indonesia, 1972	21	6
Khmer Republic, 1971	15	2
Laos, 1971	13	4
Malaysia (West), 1970	4	2
Singapore, 1971	1	2
Thailand, 1970	11	5
Viet-Nam (South), 1970	12	5
Approximate range for developed countries	0.4-0.9	0.2-0.4

Source: Nortman, op. cit.

of secondary education to a larger proportion of males and females may prove conducive to the reduction of fertility and mortality. The problem of " educated unemployment " must, however, be avoided, for otherwise the favourable impact of education on population growth may be outweighed by the unfavourable social effects. The dilemma can be resolved to a great extent by appropriate educational policies and reforms which emphasise the virtues of and prepare students for a productive and healthy life, and provide an education that fosters character development,

TABLE 3. MALE AND FEMALE ENROLMENT IN PRIMARY AND SECONDARY SCHOOLS

Country and year	% of eligible age group enrolled			
	Primary schools		Secondary schools	
	Males	Females	Males	Females
Burma, 1966	83	77	17	11
Indonesia, 1965	69	63	11	.
Laos, 1968	58	34	5	1
Malaysia (West), 1969	94	88	34	24
Philippines, 1967	87	86	42	42
Singapore, 1972	97	94	72	69
Thailand, 1968	82	76	13	10
Viet-Nam (South), 1968)	100	82	31	21

Source: Nortman, op. cit.

TABLE 4. GOVERNMENT EXPENDITURES ON SOCIAL SERVICES AS PERCENTAGE OF GDP

Country	Year	Total	Education	Health	Social security and welfare	Housing, etc.
Singapore	1961	6.1	2.9	2.0	0.6	0.6
	1966	7.5	4.0	2.1	0.3	1.1
West Malaysia	1960	5.7	3.5	1.5	0.5	0.2
	1965	6.8	4.8	1.8	0.1	0.1
Philippines	1966	3.8	3.1	0.6	← 0.1 →	
Thailand	1959	3.6	2.7	0.4	0.4	0.1
	1966	4.3	2.6	0.6	0.6	0.5

Source: *Economic Bulletin for Asia and the Far East* (New York, United Nations), June 1969, p. 38.

inter-racial and inter-denominational understanding and the quality of life in general.

Data on government expenditure on social services as a proportion of the gross domestic product of selected countries are given in table 4. In general, there is increasing allocation of expenditure to education, health, social security, social welfare and public housing. This is in line with the general feeling of governments that social services do contribute to economic betterment and that economic development is, in the last resort, only a means to social progress. Many national development plans of south-east Asian countries aim at improving living standards, which is taken to mean better health, education, housing and welfare. For instance, the National Overall Development Plan (1961-69) of Indonesia states the goal of " sufficient food, clothing, proper housing and proper health and education ".

Singapore and Malaysia have introduced free primary education. In Indonesia, a presidential decree has been issued concerning the adoption of a more intensive literacy programme in the over-all development plans. In the Philippines, the Educational Act prescribed compulsory primary schooling as long ago as 1940. These policies have helped in checking the prevalence of child labour in the postwar years.[1]

[1] The situation was different before the Second World War. Prohibition of child labour was not taken seriously and legislation, where it existed, was largely aimed at reducing the workload on children, not at prohibiting child labour itself. In the postwar years, several factors, including expanded educational opportunities and the work done and assistance rendered by the ILO, contributed to the rapid reduction of child labour. While the present dimensions of the problem are not clearly known, there may still be pockets of economic activity where children are employed because they are dropouts from school or for other reasons.

Social insurance schemes of some form exist in most countries, affording protection to employees in certain occupations against such risks as sickness and industrial accidents, while employees in the modern industrial and service sectors are generally covered by provident fund schemes in respect of old age. Social security schemes, however, have not yet generally been extended to cover the rural and unorganised sectors. Thus the Sixth Asian Regional Conference of the ILO (Tokyo, September 1968), in its resolution concerning social security development in Asia, recognised that " while a number of Asian countries have introduced social security measures and succeeded to a considerable extent in their development, the fact remains that the existing social security schemes still have a limited basis in many countries of the region, either because they do not cover certain large categories of workers or because persons whom the law covers may not be adequately protected in practice "; further that " . . . social security protection, whatever its forms may be, for the rural population is very limited in many Asian countries . . . ".[1] The Tokyo resolution contained a set of 35 detailed recommendations for the development of social security in Asia.

In respect of public housing, Singapore, among other south-east Asian countries, has a high degree of achievement to its credit. The housing programme in Singapore also has the unique feature of linking the programme to social security in a broad sense. For instance, employees' provident funds can be used to purchase government flats. By the end of 1970, the Housing and Development Board of Singapore had built over 120,000 units, with over a third of the Republic's population accommodated in public housing at subsidised rentals. By the end of 1975, 45 per cent of the total population is expected to be living in these high-rise flats.

To the extent that children are still considered to be economically useful in supplementing the family income when they are young or in supporting their parents in old age, the expansion of educational facilities currently taking place in south-east Asia and the much needed extension of social security coverage may be expected to contribute substantially to the effective implementation of population policies.

Population policies in selected south-east Asian countries [2]

Four of the ten nations of south-east Asia, namely Burma, the Khmer Republic, North Viet-Nam and South Viet-Nam, do not have an official population policy as such. The Burmese Government has a pro-

[1] *Official Bulletin* (Geneva, ILO), Vol. LII, 1969, No. 1, p. 64.

[2] The discussion in this section is based on the country profiles issued from time to time by the Population Council, New York, and the Council's other publications, especially *Studies in Family Planning* (New York), July 1972 and May 1973.

natalist attitude, and even though family planning is viewed as acceptable on maternal and child health grounds, contraceptives are not easily available.[1] The Khmer Republic has no population policy and there is no governmental support for population activities. In North and South Viet-Nam, on the other hand, such government support exists. South Viet-Nam is, in fact, moving towards the formulation of a population policy.[2] In addition to these four countries, Laos until recently did not have a population policy. In early 1972, however, the National Commission for Population and Family Well-Being was established by the Government, with the objective of reducing the population growth rate from the present estimated level of about 2.4 per cent to 1.2 per cent by the year 2000. The salient features of the population policies of the other five countries of south-east Asia are detailed below.

Indonesia

The first move towards the formulation and implementation of a population policy was made in 1968 when the National Family Planning Institute of Indonesia was created by the State Minister of People's Welfare, with the following functions: *(a)* to co-ordinate family planning programmes and activities; *(b)* to make recommendations to the Government about the national programme; *(c)* to promote co-operative arrangements between Indonesia and other countries in the field of family planning; and *(d)* to develop family planning on a voluntary basis and with a broad approach, including marriage counselling and the treatment of sterility. In January 1970 a presidential order replaced the National Family Planning Institute by the National Family Planning Co-ordinating Body.

The National Family Planning Programme, which came into full operation in 1971, is limited to the three overpopulated islands of Java, Madura and Bali, which account for 67 million of Indonesia's total population of 125 million. The number of new acceptors of family planning increased from 149,000 in 1970, to 419,000 in 1971. The factors that influenced the programme favourably included: *(a)* increased awareness, greater government expenditure and a larger number of field workers; *(b)* the elimination of charges to patients for contraceptive services; and *(c)* the provision of incentive payments for client referrals. The extent of the success achieved by the programme in a very short period of time can be gauged from the fact that for Java and Bali together, the cumulative number of acceptors per 1,000 fertile women increased from 1.85 in April 1971 to 15.65 in September 1971.

[1] Nortman, op. cit.

[2] At the time of writing, a high-level National Population Council was in process of being established to formulate population policy and co-ordinate assistance in the field of population.

Under the aegis of the Ministry of Education and private institutions, programmes on population questions for in-school and out-of-school groups are being organised, and curricula and teaching materials are being developed. However, there are still a few practices which are pro-natalist in nature. These include the payment of salaries that increase as the size of the family increases, the prevalence of generous maternity leave benefits and the pro-natalist elements of the prevailing laws regarding marriage and abortion.

Malaysia

Family planning activity in Malaysia started in 1953 with the establishment of a family planning association in the state of Selangor in West Malaysia. By 1962, all the 11 states of West Malaysia had family planning associations. Government policy on population was initiated in 1966 by an Act of Parliament. Under the Act, the National Family Planning and Population Board (NFPB) was established to formulate and implement programmes for reducing the rate of population growth. In West Malaysia today, the NFPB and private family planning associations are working together in the field of family planning. East Malaysia, however, still depends largely on private family planning associations, as the NFPB activities are mostly concentrated in the West Malaysian region.

The principal target of the national population policy is to reduce the crude birth rate from the 1966 level of 41.3 to 26.0 in 1985. The crude death rate is expected to decline from 7.6 in 1966 to 6.0 in 1985. The planned reduction in the annual rate of population growth is from a little over 3 per cent at present to 2 per cent in 1985.

At the end of 1971, in West Malaysia, the NFPB had 77 main clinics and 415 satellite stations, and the family planning associations had 31 main clinics and 155 satellite stations. Additionally, 216 rubber estates and 105 private doctors participated in the national programme. During 1971, emphasis was placed on providing family planning services in urban areas to couples in low-cost housing units and to factory workers, and in some rural areas to settlers under land development schemes.[1] During 1967-71, the cumulative number of family planning acceptors was over 277,000. During this period, the proportion of couples who had ever used contraceptive devices rose from 14 to 27 per cent.

In 1972, the Malaysian Ministry of Education took a major step towards creating an in-school population education programme. A three-year project, with supporting funds from the United Nations Fund for Population Activities (UNFPA), was established in which curricula and instructional materials are being developed for use in public schools and a

[1] Malaysia has over 28 million acres of land yet to be developed, and the Government land development programme is a very important element in the national five-year plans.

teachers' training programme will be conducted. Plans are also under way to develop an out-of-school population education programme. Also in 1972, the Malaysian Trade Union Congress began an active programme of information and education on population questions.

The Philippines

Until very recently, the Philippine official standpoint, as reflected in various socio-economic policy measures, was mostly pro-natalist. Examples of such policy were tax exemptions for large families, maternity leave benefits, and tax penalties on unmarried, as opposed to married, wage and salary earners. An apparent reason for the prevalence of these pro-natalist measures was the existence of large tracts of uninhabited and uncultivated land.

In December 1968, Mr. Rafael Salas (who now heads the UNFPA, and was then Executive Secretary to President Marcos) proposed the establishment of a Commission on Population. On 19 February 1969, the President signed an executive order establishing the Commission, a prominent objective of which was the formulation of policy and programme recommendations on population, considered in relation to economic and social development. The Commission concluded that a reduction in the rate of population growth was in the vital interest of the nation and recommended various policy measures.

The next major steps to formulate and implement a population policy were initiated in early 1970, and the Population Act of the Philippines came into effect in 1971. The Act established a permanent Commission on Population to carry out the national population policy and programme, the principal features of which are: *(a)* the setting of quantitative targets; *(b)* the promotion of public understanding of the effects of population growth; *(c)* the incorporation of family planning in a broad educational programme; *(d)* the provision of safe and effective means to couples desiring to space or limit procreation; *(e)* the further reduction of mortality and morbidity rates; *(f)* the adoption of policies and programmes for guiding and regulating labour force participation, internal migration and the spatial distribution of population; and *(g)* the establishment and maintenance of liaison with organisations concerned with population problems.

In line with the population policy, measures were also taken to overcome some existing policy provisions that are pro-natalist in effect. The most significant measure was the amendment, in 1972, of the National Inland Revenue Code. The amendment limits the number of dependants in respect of whom income tax exemptions may be claimed to four, and allows a standard deduction of 10 per cent of the gross income received by a working wife. The most recent changes are in the field of labour legislation. The new Philippine Labour Code of March 1973

contains several provisions aimed at fostering the national population policy. They include limitation of the number of maternity leaves with pay for female employees to four, mandatory provision of free family planning services in clinics which employers are required to maintain, and a requirement that the Department of Labour develop incentive bonus schemes to encourage family planning.

During 1970-71, the number of new family planning acceptors increased by 81 per cent and the following year by a further 52 per cent. By the end of 1972, 2,003 clinics were providing family planning services—an increase of 80 per cent over the 1971 number of 1,115 clinics, and a tenfold rise compared with the number in 1968. It was estimated that by the end of 1969 the cumulative number of acceptors was 160,000, approximately 3.5 per cent of all eligible women. Under the national programme for 1970-76, the acceptor target for the end of the 1976 financial year is 2.5 million, or 44 per cent of all eligible women. It is expected that the birth rate will decline from the mid-1970 level of 43.2 to a mid-1976 level of 36.7, and that the population growth rate will decline from 3 to 2.5 per cent.

Singapore

Family planning activities started in Singapore on a voluntary basis with the establishment of the Singapore Family Planning Association in 1949. During 1964-65, the Association's activities were reviewed, and at the Association's own request the Government took over all responsibilities in the population field. Towards the end of 1965, the Singapore Family Planning and Population Board (SFPPB) was established, with the aim of implementing a clearly defined population policy. Initially, the target was to reduce the crude birth rate from the 1964 level of about 32 per thousand to 20 per thousand by 1970.[1]

Up to 1966, the annual number of new family planning acceptors was less than 10,000. In 1966, the number was a little over 30,000. By the end of 1970, some 64 per cent of all married women aged 15 to 44 years were reached by the family planning programme. The crude birth rate was 22 per thousand in 1970, with an all-time low of 21.8 in 1969.

For the period 1971-75, the SFPPB has set a target of 80,000 new acceptors to be recruited evenly throughout the period. This programme is aimed at meeting the principal challenges coming from the hard-core non-acceptors, the rising number of newly-weds (resulting from the arrival on the scene of females born in the postwar " baby boom " period) and the continued desire for big families (an estimated 3.6 children per family), stemming largely from the wish to have male children.

[1] It should be noted that in the years before 1965 the Government was already aware of the population problem. For instance, it organised a three-month family planning campaign as part of its mass health education programme in late 1960.

With the help of a long-term family planning publicity campaign, the Government is advocating a two-child family norm as a national target. The SFPPB's most intensive campaign, spread over three months throughout the Republic, was waged in 1972 (this campaign won the Max Lewis Memorial Challenge Trophy at the 8th Asian Advertising Congress in Bangkok).

To tackle the problem of non-acceptors, a two-pronged attack was launched recently. Firstly, stronger social disincentives, as follows, were introduced in 1973 in order to discourage large families: *(a)* increased hospital lying-in fees, resulting in higher delivery fees, rising with successive children; *(b)* reduction of income tax allowances to cover the first three children only; *(c)* reduction of paid maternity leave to only two confinements (the confinement period was earlier reduced from six to four weeks); and *(d)* highest priority for subsidised public housing to families with two or fewer children. Secondly, steps have been taken to introduce population education in the school curriculum.

Thailand

Until the late 1950s, Thailand pursued a pro-natalist population policy. Thus bonuses for large families were introduced in 1956 under a government Act. Previously, during the Second World War, a Wedding Promotion Committee was appointed by the Minister of Health to encourage early marriages. It was only in 1959, after receiving a World Bank report stating that Thailand's population growth rate was too high and recommending the dissemination of birth control, that the Government began to show serious concern about the rate of population increase. In spite of this, there was no real anti-natalist activity directly sponsored by the Government for almost a decade. In early 1968, family planning services began to be offered as part of a newly introduced family health programme.

In March 1970, the Thai Government announced a national population policy, and the Ministry of Public Health established the National Family Planning Programme. A five-year programme, for incorporation in the 1972-76 development plan, was formulated with the following principal objectives: *(a)* to reduce the population growth rate from over 3 per cent to about 2.5 per cent by the end of 1976; *(b)* to give family planning information to eligible women, particularly those living in rural and remote areas, to motivate them to use contraception, and to make family planning services readily available throughout the country; and *(c)* to integrate family planning activities with the over-all maternal and child health services and thus mutually strengthen the activities in these closely related fields.

The proportion of married, fertile women between 15 and 44 years of age who were sterilised or practising contraception rose from 11 per cent

in mid-1969 to 22 per cent in mid-1972. Marital fertility declined by about 10 per cent during this period.

Concluding observations

Policies

Much as we would have liked to cover all areas of public policy which have some relation to population matters, it was clearly not possible to do so in a short article such as this. Suffice it to say that a declared policy is but the first step. Strategies and programmes generally differ from one country to another and depend very much on the stage of development, level of literacy and degree of urbanisation reached, as well as on several other factors. In countries where an insignificant proportion of the population pays income tax, it is unlikely that anti-natalist income tax measures will have an appreciable impact on population growth. Similarly, in countries where the majority of rural youths do not enter secondary and higher educational institutions, a policy of introducing population education in these institutions may have little effect on over-all population growth. Our point here is that the design and implementation of policies for the monetised, urban and modern sectors may be an easier task than in a different setting.

Organisation

Given appropriate policy objectives, strategies and programmes, the effectiveness of an organisation is judged by its achievements. In this context, we wish to record an observation which we feel is of considerable significance. Whether in Indonesia or in Malaysia, family planning associations, modern hospitals, special family planning clinics, etc., are endogenous to the urban social system. They are part and parcel of an urban way of life, and even though their presence alone cannot reduce urban fertility, in conjunction with declared policies they are of great assistance to urban households. On the other hand, the agencies implementing population policy are probably more exogenous than endogenous to the rural social system. It follows that the rural élite has a significant role to play in the success of government policy, and indeed it is not uncommon to find it playing an important role in the political process. The challenge lies in mobilising its participation in the implementation of a package of economic and social policies, geared not only to the reduction of rural fertility and mortality but to the over-all improvement of rural society.

Incentives and discentives

Government policies in south-east Asia and elsewhere are at present working towards the reduction of both poverty and population growth. It

may be possible to find workable incentive packages integrating health, education and social security benefits with suitable emphasis on fertility reduction. At the one extreme, a hard-line population policy would deny free benefits to those who opt for larger families. This policy might perpetuate ill-health, illiteracy and poverty in societies which currently have low income levels. At the other extreme, free benefits would be given regardless of family size, in which case, at least on this score, there would be no immediate need to opt for a smaller family. Whether or not, somewhere between these extremes, there is a desirable and workable alternative and whether it is at all necessary to integrate the small family norm with the provision of various government services are questions that require careful consideration by the government and people of each country concerned.