WORLD POPULATION TRENDS AND POLICIES

1981 Monitoring Report

VOLUME II

Population Policies

UNITED NATIONS

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Department of International Economic and Social Affairs
Population Studies, No. 79

WORLD POPULATION TRENDS AND POLICIES

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VOLUME II

Population Policies

UNITED NATIONS
New York, 1982

NOTE

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The term "country" as used in the text of this publication also refers, as appropriate, to territories or areas.

In some tables, the designations "developed" and "developing" economies are intended for statistical convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process.

Symbols of United Nations documents are composed of capital letters combined with figures. Mention of such a symbol indicates a reference to a United Nations document.

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PREFACE

The World Population Plan of Action, adopted by the United Nations World Population Conference at Bucharest in 1974, recommended that monitoring of population trends and policies "should be undertaken continuously as a specialized activity of the United Nations and reviewed biennially by the appropriate bodies of the United Nations system, beginning in 1977".[1] The present report is the third in a series of reports on this activity. The report of the first round was prepared in 1977[2] and the report of the second round was prepared in 1979.[3]

Prior to the report on the first round of monitoring, the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat had carried out numerous assessments of population trends. Mention should be made, for instance, of *The World Population Situation in 1970*,[4] *Population Bulletin of the United Nations, No. 7—1963, with special reference to conditions and trends of fertility in the world*,[5] *Levels and Trends of Fertility throughout the World, 1950-2000*,[6] *The Situation and Recent Trends of Mortality in the World*,[7] *Growth of the World's Urban and Rural Population, 1920-2000*,[8] and three consecutive reports on *World Population Prospects as Assessed in 1963, 1968* and *1973*.[9] Recent assessments can be found in *World Population Trends and Prospects by Country, 1950-2000: Summary of the 1978 Assessment*,[10] *Selected Demographic Indicators by Country, 1950-2000: Demographic Estimates and Projections as Assessed in 1978*[11] and *World Population Prospects as Assessed in 1980*.[12]

The outline of the report on the monitoring of population trends (volume I) was based on the discussion at the twentieth session of the Population Commission.[13] In addition to a general survey of the world population situation, special topics dealing with the relationships between population and development were included, emphasizing such important areas as the association between fertility, mortality and socio-economic variables, the developmental aspects of mortality differentials, the causes and consequences of internal migration in developing countries, the determinants of labour force participation, with special emphasis on the demographic characteristics of working women, the demographic impact on consumption patterns, the population-supporting capacity of agricultural land, and the disparities associated with socio-demographic development.

The present report on monitoring of population policies (volume II) was prepared by the Population Division on the basis of official government sources, including the "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action", statements made by Governments and national development plans.

The Population Commission at its twenty-first session, held from 26 January to 4 February 1981, reviewed a draft of this report and expressed the view that the monitoring of trends and policies provided an essential service to countries as well as to the international community.[14] The Commission recommended that the report be published and made available to Governments and institutions interested in population studies.

Acknowledgement is due to the United Nations Fund for Population Activities whose grant (GLO/78/P09) made the printing of this publication possible.

[1] *Report of the United Nations World Population Conference, 1974, Bucharest, 19-30 August 1974* (United Nations publication, Sales No. E.75.XIII.3), part one, chap. I, para. 107.

[2] United Nations publications, Sales Nos. E.78.XIII.3 and 4.

[3] United Nations publications, Sales Nos. E.79.XIII.4 and 5.

[4] United Nations publication, Sales No. E.71.XIII.4.

[5] United Nations publication, Sales No. 64.XIII.2.

[6] United Nations publication, Sales No. E.77.XIII.2.

[7] United Nations publication, Sales No. 62.XIII.2.

[8] United Nations publication, Sales No. E.69.XIII.3.

[9] United Nations publications, Sales Nos. 66.XIII.2, E.72.XIII.4 and E.76.XIII.4.

[10] United Nations publication, non-sales (ST/ESA/SER.R/33).

[11] United Nations publication, non-sales (ST/ESA/SER.R/38).

[12] United Nations publication, Sales No. E.81.XIII.8.

[13] See *Official Records of the Economic and Social Council, 1979, Supplement No. 2* (E/1979/22).

[14] See *Official Records of the Economic and Social Council, 1981, Supplement No. 3* (E/1981/13).

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Volume II

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Explanatory notes

The following symbols have been used in the tables throughout the report:

Three dots (. . .) indicate that data are not available or are not separately reported.

A dash (—) indicates that the amount is nil or negligible.

A hyphen (-) indicates that the item is not applicable.

A minus sign (−) indicates a deficit or decrease, except as indicated.

A full stop (.) is used to indicate decimals.

A slash (/) indicates a crop year or financial year, e.g., 1970/71.

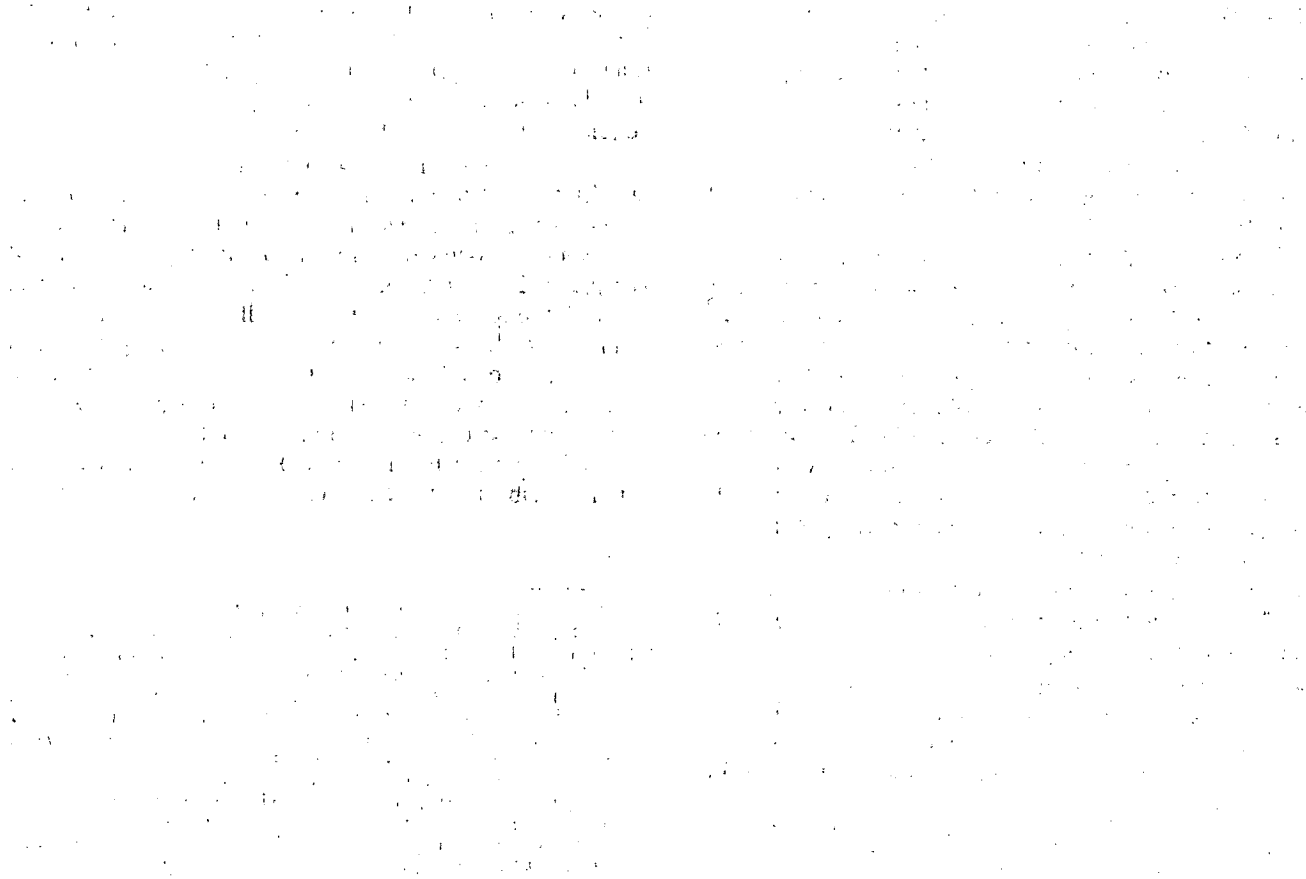
Use of a hyphen (-) between dates representing years, e.g., 1971-1973, signifies the full period involved, including the beginning and end years.

Details and percentages in tables do not necessarily add to totals, because of rounding.

Reference to "dollars" ($) indicates United States dollars, unless otherwise stated.

Part Three

POPULATION POLICIES



INTRODUCTION

The third report on monitoring of population policies was prepared in accordance with a recommendation of the World Population Plan of Action, adopted by the World Population Conference at Bucharest in 1974, that monitoring of population trends and policies "should be undertaken continously as a specialized activity of the United Nations and revised biennially by the appropriate bodies of the United Nations system, beginning in 1977".[1]

The present report on population policies is divided into four chapters, which deal, respectively, with population growth, mortality, fertility and international migration. The first three chapters consist of introductory remarks, a discussion of major issues and changes by level of development and the area of responsibility of each regional commission, and some general concluding remarks. The chapter on international migration has been organized differently from the others, in that it examines major migratory flows and related policies within and between the various areas and not by level of development.

The policies relating to spatial distribution of the population will be the subject of an extensive review in the fourth round of monitoring of population policies.

This third round of monitoring focuses more, as was the case for the second round, on measures rather than perceptions, examining in the selected sections of the report the emphasis of Governments. To ensure continuity between the second and third rounds of monitoring of population policies, the same basic tables, including those relating to spatial distribution of the population, have been retained and have been updated to reflect changes in perceptions and policies between 1978 and 1980.[2]

Particular attention has been given to measures related to fertility and international migration both in developed and in developing countries. The material from the Fourth Population Inquiry among Governments was heavily supplemented and updated with material from the Population Policy Data Bank. Although the experiences of all Governments are not examined in the text, the annex tables give the perceptions and policies of all Governments in 1980 (the tables are organized by area of responsibility of the regional commissions, geographical regions[3] and level of development). The test of the present monitoring report includes a number of summary tables with data according to the 24 geographical regions.

[1] *Report of the United Nations World Population Conference, 1974, Bucharest, 19-30 August 1974* (United Nations publication, Sales No. E.75.XIII.3), part one, chap. I, para. 10.

[2] See annex tables 38-52 to the present report.

[3] For convenience, the largest groupings used in the present report are the categories of "less developed regions" and "more developed regions" as established by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat, on the basis of socio-economic and demographic criteria. The former category includes all the countries of Africa, Latin America, East Asia (excluding Japan), South Asia and Oceania (excluding Australia and New Zealand). The latter category includes all the countries of Northern America and Europe, the Union of Soviet Socialist Republics and the countries just cited as being outside the "developing" classification. Within these two broadest groupings, there are eight "major areas" subdivided into 24 geographical regions, which are used at numerous points in the text and tables.

Chapter XX

NATURAL INCREASE OF THE POPULATION

The trend in the rates of natural increase of the population is one of the main concerns of most Governments, in both developed and developing countries.[1] It is also one of the mainstays of their activities in the population field. There are fewer and fewer Governments today that do not regard control over the various parameters of their population trends as their responsibility and a vitally important factor for the success of their national development plans. The way in which Governments assess the possible repercussions of the population situation on the attainment of development goals is the result of a process which, though complex, can be outlined as follows: Governments carry out an analysis of the advantages and drawbacks, over the short, medium and long terms, of the rate of natural increase of the population in relation to the various economic and social, aggregate and individual, regional and sectoral goals they have set themselves.

On completion of this analysis, which provides them with an evaluation of the net balance between the advantages and the drawbacks, and hence with an over-all view of the acceptability or otherwise of rates of natural increase, Governments will decide to take action or not to do so. Viewed from this angle, an attitude of non-intervention represents at the same time a political option, in so far as Governments that do not take action adopt this attitude on the basis of an analysis of the situation. Governments have confidence in the mechanisms of spontaneous evolution, or else they regard it as inappropriate in the political and social context of the country to act directly or indirectly in the demographic field.

Once the decision to take action has been made, Governments are faced with the problem of selecting the means of action to be put into operation and the vigour to be applied. Government action can be divided into two main categories: the first is direct or indirect intervention in respect of demographic processes, such as fertility, mortality, internal migration and international migration; and the second is intervention in regard to socio-economic factors making for the establishment or re-establishment of a balance between economic and demographic trends. Actually, intervention of a single dimension is rare; Governments more frequently undertake intervention of a multidimensional type. When it has been decided to take action and the means of action have been chosen, Governments still have to decide on the vigour with which they intend to implement their policy and the resources they are prepared to invest, according to the seriousness they attach to the situation. Support may be comprehensive or partial.

In the event of comprehensive intervention, the intent of the Government is manifested in an official stand indicating the direction of the thrust of the action, the choice of a series of varied approaches to the demographic and non-demographic processes, a clear-cut indication of the goals, allocation of substantial resources to implement the policy chosen etc.

Where support is partial, the aims in view are, as a rule, many in number; and the demographic goal is no longer preponderant. It is rare to find an official stand taken—frequently, of course, for reasons of political convenience. The range of measures adopted and the financial means made available are less ambitious.

In a later section, the situation at 1 July 1980 with regard to Governments' perceptions and policies relating to growth is summarized. Special attention is paid to changes that occurred during the period 1978-1980.[2]

This examination of Governments' perceptions and policies concerning growth rates takes place within the movement of deceleration of demographic growth that had begun early in the 1960s in the developed countries and rather later in the developing countries. The movement had become so widespread in certain developed countries that the rate of natural increase in 1980 was negative, and consequently the population was decreasing.

The growth rate for the world population in 1980[3] was estimated at 1.8 per cent; in 1960, it had been 2.0 per cent. In the developed countries, the rate declined from 1.1 per cent in 1960 to 0.6 per cent in 1980. During the same period, the rate decreased from 2.4 per cent to 2.2 per cent in the developing countries. As mentioned above, the rate was falling everywhere, except in Africa, where it rose from 2.5 per cent in 1960 to 3.0 per cent in 1980. The speed of the decline, however, varied from one major area to another, being more pronounced in East Asia, for example, but very slow in Latin America.

[1] Emphasis is placed on natural increase of the population rather than on population growth, since most countries did not regard international migration as important demographically. The remaining countries considered recourse to international migration to be the answer to a rate of growth they perceived as unsatisfactory. In the interests of simplification, the term "growth" as used in this chapter is taken to mean natural increase of the population.

[2] It should be pointed out here that the changes in perceptions and policies with which this report is concerned correspond to changes of a category determined in a conventional manner. A detailed analysis carried out on a national scale would make it clear that in the majority of instances, changes take place on a continuous and not on a discontinuous basis, as an outline analysis might suggest. It may be mentioned, however, that the very concept of the tables in which these changes are revealed in the present chapter represents an attempt to illustrate the progressive nature of the changes.

[3] *Selected Demographic Indicators by Country, 1950-2000: Demographic Estimates and Projections as Assessed in 1978* (ST/ESA/SER.R/38).

That then is the context in which one must examine Governments' perceptions and policies concerning growth. On a world scale, in 1980, 75 countries out of 165 (or 46 per cent) considered their rate of growth to be satisfactory (in 1978 the total had been 76 out of 158 countries), while 35 other countries (21 per cent) wanted to see a higher rate (compared with 36 in 1978). Lastly, 55 countries (33 per cent) preferred a lower rate. In 1978, 46 countries had represented that view. The considerable increase was due mainly to the fact that the seven countries that had gained their independence since 1978 desired a lower rate of growth (Zimbabwe in Africa; Dominica, Saint Lucia, and Saint Vincent and the Grenadines in Latin America; the Solomon Islands, Kiribati and Tuvalu in Oceania).

In the developed countries, the situation was as follows in 1980: 11 countries out of the total of 39 (28 per cent) desired to attain a higher rate; 28 (72 per cent) said they were quite satisfied; and none wanted a lower rate.[4] In the developing countries, the situation was for practical purposes the reverse: 24 countries out of 126 (19 per cent) wanted to attain a higher rate, 47 (37 per cent) said they were satisfied with

[4] For views of individual Governments concerning natural increase, see annex tables 38-39.

TABLE 1. GOVERNMENTS' PERCEPTIONS OF THE EFFECT OF NATURAL INCREASE ON DEVELOPMENT, ITS ACCEPTABILITY AND THE DESIRABILITY OF INTERVENTION TO CHANGE RATES, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

(Number of Governments)

Area of responsibility of regional commission, region and level of development	*Governments' perceptions of the effect of natural increase as a constraint on development, and the desirability of intervention*							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints					*Effect of constraints*		
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates desirable*			*Lower rates desirable*		
	Full intervention appropriate	*Some support appropriate*[b]		*No intervention appropriate*		*Some support appropriate*[b]	*Full intervention appropriate*	
	(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*Total*
ECA area								
Eastern Africa	—	—	1	2	6	3	4	16
Middle Africa	3	—	2	—	3	1	—	9
Northern Africa	1	—	—	—	1	1	3	6
Southern Africa	—	—	—	—	—	—	4	4
Western Africa	2	—	3	1	7	2	1	16
TOTAL	6	—	6	3	17	7	12	51
ECE area								
Eastern Europe	2	—	3	1	—	—	—	6
Northern Europe	—	—	3	4	—	—	—	7
Southern Europe	—	1	2	3	3	—	—	9
Western Europe	4	1	3	—	1	—	—	9
Cyprus, Israel and Turkey	1	1	—	—	—	—	1	3
Northern America	—	—	—	1	1	—	—	2
USSR	—	3	—	—	—	—	—	3
TOTAL	7	6	11	9	5	—	1	39
ECLA area								
Caribbean	—	—	—	—	1	4	6	11
Middle America	—	—	—	—	2	2	3	7
Temperate South America	2	1	—	—	—	—	—	3
Tropical South America	1	1	1	2	3	1	—	9
TOTAL	3	2	1	2	6	7	9	30
ECWA area								
Western South Asia[c]	4	1	1	1	5	—	—	12
TOTAL	4	1	1	1	5	—	—	12
ESCAP area								
China	—	—	—	—	—	—	1	1
Japan	—	—	—	—	1	—	—	1
Other East Asia	2	—	—	—	—	—	1	3
Eastern South Asia	2	—	1	1	1	—	4	9
Middle South Asia	—	1	—	1	1	—	6	9
Australia-New Zealand	—	—	1	—	1	—	—	2
Melanesia	—	—	—	—	—	1	1	2
Micronesia-Polynesia	1	—	—	—	—	2	3	6
TOTAL	5	1	2	2	4	3	16	33
Developed countries	6	5	12	9	7	—	—	39
Developing countries	19	5	9	8	30	17	38	126
TOTAL	25	10	21	17	37	17	38	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 38.

[b] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level that could be considered too low or too high.

[c] Excluding Cyprus, Israel and Turkey.

the existing rate, and 55 (44 per cent) wanted to see a lower rate. Thus, of the developing countries, 63 per cent were not satisfied with their growth rate, as against only 28 per cent of the developed countries (see tables 1 and 2). The gulf between the way in which countries perceived their level of development was still further widened in the statistics based on population, which showed that 29 per cent of the world population lived in countries that were quite satisfied with their rate of natural increase. That figure accounted for 64 per cent of the population of developed countries and only 17 per cent of the population of developing countries. The rest, or 71 per cent of the population, lived in countries that were not satisfied with the rate (12 per cent because the rate was too low, 59 per cent because was too high). On the basis of level of development, these percentages became, respectively: 36 per cent for the population of developed countries who lived in countries that were not satisfied with the rate of growth, but all of them because they regarded the rate as too low; and 83 per cent of the population of the developing countries who lived in countries that were not satisfied with their rate (4 per cent because the rate was too low and 79 per cent because it was too high—see table 3). That accentuation of the gap between perceptions by number of countries and by population was due to the considerable demographic weighting of the large countries in Asia, all of which wanted to achieve a lower rate of growth.

The distribution of Governments' perceptions of population growth were considered in the context of the general decline in the growth rate. That distribution of perceptions could also be looked at in relation to the level of the rate of growth and the size of the population. In table 4, sections A and B, the countries are classified according to the way they viewed the rate of growth of the population and the level of that rate.

It was found that among developed countries, where the growth rate was almost universally lower than 1.5 per cent, approximately one third considered the rate too low; but two thirds said they were satisfied with it, especially those

TABLE 2. GOVERNMENTS' PERCEPTIONS OF THE EFFECT OF NATURAL INCREASE AS A CONSTRAINT ON DEVELOPMENT, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND LEVEL OF DEVELOPMENT, JULY 1980

(Number of countries as a percentage)

Area of responsibility of regional commission and level of development	*Rates too low*	*Rates neither too low nor too high*	*Rates too high*	*Total*
ECA area	12	51	37	100
ECE area	33	64	3	100
ECLA area	17	30	53	100
ECWA area	42	58	—	100
ESCAP area	18	24	58	100
Developed countries	28	72	—	100
Developing countries	19	37	44	100
TOTAL	21	46	33	100

TABLE 3. GOVERNMENTS' PERCEPTIONS OF THE EFFECT OF NATURAL INCREASE ON DEVELOPMENT, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Area of responsibility of regional commission and level of development	*Rates too low*	*Rates neither too high nor too low*	*Rates too high*	*Total*
A. *Percentage distribution of countries by type of perception in areas of responsibility of regional commissions*				
ECA area	4	55	41	100
ECE area	40	56	4	100
ECLA area	14	53	33	100
ECWA area	24	76	—	100
ESCAP area	1	9	90	100
Developed countries	36	64	—	100
Developing countries	4	17	79	100
TOTAL	12	29	59	100
B. *Percentage distribution of countries in areas of responsibility of regional commissions according to type of perception*				
ECA area	4	20	7	11
ECE area	78	46	2	24
ECLA area	10	15	5	8
ECWA area	2	3	—	1
ESCAP area	6	16	86	56
Developed countries	78	56	—	26
Developing countries	22	44	100	74
TOTAL	100	100	100	100

TABLE 4. RELATIONSHIP BETWEEN GOVERNMENTS' PERCEPTIONS OF ACCEPTABILITY OF NATURAL INCREASE, JULY 1980, AND ACTUAL RATES OF NATURAL INCREASE, 1975-1980

Category of actual average annual rate of natural increase 1975-1980 (percentage)	Governments' perceptions of acceptability of natural increase											
	Total number of countries				Countries in more developed regions				Countries in less developed regions			
	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total
A. *Countries classified according to annual rate of natural increase, 1975-1980, by level of development*												
0.4 or less	7	12	—	19	7	12	—	19	—	—	—	—
0.5-0.9	5	11	—	16	4	11	—	15	1	—	—	1
1.0-1.4	5	5	10	20	—	4	—	5	5	1	10	16
1.5-1.9	2	3	6	11	—	—	—	—	2	3	6	11
2.0-2.4	6	9	12	27	—	1	—	1	6	8	12	26
2.5-2.9	4	24	11	39	—	—	—	—	4	24	11	39
3.0-3.4	5	10	15	30	—	—	—	—	5	10	15	30
3.5 or more	1	1	1	3	—	—	—	—	1	1	1	3
TOTAL	35	75	55	165	11	28	—	39	24	47	55	126
B. *Countries classified according to annual rate of natural increase, 1975-1980, by areas of responsibility of regional commissions*												
	Countries in ECA area				Countries in ECE area				Countries in ECLA area			
0.4 or less	—	—	—	—	7	12	—	19	—	—	—	—
0.5-0.9	—	—	—	—	5	8	—	13	—	—	—	—
1.0-1.4	2	—	1	3	—	4	—	4	2	1	5	8
1.5-1.9	—	2	1	3	—	—	—	—	1	—	1	2
2.0-2.4	2	4	4	10	1	1	1	3	—	—	3	3
2.5-2.9	2	16	5	23	—	—	—	—	1	5	3	9
3.0-3.4	—	4	7	11	—	—	—	—	1	2	4	7
3.5 or more	—	—	1	1	—	—	—	—	—	1	—	1
TOTAL	6	26	19	51	13	25	1	39	5	9	16	30
	Countries in ECWA area				Countries in ESCAP area							
0.4 or less	—	—	—	—	—	—	—	—				
0.5-0.9	—	—	—	—	—	3	—	3				
1.0-1.4	—	—	—	—	1	—	4	5				
1.5-1.9	—	—	—	—	1	1	4	6				
2.0-2.4	—	2	—	2	3	2	4	9				
2.5-2.9	—	1	—	1	1	2	3	6				
3.0-3.4	4	4	—	8	—	—	4	4				
3.5 or more	1	—	—	1	—	—	—	—				
TOTAL	5	7	—	12	6	8	19	33				

Source: Selected World Demographic and Population Policy Indicators 1978, data sheet prepared by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat (New York, 1979).

where the rate was lowest (12 countries with a rate lower than 0.4 per cent and 11 countries with a rate between 0.5 and 1 per cent).

In the developing countries, where almost 80 per cent had a growth rate higher than 2 per cent, 44 per cent of the Governments regarded the rate as too high, 37 per cent regarded it as satisfactory and 19 per cent found it too low. Of the three countries that had a growth rate higher than 3.5 per cent, one was in each of those three categories. Thus, there is no obvious correlation between the perception of the rate and the level of the rate, and it would appear that the Governments' perceptions were only partially based on demographic considerations.

If one then looks at the relationship between the perception of the rate and population volume (table 5, sections A and B), one finds that among the 36 countries with more than 20 million inhabitants, very few, in fact only five, wanted to see a higher rate. The others were likewise divided into 16 countries that were satisfied and 15 countries that were not satisfied because the rate is too high. By level of development, of the developed countries with a population over 20 million, the majority, or nine out of 13, found their growth rates satisfactory. Only France, the Federal Republic of Germany, the Ukrainian Soviet Socialist Republic and the Union of Soviet Socialist Republics desired the level to be higher. Among the developing countries with more than 20 million inhabitants, the proportion was the reverse: only one country out of 23, Argentina, wanted to attain a higher rate; while seven others found the rate satisfactory: Ethiopia, Nigeria and Zaire in Africa; Brazil and Colombia in Latin America; and Afghanistan and Burma in Asia. The other 15 wanted a lower growth rate. Developed countries with fewer than 5 million inhabitants were found both among the countries with a satisfactory growth and among those not satisfied with the growth rate. The small developing countries in general desired a higher growth rate or were content with the current rate.

A. DEVELOPED COUNTRIES[5]

As might have been expected following the comments and distinctions made above concerning the differences in

[5] The developed countries include all the countries, except Cyprus, Israel and Turkey, in the area of responsibility of the Economic Commission for Europe (ECE); and Australia, Japan and New Zealand in the area of responsibility of the Economic and Social Commission for Asia and the Pacific. For list of countries in the ECE area, see annex table 38.

TABLE 5. RELATIONSHIP BETWEEN GOVERNMENTS' PERCEPTIONS OF ACCEPTABILITY OF NATURAL INCREASE, JULY 1980, AND SIZE OF POPULATION, 1980

Category of country by size of population, 1980 (millions)	Total number of countries				Countries in more developed regions				Countries in less developed regions			
	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total	Higher rates desirable	Neither higher nor lower rates desirable	Lower rates desirable	Total
A. *Countries classified according to size of population in 1980, by level of development*												
0-0.9	11	12	17	40	4	3	—	7	7	9	17	33
1-4.9	9	19	9	37	—	5	—	5	9	14	9	32
5-9.9	7	18	7	32	2	7	—	9	5	11	7	23
10-19.9	3	10	7	20	1	4	—	5	2	6	7	15
20-49.9	2	10	7	19	1	5	—	6	1	5	7	13
50 or more	3	6	8	17	3	4	—	7	—	2	8	10
TOTAL	35	75	55	165	11	28	—	39	24	47	55	126

B. *Countries classified according to size of population in 1980, by areas of responsibility of regional commissions*

	Countries in ECA area				Countries in ECE area[a]				Countries in ECLA area			
0-0.9	2	5	5	12	5	3	—	8	—	2	6	8
1-4.9	2	8	3	13	1	4	—	5	2	2	5	9
5-9.9	2	7	4	13	2	7	—	9	1	2	3	6
10-19.9	—	3	4	7	1	3	—	4	1	1	1	3
20-49.9	—	2	3	5	1	5	1	7	1	1	—	2
50 or more	—	1	—	1	3	3	—	6	—	1	1	2
TOTAL	6	26	19	51	13	25	1	39	5	9	16	30

	Countries in ECWA area				Countries in ESCAP area			
0-0.9	3	1	—	4	1	1	6	8
1-4.9	1	3	—	4	3	2	1	6
5-9.9	1	2	—	3	1	—	—	1
10-19.9	—	1	—	1	1	2	2	5
20-49.9	—	—	—	—	—	2	3	5
50 or more	—	—	—	—	—	1	7	8
TOTAL	5	7	—	12	6	8	19	33

Source: Selected World Demographic and Population Policy Indicators 1978, data sheet prepared by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat (New York, 1979).

[a]Population figures for the Byelorussian SSR and the Ukrainian SSR are those for 1975.

perception according to level of development, the largest proportion of satisfied countries—25 out of 36, or nearly 70 per cent—was found in the area of responsibility of the Economic Commission for Europe (ECE), but that area also ranked second, following the area of responsibility of the Economic Commission for Western Asia (ECWA), among the areas with the highest proportion of countries not satisfied with the rate, which they regarded as too low, namely, 11 countries out of 36, or 30 per cent. Among the last-named group, there were both centrally planned economies (Bulgaria, German Democratic Republic, Byelorussian SSR, Ukrainian SSR and Soviet Union) and market economies (France, Federal Republic of Germany, Liechtenstein, Luxembourg and Monaco in Western Europe), plus the Holy See in Southern Europe. All the other European countries, the two countries of Northern America and the three developed countries in the area of responsibility of the Economic and Social Commission for Asia and the Pacific (ESCAP) regarded their growth rate as satisfactory. During the period of reference in question, i.e., since 1978, none of the developed countries had altered its perception radically; however, of the countries which were satisfied with their growth rates, some had changed certain aspects of their policies in the light of the trend in the situation.

But before taking a closer look at those changes and the way in which the developed countries faced the problems brought about by growth rate perceived as satisfactory or too low, one might consider which action strategies were most frequently employed.

In the more developed regions, where the experience of Governments in regard to government intervention was of long standing (for some of them it went back to the 1930s), the decline in growth rates had led many of the countries to question the need to intervene or the feasibility of improving the effectiveness of policies that had already been put into operation. Not all the social and economic processes that in theory form part of the complex systems of interaction determining the trends and levels of the rate of natural increase are equally susceptible to intervention. It would be fair to say that in most countries the trend of some of those processes are irreversible or at best could only be curbed or stopped temporarily. Among the social processes that appear to have a decisive effect on fertility, changes in the status of women have a special place. That trend appears to be irreversible. Similarly, the trend towards liberalization of the laws in regard to contraception and abortion might be curbed or temporarily stopped, but it could hardly be reversed. At the very most, there might be a period during which that trend would be dormant, for example, when public opinion expressed doubts concerning an unduly rapid evolution or where the authorities were worried that too radical changes in individual behaviour might be unfavourable to the achievement of national goals. Reactions of a moral or religious nature have also been observed. Lastly,

the "private nature of marriage", as illustrated by the liberalization of divorce and the postponement or refusal of marriage, raises a challenge to the institution and likewise represents a spontaneous trend common to the countries of both West and East, which Governments find it difficult to gainsay.

One may ask then what options are available to the Governments of developed countries that regarded their growth rate as too low in 1980 and wanted to take action to change the situation. For the purposes of this report, these measures may be grouped into a small number of categories. First, there is demographic intervention, which is limited in its effect as far as mortality is concerned. Something can be achieved in countries where it is still relatively high: a reduction in child mortality, for example, can help in some measure to keep the number of births at the maximum level. But in the final analysis, few Governments considered their mortality and health policy to have any objective other than the ensurance of the well-being of the individual. Direct intervention in fertility offers a possibility of action which would appear to be less limited, but it has to take account of the social, economic and political constraints already mentioned.

Another direct option consists in encouraging international migration. A dual effect is looked for from immigration: first, absorption of immigrants into the population adds to the natural population growth; secondly, immigrants help slightly, through their relatively higher fertility rate, to raise the national fertility level. Yet another approach is the systematic encouragement of the development of settlement zones where fertility is higher (for example, small and medium-sized towns in certain European countries); or the transfer, where it is possible, of young rural populations to metropolitan areas where the population is aging.

Governments often have recourse to action in regard to certain demographic variables where the effect anticipated is mainly non-demographic: for example, control of international migration flows is a traditional means of temporarily adjusting the volume and structure of the active population to the ups and downs of the economy and hence is a form of response to a growth rate regarded as inadequate. Another example of this type of action is illustrated by countries that tried to redistribute the available human resources in the best possible manner over the whole of their territory, which is what happened in the Eastern European countries, where the participation of women in the labour force was already very high and recourse to foreign immigration was restricted.

Lastly, action that consists of adapting the economic apparatus to the trends in the volume and structure of the population is obviously of major importance. The fixing of growth rates for the economy, and also the choice of a particular type of growth, represent structural responses to the problems posed by population growth. As a complement to these structural responses, mention may be made also of frequent recourse to socio-economic measures which have a direct link with the fluctuations of the active population—changes in retirement age, number of working hours etc.

In the light of these general remarks concerning the options open to the Governments of developed countries, one may look more specifically at the problems with which they were confronted in the period 1978-1980 and the way in which they tackled them. Table 6 indicates that only a few European countries had changed their policies since 1978, while they continued to regard their existing growth rate as satisfactory. Except for Poland, which appeared to be satisfied with the spontaneous trend in its growth rate, the other countries that had changed their positions had done so in the direction of strengthening their policies so as to maintain the rate at its existing level. The demographic situation of the developed countries was fairly homogeneous and there was little if any difference between those countries which regarded their growth rate as unduly low and those which regarded it as satisfactory. The difference in perception would thus seem to be bound up rather with a divergence in the way they looked at the socio-economic consequences of population trends. Hence, one must consider all the countries—whether satisfied or not satisfied with their growth rate—that had, in varying degrees, taken steps to increase or maintain the rates. Among the developed countries, Poland in Eastern Europe; Spain, Portugal and Yugoslavia in Southern Europe; and the United States of America had no desire to intervene in order to alter or maintain their rates; they had faith in the spontaneous mechanisms of the rate trend.

Eastern and Western countries alike had witnessed a decided decline in fertility since the 1960s. Some of them, however, had resisted better than others (e.g., Albania, Poland and Yugoslavia), which explained the satisfaction expressed in regard to their current increase in population and the trends shown.[6]

Some of the Eastern European countries most affected by that decline (Czechoslovakia, Hungary and Romania) had found it convenient to curb the access to modern methods of contraception, in particular, to restrict the legal authorization of abortion[7] (e.g., Romania), and to take pro-natalist measures. At the outset, the birth rate had increased quite noticeably, but that increase had been followed by a decline in the rate, which casts doubt on the lasting effect of the legislative changes made in the past few years.[8] Consequently, while those Governments still stated that they were quite satisfied with the rates, they continued to be extremely vigilant in regard to future trends. Reactions to the decline in growth rates in the Western European countries were far less homogeneous.[9] France, for example, where the birth rate was relatively high in comparison with most other developed countries and where the growth potential bound up with the age structure should make it possible for the country to envisage its future growth with relative opti-

[6] E. Brennan and J. C. Chasteland, "Population policies in the socialist countries of Europe and the third world," paper submitted to the Malthus Symposium, Paris, 27-29 May 1980 (mimeographed).

[7] Apart from legal authorization for health reasons or to save the life of the mother, abortion was no longer authorized unless the woman was more than 45 years of age or had four dependent children. Approval by a medical committee was required in all instances.

[8] Roland Pressat, "Mesures natalistes et relèvement de la fécondité en Europe de l'Est", *Population* (Paris), vol. 34, No. 3 (May-June 1979), pp. 533-548.

[9] C. Alison McIntosh, "Population policy in the liberal democracies: a comparison study of France, Sweden and West Germany", unpublished doctoral dissertation, Ann Arbor, Michigan, University of Michigan, Center for Population Planning, 1980.

TABLE 6. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE ACCEPTABILITY OF NATURAL INCREASE, AND DESIRABILITY OF INTERVENTION TO CHANGE RATES, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR EUROPE, JULY 1978–JULY 1980

	Governments' perceptions of the effect of natural increase as a constraint on development, and desirability of intervention							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints					*Effect of constraints*		
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates desirable*			*Lower rates desirable*		
	Full intervention appropriate (1)	*Some support appropriate[a] (2)*	*(3)*	*No intervention appropriate (4)*	*(5)*	*Some support appropriate[a] (6)*	*Full intervention appropriate (7)*	*Total*
Number of countries in each category in 1978	7	6	7	12	6	—	1	39
Changes in perception								
Countries that left a category	—	—	—	Belgium Czechoslovakia Hungary Romania	Poland	—	—	
Countries that entered a category	—	—	Belgium Czechoslovakia Hungary Romania	Poland	—	—	—	
Number of countries in each category in 1980	7	6	11	9	5	—	1	39

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level that could be considered too low or too high.

mism, had been one of the first countries to take an entire series of measures to reverse the trend. The Government of the Federal Republic of Germany, where the population was already decreasing, stated that it was not satisfied with the rate, although, on the other hand, it apparently was not disposed to adopt a pro-natalist policy. However, in a recent address concerning the general policy of the Government, the Chancellor had invited "all the social forces in the country to adopt a more positive attitude towards the child and to take action to improve the lot of families with children."[10] The decline in the rate of natural increase and dwindling population figures had created manpower problems in most of the developed countries. The market economies had compensated to some extent for the lack of manpower by calling in immigrant workers. The immediate economic effects represented by that influx of immigrants were compounded by a significant effect of a demographic kind. They were more fertile than the native population, which helped to raise the growth rate of the population in the host countries. Thus, for example, in Luxembourg, the European country with the lowest birth rate (deaths had exceeded births each year since 1972), it was felt that without the births due to the presence of large numbers of immigrants, deaths would have surpassed births since 1966. In 1974, the birth rate for the population of Luxembourg amounted to 8.5 per 1,000 and the death rate to 14.3 per 1,000 (rate of natural increase: 0.58 per cent). The birth rate for foreigners who were residents in the country in that same year was 19.1 per 1,000 and the death rate 4.8 per 1,000 (rate of natural increase: 1.43 per cent).[11] In France, more than 10 per cent[12] of children born in 1978 were the progeny of families where one or both parents were foreigners.[13] The effect on the rate of fertility as such was less marked, but it was not negligible if one bears in mind the relatively low levels of fertility among nationals of these countries. Thus, it has been calculated that in France and the Federal Republic of Germany, that contribution probably represented some 5 per cent of the total fertility rate.

However, systematic recourse to foreign immigration as a palliative both for certain manpower problems and for shortcomings in demographic growth tends to give rise at the social level to misgivings on the part of public opinion, and at the demographic level to doubts as to its long-term effectiveness. While it is true that the demographic behaviour of the foreign population in regard to fertility helps to maintain or increase over-all population numbers, this phenomenon can only operate temporarily, because, as is known, this type of behaviour tends to become adjusted over the more or less long term to that of the national population.

The next point to be examined, among the Governments

[10] Detrev B. Rein, "Policy concepts relevant to the population in the Federal Republic of Germany", paper submitted to the Fourth European Population Seminar, Athens, 2-5 October 1979.

[11] "Un exemple à ne pas suivre", *Population et Sociétés*, No. 95 (October 1976).

[12] This is the ratio of the number of legitimate births of foreigners to the total number of births recorded in France.

[13] "Situation démographique de la France", *Population* (Paris), Vol. 35, No. 4-5 (July-October 1980).

that had decided to take action, concerns which of them opted for a comprehensive intervention policy and which preferred merely to provide partial support for the action taken.

Of the 11 developed countries that desired to achieve a higher growth rate, six had decided to implement a comprehensive intervention policy. Those countries comprised both market economies and centrally planned economies. Intervention was multidimensional in scope and affected several demographic and socio-economic factors at the same time. All the countries had policies in the fertility sphere. The immediate goal was to increase fertility so as to increase at the same time the level of natural increase, but those policies also contained measures designed to improve individual well-being. Thus, financial incentives (family allowances and income-tax reliefs) were designed to encourage the advent of an additional child, but at the same time to give the family some compensation for the expenditure occasioned by the upbringing of children. Mortality in the developed countries was more rarely regarded for its potential effects on the growth rate, simply because it had already reached very low levels. The role given to action on internal spatial mobility was all the more important as recourse to international migration was limited (the case with the centrally planned economies). That means of action was similarly non-existent in Liechtenstein, Luxembourg, and Monaco, for obvious reasons bound up with the size of the country. Consequently, Luxembourg had more frequently made use of immigration, like the other market economies. But the economic crisis that had been rampant for the previous few years had curbed and even stemmed the immigration of foreign workers. The immigration policy of such countries as France, for example, was currently concentrated on the admission of the families of workers already established in its territory whom France would like to keep, or on the hosting of refugees.

The other five countries that wanted to attain a higher growth rate, and the 19 countries that were satisfied with the existing rate but were keeping an eye on the trend, had decided to adopt a partial support policy. In most instances, action by the Government was multidimensional, especially in the centrally planned economies, but it was applied less intensively and for purposes that might be different: the objective of individual well-being took precedence over the demographic objective in regard to the measures taken in the field of fertility. Intervention in regard to spatial distribution, international migration and changes in socio-economic structure played an important but no longer a vital role.

Several Governments, especially in Eastern Europe, in their concern to increase their growth rate or at least to maintain it at its existing level, had specified the nature of their intervention through the establishment of targets, often expressed in implicit form, which they planned to achieve (see table 7). In Bulgaria, the Government stressed the collective and individual aspect of its population policy: the attainment of a higher and more stable rate of growth. The birth and upbringing of a larger number of children in the family (from two to three) was a national goal of the utmost importance both for the development of the country and for the consolidation of the family itself. The Government of Hungary was endeavouring to bring the public to accept the idea of a three-child family and wanted to increase fertility so as to achieve a net reproduction rate equivalent to unity. The Government of the German Democratic Republic was anxious that families should have at least two children, while the Government of Romania was establishing a growth rate equivalent to 1.1 per cent, so as to increase the size of the population to 24 million or 25 million by 1990 and to 30 million by the year 2000. In the other regions of Europe, France had laid down as its objective a rate of fertility equal to or slightly higher than that required to ensure generation replacement, while Greece had set a net reproduction rate higher than unity. In Finland, the Government had stated that the population should not fall in any part of the country and that the net reproduction rate should increase. In Japan, the goal fixed was a stationary population.

B. Developing countries

In the developing countries, the maintenance of net reproduction rates at a high level, the growing excess of births over deaths and the worsening of the already very high dependency ratio, together with the increase in the active population, were causing many Governments to express their dissatisfaction with the levels and trends of the growth rates. As previously stated, 37 per cent of the countries were satisfied about their population growth rates; of the 63 per cent that were not satisfied about them, 19 per cent considered the rates to be too low and 44 per cent considered them too high.

At the regional level, the area of responsibility of ESCAP was where the satisfaction was greatest: 19 developing countries out of 30, or 63 per cent, wanted to attain a lower rate. Second was the area of the Economic Commission for Latin America (ECLA), with 16 countries out of 30, or 53 per cent; followed by the area of the Economic Commission for Africa (ECA), with 19 countries out of 51, or 37 per cent. No country in the ECWA area was anxious to have a lower rate. The area that contained most of the countries satisfied with their growth rate was that of ECWA, with seven countries out of 12 (58 per cent); followed by that of ECA with 26 countries (51 per cent); that of ECLA with nine countries (30 per cent); and that of ESCAP with only five countries (17 per cent).

The ECWA area had the greatest proportion of countries who were anxious to have a higher growth rate: five countries, or 42 per cent. Then, within a close range, there was the ESCAP area, with six countries (20 per cent); that of ECLA, with five countries (17 per cent); and that of ECA, with six countries (12 per cent) (see tables 1 and 2).

An analysis based on population numbers makes it clear that the gap between the various perceptions in relation to the areas was decidedly more marked than in the analysis by countries. While 73 per cent of the population of the ECWA area of responsibility lived in countries that were satisfied about their growth rate (3 per cent of the world population lived in countries with the same attitude), 90 per cent of the population of the ESCAP area lived in countries that considered the rate too high; but those countries represented 86 per cent of the world population (see table 3). As already stated in connection with the examination by level of development,

TABLE 7. GOVERNMENT GROWTH TARGETS

	Targets expressed explicitly in the form of demographic indicators[a]									
	Growth rate (percentage)	*Rate of natural increase*	*Crude birth rate (per 1,000)*	*Fertility rate*	*Gross reproduction rate*	*Net reproduction rate*	*Number of children per woman*	*Number of children per family*	*Size of population*	*Targets expressed implicitly*
ECA area										
Eastern Africa										
Kenya	3.0 in 1980 2.8 in 2000	b	b	b	b	b	b	b	b	None
Mauritius	b	b	22.5 in 1980s	b	1.12 in 1982–1987	b	b	b	b	None
Northern Africa										
Egypt	b	10.6 per 1 000 in 1982	23.6 in 1982	b	b	b	b	b	Attainment of a population of 41 million by 1982	None
Morocco	b	b	35 in 1985	b	b	b	b	b	b	None
Tunisia	1.0 in 2000	b	32.3 in 1981	b	b	b	b	b	b	None
Southern Africa										
Lesotho	2.0 (no date)	b	b	b	b	b	b	b	b	None
Western Africa										
Ghana	1.8 by 2000	b	b	b	b	b	b	b	b	None
Eastern Europe										
Bulgaria	b	b	b	b	b	b	b	b	b	The target was to attain higher and more stable population growth rates. It was felt that the birth and upbringing of a larger number of children in the family (2 or 3) was a national goal of major importance both for the country's development and for the consolidation of the family itself
German Democratic Republic	b	b	b	b	b	b	b	b	b	A family of at least two children, to ensure population renewal
Hungary	b	b	b	b	b	b	b	b	b	Promotion of the ideal of the three-child family Increase in fertility to attain a net reproduction rate equal to unity
Romania	b	1.1%	b	b	b	b	b	b	Attainment of a population of from 24 million to 25 million in 1990 and 30 million by 2000	None
Northern Europe										
Finland	b	b	b	b	b	b	b	b	b	There should be no decrease in population in any part of the country The net reproduction rate should increase If there should be a change in trend, greater vigilance should be exercised

TABLE 7. *(continued)*

	Targets expressed explicitly in the form of demographic indicators[a]									
	Growth rate (percentage)	*Rate of natural increase*	*Crude birth rate (per 1,000)*	*Fertility rate*	*Gross reproduction rate*	*Net reproduction rate*	*Number of children per woman*	*Number of children per family*	*Size of population*	*Targets expressed implicitly*
ECE area *(continued)*										
Southern Europe										
Greece	Not under 1	b	b	b	b	Above 1	b	b	b	None
Western Europe										
France	b	b	b	b	b	b	b	b	b	1975: target adopted by the French Economic Planning Council. A fertility level close to or preferably slightly higher than that needed to ensure generation replacement
ECLA area										
Caribbean	b	b	15.5 in 1980	b	b	b	b	b	b	None
Trinidad and Tobago										
Middle America										
El Salvador	2.9 in 1982	b	40.2 in 1982	b	b	b	b	b	b	None
Mexico	2.5 in 1982 1.0 after 2000	b	b	b	b	b	b	b	b	None
Temperate South America										
Argentina	b	b	b	b	b	b	b	b	Attainment of a population of from 40 million to 50 million by 2000	None
ESCAP area										
East Asia										
China	b	5 per 1 000 in 1985 0 per 1 000 in 2000	b	b	b	b	b	1	b	None
Japan	b	b	b	b	b	b	b	b	b	Stationary population considered desirable and planned
South Asia										
Eastern South Asia										
Indonesia	2 in 1979–1984	b	34 in 1984	b	b	b	b	b	b	None
Malaysia	2 in 1985	b	28.2 in 1980	b	b	b	b	b	b	
Philippines	2.3 in 1980 2.0 in 1985	b	b	b	b	1 in 2000	b	b	b	None
Republic of Korea	1.6 in 1981	Above 1.5% in 1980s	b	b	b	b	b	b	b	None
Singapore	0 in 2000	b	b	b	b	1 (to be maintained)	b	2	b	None
Thailand	2.1 in 1981	b	b	b	b	b	b	b	b	None
Viet Nam	2 in 1980 1.5 in 1985 1.0 in 2000	b	b	b	b	b	b	b	b	None

TABLE 7. *(continued)*

	Targets expressed explicitly in the form of demographic indicators[a]								
	Growth rate (percentage)	*Rate of natural increase*	*Crude birth rate (per 1,000)*	*Fertility rate*	*Gross reproduction rate*	*Net reproduction rate*	*Number of children per woman*	*Number of children per family*	*Size of population*	*Targets expressed implicitly*
ESCAP area *(continued)*										
Middle South Asia										
Bangladesh	1.5 in 1980 1.5 in 1985	[b]	[b]	[b]	[b]	[b]	2.6	[b]	[b]	None
India	[b]	[b]	[b]	[b]	[b]	Unity everywhere in the country in 2000	[b]	[b]	[b]	None
Iran	1.9 in 1982	[b]	30 in 1982	[b]	[b]	[b]	[b]	[b]	[b]	None
Nepal	1.0 in 1985	[b]	38 in 1979/80	[b]	[b]	[b]	[b]	[b]	[b]	None
Pakistan	2.5 in 1982/83	[b]	35.5 in 1982/83	[b]	[b]	[b]	[b]	[b]	[b]	None
Sri Lanka	[b]	[b]	23.0 in 1980	[b]	[b]	[b]	[b]	[b]	[b]	None
Oceania										
Melanesia										
Papua New Guinea	2.5 (no date)	[b]	[b]	[b]	[b]	[b]	[b]	[b]	[b]	None
Micronesia-Polynesia										
Fiji	[b]	[b]	22.0 in 1980	[b]	[b]	[b]	[b]	[b]	[b]	None

Sources: Replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; targets set in national development plans; national official publications; and Economic and Social Commission for Asia and the Pacific, Division of Population, *Population Headliners*, No. 66 (Bangkok, September 1980).

[a] As concerns the date of formulation of the targets, most of the countries not listed below reported their target in their replies to the Fourth Population Inquiry:

Africa: Egypt, 1978; Ghana, development plan, 1973-1978; Kenya, development plan, 1979-1983; Morocco, development plan, 1973-1977.

Europe: Bulgaria, reply to "Third United Nations Inquiry among Governments: population policies in the context of development in 1976".

Latin America: El Salvador, 1977; Mexico, 1977; Trinidad and Tobago, national family planning for 1968-1972.

Asia: China, 1979; India, 1979; Indonesia, development plan, 1979-1984; Malaysia, development plan, 1976-1980; Nepal, development plan, 1975-1979; Pakistan, development plan, 1978-1983; Philippines, development plan, 1978-1982; Republic of Korea, development plan, 1977-1981; Singapore, 1980; Thailand, development plan, 1977-1981; Viet Nam, development plan, 1976-1980.

Oceania: Fiji, development plan, 1976-1980.

[b] Target not stated in this form.

the widening gap between the various perceptions by areas is due to the preponderant role of the large countries of Asia, all of which desired to attain a lower growth rate.

Between 1978 and 1980, a number of developing countries had changed their perception very considerably. The greater number had strengthened their policies with a view to the modification of natural increase levels regarded as being unsatisfactory. It is proposed to follow the same analytical method as in the case of the developed countries, and hence before systematically considering the changes in perceptions and policies, to discuss the intervention strategies at the disposal of the developing countries.

In the developing countries, variations in the extent and intensity of government intervention reflected a greater variety of demographic situations than those in developed countries. Some countries had entered upon the final phase of their demographic transition, while others had scarcely embarked on the first phase. Rates of natural increase of between 3 and 1 per cent were frequently observed. In addition, economic, social and political conditions also varied considerably and thus greatly influenced the possibility of government action. As shown below, the priority given to certain options was thus frequently very different from that in the developed countries. Those various options are grouped into the same categories used for developed countries.

Among the policy options open to developing countries, direct action in regard to mortality and fertility was the most frequent type. First to be considered is the effect of variations in the level of mortality on the choice of those options. The intention here is not to examine the strategies that were adopted by the developing countries for lowering the mortality level, which are the subject of chapter XXI, but to indicate the demographic role assigned to action taken in regard to mortality in some countries.

It is well known that the Governments of all developing countries considered that a decline in the death rate and the improvement of health by which it was brought about were an end in themselves. However, in the case of certain of those countries which regarded their growth rate as too low or even as satisfactory, and where mortality was high, a reduction in mortality was regarded as a method to maintain or to improve the growth rate. In contrast, for the larger number of countries that felt it desirable to reduce their growth rate and hence their fertility rate, a reduction in mortality was seen to constitute a prerequisite of a subsequent modification of the reproductive behaviour of couples.

Meanwhile, the reduction of mortality, with its effects on the growth rate, had led many Governments to take direct action on fertility, which might reflect a demographic objective and might at the same time improve individual well-being. Recent experiments had shown that intervention in regard to fertility had no chance of success unless it formed part of a whole series of measures designed to improve levels of living. Another type of direct intervention that had relatively slight demographic effects also was at the disposal of Governments, namely, recourse to international migration. For most countries, the effect of migration was marginal, and hence migration was rarely used for that end alone. On the other hand, changes in the spatial distribution of the population in countries where over-all levels of fertility and mortality were high and regional differences were considerable could play a significant role in the evolution of growth rates.

Certain types of action in regard to demographic variables could have an indirect effect in the socio-economic field, which some Governments regarded as more important than a direct demographic effect. Thus, many countries regarded reduction in morbidity and mortality as an important contribution to the increase of productivity in the active population.

A better geographical distribution of the population also could contribute very considerably to the solution of problems that derived from an unsatisfactory rate of natural increase by permitting the best use to be made of human and natural resources. That objective was, indeed, one of the priorities of government action in a large number of developing countries. Lastly, international migration could in turn help to bring about a temporary solution to the problems of employment, balance of payments etc.

With regard to non-demographic options, for many Governments the introduction of more or less radical internal changes in the economic, social and technological organization of society, in other words, in the choice of development strategies, constituted a decisive factor both in the success of their population policies and in their capacity to cope with the problems raised by the growth rate. It should also be pointed out that some Governments regarded a change in the system of international economic relations as important in the solution of some of the demographic problems already mentioned.

The discussion now turns to the perceptions of Governments in the various areas of responsibility of the regional commissions, concerning population growth, the changes that took place in the period 1978-1980 and the intervention options chosen with a view to the maintenance or adjustment of growth rates regarded as unsatisfactory.

Area of responsibility of Economic Commission for Africa

Six countries (Central African Republic, Equatorial Guinea, Gabon, Guinea, the Ivory Coast and the Libyan Arab Jamahiriya), in the ECA area of responsibility considered the growth rate to be too low, 26 considered it satisfactory, and 19 considered it too high (see table 1). Since 1978, several countries had radically changed their perception, whereas others, more numerous, had adjusted their policies (see table 8). Mozambique, which in 1978 had regarded its growth rate as too low, currently considered it to be satisfactory. The trend of fertility and its incidence on the growth of the population constituted one of the major factors in the demographic policy of Mozambique, and it was anxious at the very least to maintain the rate at its existing level.

The United Republic of Cameroon, which had similarly considered its growth rate unduly low in 1978, regarded it as too high in 1980. The party known as the Cameroon National Union, in a report published following the Third Regular Congress held at Bafoussam (United Republic of Cameroon) in February 1980, stated in the resolutions on social and cultural policy which act as government policy directives:

> ". . . considering that harmonious demographic evolution makes for better control of development factors, especially in regard to the family and employment . . . exhorts the Government to take adequate measures to assist the people of Cameroon in dealing with the consequences of demographic growth in such a way as to continue to develop conditions favourable to their expansion".[14]

In a speech made on the occasion of the closure of that Congress, the Chief of State remarked:

> ". . . our achievements, although enormous, are not sufficient to guarantee the future of this country, in an international crisis context, as a young nation exposed to the spiral of uncontrolled, runaway growth . . . the time has come to muster and mobilize all resources . . . by means of more imaginative management of men and institutions . . . the time has come for the nation to take over control in its emergence and to fortify itself against future uncertainties. . . ."[15]

Algeria, which in 1978 had regarded its growth rate as satisfactory, currently considered it too high. The Central Committee of the National Liberation Front, at its second regular session held from 2 to 30 December 1979, adopted the following resolution:

> "Activities aimed at health information and education and maternal and child protection, and the institution of a population policy based on individual adherence, and consonant with our socio-cultural values, must be taken over, developed and facilitated. . . ."[16]

[14] *Cameroon Tribune* (Yaoundé), 29 February 1980.
[15] *Ibid.*
[16] *Moudjahedine* (Algiers), 1 and 6 January 1980.

TABLE 8. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE ACCEPTABILITY OF NATURAL INCREASE, AND DESIRABILITY OF INTERVENTION TO CHANGE RATES, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR AFRICA, JULY 1978–JULY 1980

	Governments' perceptions of the effect of natural increase as a constraint on development, and desirability of intervention							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints				*Effect of constraints*			
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates available*			*Lower rates desirable*		
	Full intervention appropriate (1)	*Some support appropriate[a] (2)*	*(3)*	*No intervention appropriate (4)*	*(5)*	*Some support appropriate[a] (6)*	*Full intervention appropriate (7)*	*Total*
Number of countries in each category in 1978	8	—	3	4	19	3	13	50
Changes in perception								
Countries that left a category	Mozambique United Republic of Cameroon	—	—	Algeria Benin Mali	Nigeria Zambia	—	Rwanda	
Countries that entered a category	—	—	Benin Mali Mozambique	Nigeria Zambia	—	Algeria Rwanda United Republic of Cameroon Zimbabwe[b]	—	
Number of countries in each category in 1980	6	—	6	3	17	7	12	51

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level which could be considered too low or too high.

[b] State that became a member of the United Nations or a member of its specialized agencies during the period 1978–1980.

The resolution further states that "the rate of growth of the population, if maintained, would constitute a heavy burden on the economy, thus putting a curb on all efforts for development and improvements in the living conditions of the citizen". The Central Committee also adopted a resolution that stressed the need to achieve "the definition and implementation of a policy for controlling demographic growth closely related with the potential of our national economy and the goal of improving living conditions and satisfying social needs".

Some countries in this area had, without a change in their perceptions, adapted their policies to the evolving trends. Benin, Mali, Nigeria and Zambia still regarded their growth rates as satisfactory, but whereas the first two countries had intervened only partially with a view to the maintenance of the growth trends, the other two countries placed full confidence in its spontaneous evolution. (In the light of more recent data, it is now considered that the Government of Rwanda has embarked on a policy of partial intervention with a view to lowering its growth rate, while Zimbabwe,[17] a country that recently achieved independence has been placed in the same category.)

The six countries of Africa that desired to have a higher growth rate had all embarked on a policy of comprehensive intervention with a view to attaining that goal. Gabon, Guinea, the Ivory Coast and the Libyan Arab Jamahiriya were bringing action to bear jointly on mortality, fertility, spatial distribution of the population and international migration, while they endeavoured to modify socio-economic conditions, calculated in turn to affect certain aspects of the demographic behaviour of their population. Equatorial Guinea had taken action in respect of all those factors but did not wish to intervene in the sphere of fertility, whereas the Central African Republic[18] considered that action on spatial distribution and on socio-economic factors should be sufficient to bring the growth rate up to the higher level regarded as necessary from the point of view of development.

Of the 26 countries that stated that they were satisfied with the existing level of the growth rate, only three (Nigeria, Somalia and Zambia) considered the spontaneous trends in the rate to be satisfactory and hence were taking no measures, unlike the other 23 countries, whose Governments had decided to institute a partial intervention policy with a view to maintaining the rate at its current level.

Of the 19 countries that wanted to achieve a lower natural growth rate, 12 have a comprehensive intervention policy. Government measures were applied to most of the demographic variables, but the emphasis was on fertility and mortality. All of them considered that change in socio-economic conditions would simultaneously bring about a change in demographic behaviour.

Some of those countries has established goals for their population policy through the device of demographic indicators that specified the objectives to be attained within

[17] Zimbabwe has not yet officially expressed its attitude towards demographic policies.

[18] Situation in 1978.

TABLE 9. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE ACCEPTABILITY OF NATURAL INCREASE, AND DESIRABILITY OF INTERVENTION TO CHANGE RATES, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR LATIN AMERICA, JULY 1978-JULY 1980

	Governments' perceptions of the effect of natural increase as a constraint on development, and desirability of intervention							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints				*Effect of constraints*			
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates available*			*Lower rates desirable*		
	Full intervention appropriate (1)	*Some support appropriate[a] (2)*	*(3)*	*No intervention appropriate (4)*	*(5)*	*Some support appropriate[a] (6)*	*Full intervention appropriate (7)*	*Total*
Number of countries in each category in 1978	3	1	—	3	7	5	8	27
Changes in perception								
Countries that left a category	—	—	—	Cuba	Chile Ecuador	Costa Rica	—	
Countries that entered a category	—	Chile	Ecuador	—	Cuba	Dominica[b] Saint Lucia[b] Saint Vincent and the Grenadines[b]	Costa Rica	
Number of countries in each category in 1980	3	2	1	2	6	7	9	30

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level which could be considered too low or too high.

[b] State that became a member of the United Nations or a member of its specialized agencies during the period 1978-1980.

specific time periods (see table 7). The countries that had done so were those which wanted to lower their growth rates; and in general, they were countries already well on the way towards the process of demographic transition. Kenya had adopted a growth rate of 3 per cent, to be attained in 1980; and a rate of 2.8 per cent by 2000. Mauritius desired a crude birth rate of 22.5 per 1,000 during the early 1980s and a gross reproduction rate of 1.12 during the period 1982-1987.

In Northern Africa, Egypt had set its goals for 1982: a rate of natural increase of 10.6 per 1,000 (birth rate of 23.6 per 1,000), with a view to attainment of a total population of 41 million. Tunisia wanted to achieve a growth rate of 1 per cent by the year 2000 and the various stages of its strategy had already been planned: crude birth rates of 32.3 per 1,000 in 1981 and 29.9 in 1986.

Lesotho wanted to achieve a growth rate of 2 per cent, but no time period was mentioned; and Ghana wanted to have a rate of 1.8 per cent by the year 2000.

Area of responsibility of Economic Commission for Latin America

Most of the countries in the ECLA area of responsibility (16 out of 30) regarded the natural growth rate as unduly high (see tables 1 and 9). The group included the countries discussed in relation to 1978, plus three new-comers: Dominica, Saint Lucia, and Saint Vincent and the Grenadines.[19] Costa Rica had reinforced the measures it had already taken to reduce its growth rate. The Government of Costa Rica had previously taken population measures in regard to fertility and international migration; it recently adopted a series of measures in regard to spatial distribution. The Government desired to curb the internal movements of population, particularly the drift towards the urban centres, while at the same time it restructured the rural and urban configuration of the country. Five countries, on the other hand, desired to reach a higher growth rate. Four of those countries had already held that view in 1978—namely, Argentina, Bolivia, Paraguay and Uruguay; Chile, which in 1978 had declared itself to be satisfied with its growth rate, had changed its perception. A statement by the Chilean National Planning Office in 1979 referred to the need for a national pro-natalist policy: "A substantial increase in population is regarded as desirable with a view to strengthening national security and improving economic development."[20] In Argentina, in particular, and to a lesser extent in Bolivia and Uruguay, the Governments were implementing a comprehensive intervention policy which comprised a multidimensional policy in regard to mortality, fertility, internal migration, and rural and urban configuration in Argentina and Bolivia; internal migration and urban configuration only in Uruguay; and international migration and socio-economic factors.

Argentina, in particular, encouraged immigration, but the Government did not conceal the fact that it would prefer any

[19] These three countries have not yet officially expressed their attitudes concerning population policies.

[20] Chile, Oficina de Planificación Nacional (ODEPLAN), "Politica de población, política de cultura", *Plan Nacional Indicativo de Desarrollo, 1979-1983*.

increase in population to take place mainly on the basis of internal growth, while it realized that the country would not attain a growth rate comparable to that of the neighbouring countries. It therefore considered that immigration should provide the necessary topping-up that would enable it to achieve the goal established, while at the same time severe restrictions were placed on emigration. An entire series of measures had been introduced with a view to the reduction of regional and sectoral differences—creation of employment in rural areas, improved distribution of income and earnings, etc.

In Bolivia, as part of the development plan currently under way (1976-1980), the Government placed stress on an increase in population associated with reorganization of the economic and social structures with a view to making the most of the economy of a vast country, rich in natural resources, with a population that was poorly distributed. Among those socio-economic measures, the Government was developing irrigation, marketing of national products etc. with a view to a better spatial distribution of the population and an improvement in national productivity that would make it capable of feeding a larger population.

Lastly, nine countries in the area stated that they were satisfied with the growth rate in their countries in 1980, which was roughly the same situation as that which had existed in 1978. However, most of those countries were maintaining viligance while they continued their policy of partial support. Thus, in Ecuador, the new five-year development plan (1980-1984) emphasized substantial socio-economic changes and rural development, including the redistribution of expropriated territory to 77,000 families, the construction of schools, social housing and doubling of the minimum wage.

In Cuba,[21] the crude birth rate was not more than 15 per 1,000, which represented a decline of 39 per cent over five years (from 1973 to 1978). The current general fertility rate (70 per 1,000 for women aged 15-44 years) was one of the lowest in Latin America, and the most recent decline had come about at a time when mortality was more or less stabilized at the very low rate of 5.6-5.8 per 1,000, which meant that the growth rate also had diminished. The situation in Cuba appeared to be unique in the sense that the decline in fertility and natural increase had not been the outcome of anti-natalist measures or pre-established population goals, as it had been in some other developing countries. It would appear to have been caused by a series of political and economic factors. (A more detailed examination of the measures involved is contained in chapter XXII of this report, which concerns fertility.) However, the situation seems likely to change in the near future; the crude birth rate appeared to be stabilized, but it could increase with the arrival at childbearing age of large cohorts of women who were born during the high birth rate period that followed the revolution and reached its peak in the years 1963-1964.

Of the countries that were satisfied with their existing growth rates, only Brazil and Guyana had not implemented any intervention policy. They had confidence in the spontaneous evolution of the rates.

Few countries (see table 7) had set quantitative targets in support of their policies. Those which had done so were the four countries that had adopted a comprehensive intervention policy with a view to reducing the growth rate, plus one country (Argentina) with a view to increasing it. Trinidad and Tobago was anxious for the birth rate to reach 15.5 per 1,000 from 1980 onward. El Salvador envisaged the possibility of achieving a growth rate of 2.9 per cent by 1982, or a crude birth rate of 40.2 per 1,000. Mexico had plans to achieve a growth rate of 2.5 per cent by 1982 and 1 per cent after the year 2000. Argentina expressed its goals differently: it would like to have a population of between 40 million and 50 million by the year 2000.

Area of responsibility of Economic Commission for Western Asia

No country in the ECWA area of responsibility had changed either its perceptions or its policies since 1978 (see tables 1 and 10). A higher growth rate was desired by five countries, while seven others stated that they were satisfied with the existing rate. Western South Asia was the only less developed region where no country desired to see the rate fall. Of the countries that desired to increase their growth rate, four had a comprehensive intervention policy, but none envisaged the attainment of an increase by measures in regard to fertility. The only action in that direction had been taken by countries that were satisfied with the current growth rate and in general wanted to maintain their existing level of fertility, except for Iraq, which wanted to see it rise; and Bahrain and Jordan, which wanted to see it fall.

On the other hand, almost all the countries in the ECWA area had taken steps in regard to spatial distribution, international migration and socio-economic conditions. (Bahrain had no policy in those areas, and Jordan had no policy in regard to international migration.) Most of the countries in the area thus continued to rely on immigration in the absence of a satisfactory rate of natural increase. However, some of the countries (e.g., Oman, Qatar, Saudi Arabia and the United Arab Emirates) were unwilling to base their long-term population growth policy on immigration. Nevertheless, for the time being, in order to reach the economic development targets they had set, those countries were obliged to continue to call in large contingents of foreign manpower; but no country in the region had set any quantitative target to make its policy more concrete.

Area of responsibility of Economic and Social Commission for Asia and the Pacific

In 1978, most of the developing countries in the ESCAP area of responsibility (19 out of 30) had wanted to attain a lower population growth rate (see tables 1 and 11). That group included the largest countries in the world: China (994.9 million population); India (684.4 million); and Indonesia (148.0 million). All of them[22] had a comprehensive intervention policy, and their efforts were concentrated in

[21] Paula E. Hollerbach, "Recent trends in fertility, abortion, and contraception", Center for Policy Studies Working Paper No. 61, New York, The Population Council, September 1980.

[22] The Governments of Kiribati, the Solomon Islands and Tuvalu, which recently gained independence, have not yet officially expressed their perceptions of their policies.

TABLE 10. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE ACCEPTABILITY OF NATURAL INCREASE, AND DESIRABILITY OF INTERVENTION TO CHANGE RATES, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR WESTERN ASIA, JULY 1978-JULY 1980

	Governments' perceptions of the effect of natural increase as a constraint on development, and desirability of intervention							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints				*Effect of constraints*			
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates available*			*Lower rates desirable*		
	Full intervention appropriate (1)	*Some support appropriate[a] (2)*	*(3)*	*No intervention appropriate (4)*	*(5)*	*Some support appropriate[a] (6)*	*Full intervention appropriate (7)*	*Total*
Number of countries in each category in 1978	4	1	1	1	5	—	—	12
Changes in perception								
Countries that left a category	—	—	—	—	—	—	—	
Countries that entered a category	—	—	—	—	—	—	—	
Number of countries in each category in 1980	4	1	1	1	5	—	—	12

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level which could be considered too low or too high.

TABLE 11. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE ACCEPTABILITY OF NATURAL INCREASE, AND DESIRABILITY OF INTERVENTION TO CHANGE RATES, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC, JULY 1978-JULY 1980

	Governments' perceptions of the effect of natural increase as a constraint on development, and desirability of intervention							
	Rates too low		*Rates neither too low nor too high*			*Rates too high*		
	Effect of constraints				*Effect of constraints*			
	Predominant (A)	*Significant (B)*	*Minor (C)*	*No constraints*	*Minor (C)*	*Significant (B)*	*Predominant (A)*	
	Higher rates desirable		*Neither higher nor lower rates available*			*Lower rates desirable*		
	Full intervention appropriate (1)	*Some support appropriate[a] (2)*	*(3)*	*No intervention appropriate (4)*	*(5)*	*Some support appropriate[a] (6)*	*Full intervention appropriate (7)*	*Total*
Number of countries in each category in 1978	5	1	1	2	5	—	16	30
Changes in perception								
Countries that left a category	—	—	—	Singapore	Burma	—	—	
Countries that entered a category	—	—	Singapore	Burma	—	Kiribati[b] Solomon Islands[b] Tuvalu[b]	—	
Number of countries in each category in 1980	5	1	2	2	4	3	16	33

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level which could be considered too low or too high.

[b] State that became a Member of the United Nations or a member of its specialized agencies during the period 1978-1980.

part on lowering fertility. In the ESCAP area, China had in recent times attracted the most attention because of statements by its leaders concerning the need to curb the growth of population still more radically than had been done in the past.[23] The Constitution had been amended to introduce a precise reference to the fact that the State encouraged birth control; and, as in the case of other political campaigns, a campaign to mobilize the masses was introduced immediately.

In Indonesia, where the growth rate was still high (2.3 per cent), the Government was continuing to do its utmost to reduce fertility and to solve the problem caused by the population increase in certain parts of the country.[24] Thus, it decided to transfer half a million families from the overpopulated island of Java to other islands in the area by 1984. That extremely costly programme formed part of its five-year development plan for the period 1979-1984 and was designed, in addition to the immediate objective mentioned above, to speed the agricultural development of the other islands so as to ensure self-sufficiency for the country in the face of a lack of food crops and the need to increase industrial export crops, such as rubber and palm-oil.

In India, successive changes of Governments had seriously affected programmes intended to reduce population

[23] E. Brennan and J. C. Chasteland, *op.cit.*

[24] Dilip Mukerjee, "Populating Indonesia's outer islands", *People* (London), vol. 7, No. 2 (1980), Earthwatch p. 3.

growth, particularly at the level of family planning programmes.[25] The speed of the decline in the birth rate had slowed considerably over the previous few years, in direct proportion to the decreasing numbers of couples who were practising contraception. The government authorities responsible were endeavouring to relaunch the over-all policy of reducing the rate of natural increase through redefinition of new targets, as is discussed more fully below (see also table 7).

Five countries in the ESCAP area stated that they were satisfied with their growth rate. That group included two countries that had no policy (Burma and Maldives) and three that had a policy (Afghanistan, Malaysia and Singapore).[26] In Singapore, rapid industrialization combined with a steep decline in fertility might well, in the more or less long term, raise a problem of manpower, especially as immigration was strictly controlled.

Only six countries regarded their growth rate as unduly low. Most of them (Democratic Kampuchea,[27] the Democratic People's Republic of Korea,[28] the Lao People's Democratic Republic and Mongolia), all centrally planned economies, had comprehensive intervention policies. The Lao People's Democratic Republic and Mongolia placed special emphasis in their intervention on the increase or maintenance of fertility levels. In Mongolia, a full programme of incentives and disincentives had been implemented in connection with the execution of the fifth development plan (1971-1975) and had been further reinforced in the sixth development plan (1976-1980).[29]

A large number of countries in Asia had defined quantitative goals in support of their policies (see table 7). China had established a rate of natural increase of 5.0 per 1,000 to be attained by 1985 and a zero rate by the year 2000; families were required to limit themselves to one child. The Republic of Korea wanted its growth rate to amount to 1.6 per cent in 1981; Indonesia desired 2 per cent during the period 1979-1984, with a crude birth rate of 34 per 1,000 by 1984; and Malaysia aspired to 2 per cent in 1985, with a crude birth rate of 28.2 per 1,000 from 1980 onward. Singapore had established as its target a zero growth rate by the year 2000; Viet Nam desired a 2 per cent rate in 1980, 1.5 per cent by 1985 and 1 per cent by 2000; Thailand wanted a 2.1 per cent rate in 1981; and India desired a net reproduction rate of 1.0 everywhere in the country by the year 2000.

Several countries periodically reviewed their targets in the light of the evolution of the situation, and at the time they defined those targets, they established a detailed strategy for achieving them.

The Philippines, in its response to the Fourth Population Inquiry in 1978, had established as its target a growth rate of 2.3 per cent to be achieved in 1982 and 2.1 per cent by 1987. At its eleventh seminar,[30] held at Manila in June-July 1980, the Population Commission fixed as an immediate goal for the population programme a reduction in the annual growth rate from 2.3 per cent in 1980 to 2.0 per cent by 1985. That reduction should make it possible to attain a net reproduction rate equal to unity by the year 2000, in which case the population of the Philippines would consist of 67 million, according to current projections. The Commission also established a strategy that should make it possible to reach the targets thus defined, namely; to raise family planning acceptance from a projected 45 per cent (in 1981) to 53 per cent (1985); to promote delayed marriage and to lower the proportion of married women under age 20 from 50 per cent (1978) to 42 per cent (1985); to promote a small family-size norm and to influence the desired number of children to drop from 4.4 (1978) to 3.0 (1985); and to monitor and study other development factors (such as income, employment, health and education) and how they affect the decision-making process in population.

Another example of target-reviewing was that of India. The declared goal at the time of the Fourth Inquiry had had as its main feature a crude birth rate of 30 per 1,000 to be attained by 1983 and 27 per 1,000 by 1986-1991. But in recent years, after the relaxation of government policies, the percentage of couples who used contraceptives had fallen. In 1977, 24 per cent of couples between 15 and 44 years of age had used some method of contraception; in 1978, the percentage had been 22.8 per cent; and in June 1979, it had been 21.6 per cent. In 1980, the Working Party on Population Policies submitted a report to the Planning Commission in which it proposed as an objective a net reproduction rate of unity by the year 2000 for the country as a whole, and earlier in certain regions.[31] In order to attain that goal, the average size of family: six live-born children, with 4.2 surviving children, would have to fall everywhere in the country to two children. The crude birth rate would thus have to fall from its current level of 33 to 21 per 1,000 by 1996.

In the developing countries, the extent and vigour of government intervention varied considerably from one region or country to another and reflected the variety of situations that actually arose in regard to population. Those developing countries which were still at the early stages of the demographic transition and regarded their growth rate as too low gave priority, as a rule, to the reduction of deaths and to the problems of spatial distribution of the population, while fertility and international migration were given a lower priority. Among the countries where fertility and mortality were at a low level, intervention in respect of fertility predominated. Developing countries that perceived their growth rate as too high generally took action to reduce fertility and control internal population movements, and to reorganize the rural and urban configuration of the country. Efforts towards economic restructuring were given high priority. In those developing countries which regarded the growth rate as satisfactory, government intervention tended

[25] "Indian standstill", *People* (London), vol. 7, No. 3 (1980), pp. 28-29.
[26] For Afghanistan, that was the situation in 1978.
[27] Situation in 1977.
[28] Situation in 1976.
[29] *Population Policy Compendium: Mongolia*, situation as assessed in June 1979, a joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities. (New York, 1979).

[30] Economic and Social Commission for Asia and the Pacific, Population Division, *Population Headliners*, No. 66 (Bangkok, September 1980).
[31] "Indian standstill", *People* (London), vol. 7, No. 3 (1980).

to follow the pattern of developed countries, where action in regard to fertility was geared more to individual well-being than to any demographic objective. Action in regard to the other demographic variables still played an important part, but not an essential part, while changes in socio-economic structures invariably continued to be given high priority as in the developing countries in general.

Conclusion

The inference to be drawn from all the comments made in the present chapter is that considerable differences existed between one area and another, and even between one country and another within a given area, with respect to perceptions of the rate of natural increase, the options for intervention and the vigour of the policies implemented. In the developed countries, where the demographic situation was more homogeneous, the response by Governments was nevertheless varied, both in regard to perception and in regard to the type of action to be taken. That response was actually based mainly on divergent assessments of the social and economic consequences of demographic trends. In the developing countries, the demographic and economic situation was far more varied. The responses by Governments rested rather on economic considerations; the countries most deeply involved in the demographic transition were also those which in general showed themselves to be the most concerned about demographic problems. The responses differed, although a certain similarity of attitudes was found among the countries in the ECWA and ESCAP areas of responsibility.

By and large, countries had decided to intervene with greater or lesser energy with a view to the alteration or control of the population growth rate. Only 17 out of 165 countries had taken no steps at all and had left it to the workings of spontaneous evolution of the rates, or else regarded action as inopportune in the political and social climate of the particular country. The majority of countries that did not consider their growth rates to be satisfactory had a comprehensive intervention policy; 25 out of 35 countries regarded the rates as too low and 38 out of 55 regarded them as too high.

However, Governments do not always have entire freedom of action. Their desire to intervene or the strategies they devise may encounter circumstances that curb or even call in question the action proposed. In the developed countries, apart from long-term social tendencies that introduce constraints into the context of government intervention, economic events can play a significant role in the demographic evolution of industrialized countries over the short term. Thus, inflation, recession and reduction in levels of employment might have contributed to modify the plans of couples with respect to the final size of their families. Account must also be taken of the curbs or cuts in some countries that affected government expenditure on families. Furthermore, the increase in unemployment helped to reduce very severely the demand for foreign manpower, with the consequent closing of frontiers to new immigrants; and that factor could also bring about a shift in population in regions affected by the employment crisis.

In the developing countries, in addition to the structural constraints (economic, financial, administrative, technological, cultural etc.) that limited the real possibilities of intervention by Governments, economic events had definite repercussions on their capacity to take action. The recession and inflation situation had particularly affected those countries whose economies depended very closely upon the importation of foodstuffs, manufactures or oil. Because the resources at the disposal of Governments had been reduced, the crisis had led many of them to restrict their action in regard to expenditure on public services (education, health etc.). On the other hand, it had led some Governments to place the stress even more on autonomous development, such as the development of the rural sector.

Chapter XXI

MORTALITY, MORBIDITY AND HEALTH POLICIES

All countries have policies to improve the health and well-being of their citizens, but many Governments are not satisfied with the achievements of their policies. The recent Fourth Population Inquiry Among Governments and the subsequent *1979 Monitoring Report*[1] found that 107 of the 165 countries viewed their existing levels of average life expectancy as unacceptable in the prevailing economic and social circumstances (see table 12).[2]

Population policies are fundamentally related to those of health, morbidity and mortality. Policies to reduce morbidity are directly linked with lowering mortality; they will affect the natural rate of population increase and are also likely to affect fertility in different ways. The complex interrelationships between fertility and infant and child mortality are matched by the complex relationships among population policies and health policies. There are overlapping targets for high-risk groups—children and women of reproductive ages—and thus the joint emphasis on family health, maternal and child health care, including family planning, is particularly linked with the emerging emphasis on primary health care. The decentralization of medical services and the extension of health coverage to the rural areas may complement policies affecting spatial distribution. The greater attention to the non-medical determinants of health and the emphasis being given to widening the population's access to those elements are also of increasing interest to those countries which are formulating various population policies. Governments emphasized their concern about mortality in their replies to the Fourth Population Inquiry.

The World Population Plan of Action established the goal for the achievement of a life expectancy at birth of 62 years as a world average by 1985 and of 74 years by the end of this century. On average, the developed countries are expected to reach these targets. However, estimates and projections developed by the Population Division indicate that Africa and much of Asia—and thus the developing countries, on average—are no longer likely to reach this level. In fact, the developing countries may only achieve a life expectancy at birth of from 63 to 64 years by the year 2000, which would be a modest gain, only slightly above the target set for 1985.

Of the 39 developed countries, nine considered their average levels of life expectancy to be unacceptable in their prevailing economic and social circumstances (see table 12). Among many developed countries, there was continued concern over the substantial differentials in mortality of various groups and social classes. Also of particular interest was the excess mortality among adult males and the gap, which was widening in some countries, between male and female mortality at older ages. A number of new policies were being formulated in response to those concerns, which included measures especially targeted to high-risk groups as well as various preventive health programmes. Some of the same types of measures were being integrated into the quite diverse health and social services found among the centrally planned economies and mixed economies of the more developed regions.

Among the 126 developing countries, only 28 considered their level of life expectancy to be acceptable, while 98 considered it unacceptable even in their prevailing economic and social circumstances (see table 12). By far, the greatest number of Governments that viewed their mortality levels as unacceptable were found in the area of responsibility of the Economic Commission for Africa (ECA)—49 out of 51 countries, followed by the areas of responsibility of the Economic and Social Commission for Asia and the Pacific (ESCAP), the Economic Commission for Latin America (ECLA) and the Economic Commission for Western Asia (ECWA).

In the ECA area, where life expectancies were lowest, the Governments themselves often considered poor health and high mortality their most serious population problems. Only two countries considered their mortality levels acceptable. In 1980, the mortality conditions in sub-Saharan Africa were the world's most severe; as few gains had been made in recent years, life expectancy levels were well below 50 years. Substantial improvements had been made in a few island countries. In Northern Africa, estimates of levels of life expectancy often ranged between 55 and 60 years, with certain notable exceptions.

Recently, there had been widespread changes in the formulation of health policies in countries in the ECA area, in support of the principles of primary health care, which if implemented would be likely to have a significant demographic impact. Because of the changes in health and mortality policies and their potential impact in the ECA area, this chapter gives special attention to the diversity of those health policy objectives.

In the ECWA area, where many of the countries had experienced rapid economic growth, there had not been a parallel implementation of primary health care nor had there been an accelerated decline in mortality. Of the 12 countries in the ECWA area, half considered their average level of live expectancy at birth to be unacceptable in the prevailing economic and social circumstances. A number of countries

[1] *World Population Trends and Policies: 1979 Monitoring Report*, vol. II: *Population Policies* (United Nations publication, Sales No. E.79.XIII.5).

[2] For views of individual Governments concerning mortality, see annex table 40.

TABLE 12. AVERAGE LIFE EXPECTANCY AT BIRTH, 1975-1979, AND GOVERNMENTS' PERCEPTIONS OF ITS ACCEPTABILITY IN PREVAILING ECONOMIC AND SOCIAL CIRCUMSTANCES, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

(Number of Governments)

Area of responsibility of regional commission, region and level of development	*Levels of life expectancy at birth*										
	Under 50		*50-61*		*62[b]-69*		*70 years and over*		*All ages*		
	Acceptable	*Unacceptable*	*Acceptable*	*Unacceptable*	*Acceptable*	*Unacceptable*	*Acceptable*	*Unacceptable*	*Acceptable*	*Unacceptable*	*Total*
ECA area											
Eastern Africa	1	9	—	4	1	1	—	—	2	14	16
Middle Africa	—	9	—	—	—	—	—	—	—	9	9
Northern Africa	—	1	—	5	—	—	—	—	—	6	6
Southern Africa	—	2	—	2	—	—	—	—	—	4	4
Western Africa	—	15	—	1	—	—	—	—	—	16	16
TOTAL	1	36	—	12	1	1	—	—	2	49	51
ECE area											
Eastern Europe	—	—	—	—	1	—	5	—	6	—	6
Northern Europe	—	—	—	—	—	—	5	2	5	2	7
Southern Europe	—	—	—	—	1	2	5	1	6	3	9
Western Europe	—	—	—	—	—	—	8	1	8	1	9
Cyprus, Israel and Turkey	—	—	—	1	—	—	2	—	2	1	3
Northern America	—	—	—	—	—	—	2	—	2	—	2
USSR	—	—	—	—	—	—	—	3	—	3	3
TOTAL	—	—	—	1	2	2	27	7	29	10	39
ECLA area											
Caribbean	—	—	1	1	1	5	3	—	5	6	11
Middle America	—	—	—	3	2	2	—	—	2	5	7
Temperate South America	—	—	—	—	2	1	—	—	2	1	3
Tropical South America	—	—	1	2	1	5	—	—	2	7	9
TOTAL	—	—	2	6	6	13	3	—	11	19	30
ECWA area											
Western South Asia[c]	—	4	4	—	2	2	—	—	6	6	12
TOTAL											
ESCAP area											
China	—	—	—	—	—	1	—	—	—	1	1
Japan	—	—	—	—	—	—	1	—	1	—	1
Other East Asia	—	—	—	—	1	2	—	—	1	2	3
Eastern South Asia	—	3	2	3	1	—	—	—	3	6	9
Middle South Asia	—	5	—	3	1	—	—	—	1	8	9
Australia-New Zealand	—	—	—	—	—	—	2	—	2	—	2
Melanesia	—	1	—	1	—	—	—	—	—	2	2
Micronesia-Polynesia	—	—	—	—	—	4	2	—	2	4	6
TOTAL	—	9	2	7	3	7	5	—	10	23	33
Developed countries	—	—	—	—	2	2	28	7	30	9	39
Developing countries	1	49	8	26	12	23	7	—	28	98	126
TOTAL	1	49	8	26	14	25	35	7	58	107	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 40.

[b] A life expectancy at birth of 62 years equals the world average life expectancy by 1985 referred to in the World Population Plan of Action (para. 22). The other categories in this table were chosen by reference to this figure.

[c] Excluding Cyprus, Israel and Turkey.

in the area were, however, formulating health and population policies which were specifically designed for and directed to rural and under privileged populations.

Countries in the ECLA area had achieved substantially higher levels of life expectancy than those in the other less developed regions. And yet, further progress in reducing mortality had apparently slowed in a number of countries and that was causing some concern. Of the 30 countries in the ECLA area, 19 considered their level of life expectancy to be unacceptable in the prevailing economic and social circumstances.

High mortality levels remained a major concern to many countries of South Asia, which still had life expectancy levels of less than 50 years, although the level in most countries of South Asia was within the range of 50-60 years. Of the 30 developing countries in the ESCAP area, 23 considered their average level of life expectancy at birth to be unacceptable in the prevailing circumstances. Health policies received considerable attention and were often an integral part of the over-all development plans. The health policies of China were particularly impressive and the country had experienced a very substantial increase in its average life expectancy.

The formulation and implementation of health policies in many countries were undergoing major changes. There was a great deal of dissatisfaction over many of the earlier approaches to health care and a broad consensus was emerging in many countries that supported the principles of primary health care.[3] To the extent that those programmes are

[3] World Health Organization, *Sixth Report on the World Health Situation 1973-1977*, parts 1 and 2 (Geneva, 1980); "Statements by participants in the plenary meetings", document ICPHC/ALA/78.11 of the International Conference on Primary Health Care, Alma-Ata, Union of Soviet Socialist Republics, 6-12 September 1978, jointly sponsored by the World Health Organization and the United Nations Children's Fund.

implemented, they are likely to have profound demographic consequences; even when they were not explicitly motivated for demographic purposes. Many of the measures, and particularly the emphasis on maternal and child health care were intended to complement population and family planning programmes. The increased attention to infant and child mortality has implications for future population growth as well as for the complex relationships between infant mortality and fertility. The non-medical determinants of health, the environmental aspects of health and the relationships between the structure of development and health also were receiving greater attention; and they have important demographic significance.

The change in emphasis was reflected in the recent planning of many Governments and in the activities of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), which jointly sponsored the International Conference on Primary Health Care, held at Alma-Ata, Union of Soviet Socialist Republics, in 1978.[4] The International Year of the Child (1979) and the International Drinking Water Supply and Sanitation Decade (1980s) designated by the United Nations Water Conference, held at Mar del Plata, Argentina, in 1977, also focused widespread attention on these problems, as have the activities of a number of other international agencies.

Implementation of such ambitious objectives remains a formidable challenge. There are numerous financial, administrative and political constraints to these policies, and they are often closely tied to the structure of development. The last section of this chapter examines some of the emerging policy trends, issues and problems.

A. Developed countries

In the developed countries,[5] even among those with a long life expectancy, progress has often been less than satisfactory in reducing differential mortality and mortality among adult males, although some new progress has recently been noted.[6] In this respect, many new measures and approaches were being undertaken in 1980 in a number of countries although few had been implemented with specific demographic rationales.[7]

A majority of countries in the area of responsibility of the Economic Commission for Europe (ECE), 29, considered their level of mortality—as measured by the average life expectancy at birth—to be acceptable, although 10 countries, including seven which had an average life expectancy of more than 70 years, considered it to be unacceptable. Countries in the ECE area with the highest levels of life expectancy shared a number of similar concerns: reducing the incidence of cardio vascular diseases and vehicular accidents; and waging campaigns against the effects of excessive alcohol consumption and tobacco smoking. In all regions of Europe, as well as in Northern America and the USSR, health education campaigns had been given a high priority. There was a greater realization that individual choices affected health life-styles and were clearly affected by social pressure and commercial advertising as well as by health education and information measures. Thus, policies that affected environmental health and preventive measures directed towards the influencing of behavioural factors were receiving greater attention. Health education and preventive programmes that emphasized the relationships between tobacco smoking, excessive alcohol consumption, over-nutrition, insufficient exercise and stress with cancer, coronary heart disease, alcoholism and obesity were being widely adopted in the ECE area.

In this connection, a number of countries were also concerned with reducing the differentials between adult male and female mortality. For example, France reported that while the level of female mortality was acceptable, that of males was unacceptable. The United Kingdom of Great Britain and Northern Ireland reported that it had focused increasing attention on preventive health measures since 1976, when it had published a white paper on prevention and health; and Finland had initiated special projects directed to reduction of the mortality of males over 45 years of age.

Contamination of air, water and food, hazards in the work place, unsafe highway and motor-car design, dangerous consumer products and radiation exposure are some of the other major risks in the physical environment that were of concern in the ECE area. Income, housing, employment, family ties and social supports also were recognized as factors that affected the mortality risks in the socio-economic environment.

Although a majority of the countries in the ECE area of responsibility had low infant and child mortality, a number of countries placed an emphasis on reducing it still further. Denmark had enacted legislation that required the examination of all expectant mothers and children; the Federal Republic of Germany had approved legislation in 1974 that required pre-natal examinations and periodic examinations of children. Finland had achieved an infant mortality rate of 10 deaths per 1,000 live births in 1976, with no significant urban/rural or regional differentials. It had a very effective immunization programme: 98 per cent of the children received diphtheria-pertussis-tetanus (DPT) and bacillus Calmette-Guérin (BCG) vaccinations. Expectant mothers averaged 13.3 visits to a nurse and 3.3 visits to a physician during pregnancy. Despite many achievements in the reduction of infant mortality, several of the most affluent developed countries continued to experience substantial regional, class and ethnic differentials in their infant mortality rates.

[4] See "Declaration of Alma-Ata", *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*, ("Health for All" Series No. 1) (Geneva, World Health Organization, 1978), pp. 2-6.

[5] The developed countries include all the countries, except Cyprus, Israel and Turkey, in the area of responsibility of the Economic Commission for Europe (ECE); and Australia, Japan and New Zealand in the area of responsibility of the Economic and Social Commission for Asia and the Pacific. For list of countries in the ECE area, see annex table 40.

[6] Jean Bourgeois-Pichat, "Long-term population projections and their social and economic consequences", paper prepared for the United Nations Training Workshop in Population Projections, Budapest, 17-28 March 1980 (mimeographed).

[7] World Health Organization, "Report of the Regional Director for the European Region", paper ICPHC/ALA/78.7 prepared for the International Conference on Primary Health Care Alma-Ata, 1978; I. P. Lidov, A. M. Stochik and G. F. Tserkovny, *Soviet Public Health and the Organization of Primary Health Care for the Population of the USSR* (Moscow, Mir Publishers, 1978); Poland, Ministry of Health and Social Welfare, *Health Care in the Polish People's Republic. Report on the International Conference on Primary Health Care, Alma-Ata, 1978*; Czechoslavakia, *The Czechoslovak Health Service* (Prague, 1978); *Primary Health Care in the Bulgarian National Public Health System* (Sofia, 1978); Swedish National Board of Health and Welfare, *Primary Health Care: A Swedish Project* (Stockholm, 1977).

Access to services that promote, maintain or restore health is associated with differential mortality. The developed countries have a number of health care systems, some of which provide free and easily accessible health care to the entire population as a social service. However, in 1980, a sizeable number of people in the United States of America had no health insurance, while a large number had inadequate coverage. Nearly 50 million people lived in rural or urban areas officially designated as "underserved".

Many of the developed countries considered regional differentials to be an area of continuing concern. A variety of programmes were being implemented, each of which reflected the needs of the individual countries concerned. The Federal Republic of Germany was attempting to reduce regional differentials through the establishment of regional health service offices; Greece, through the expansion of rural medical centres and the utilization of helicopters; the Netherlands, through hospital construction and subsidies to home-care services in rural areas; Romania, through the creation of medical dispensaries in each community; Spain, through the extension of social security to the countryside; and Sweden, through district physicians and nurses who visited patients in their homes.

Some of the principles of primary health care that had been fundamental policies in a number of countries, especially those of Eastern and Northern Europe, were receiving greater attention and acceptance throughout the ECE area.[8] The curative-medicine approach, with its high technology and requisite advanced medical training, had contributed to a rapid escalation of health costs. In that connection, there was a greater interest in the utilization of paramedical personnel, to reduce costs and improve efficiency, as well as to further integrate health within preventive, primary and social service efforts; and to foster an active rather than passive role in the identification of target populations.

In general, greater attention was being given to underserved populations, community participation and collaboration between consumers and providers. More efforts were being made to involve the consumer, both collectively and individually, in the planning and implementation of health care services. Problems that related the effectiveness and efficiency of primary health care; and the need for better evaluation, allocation of resources, new information systems and measures to screen for disease and populations at risk also were being considered.

A change of focus was appearing in a growing number of countries with regard to the relationships between primary health care and the wider health care system; and among hospitals, health centres, polyclinics and local teams. There was also greater interest in policies and measures that affected the integration of health with social care and even community development. The health policy in Finland, for example, had had a major reorientation which gave a high priority to primary health care and included a high degree of community involvement and participation.[9]

The links between changes in health conditions and changes in governmental expenditure in health are exceedingly complex. Of course, changes in the proportion of the gross domestic product spent on health services are much less likely to be reflected in changing health conditions than are changes in the level of living itself. Health and medical care are often financed by expenditures of individuals and/or by private institutions. Among the developed countries with market economies, government expenditure on health services averaged 2 per cent of the gross domestic product in the mid-1970s. However, 5 per cent or more was spent on health services by the Governments of the Federal Republic of Germany, New Zealand, Norway and the United Kingdom.[10]

Among the developed countries, even among those with the levels of highest life expectancy, progress in further reducing mortality has often been considered unsatisfactory. In 1980, differential mortality and adult male mortality remained particular concerns, as did risks from both the physical and the socio-economic environments. Preventive health policies were being implemented in much of the ECE area. Access to medical services continued to be a policy issue in some of the countries with a mixed economy. Throughout the area, health costs had increased more rapidly than those in almost any other sector.

B. Developing countries

Area of responsibility of Economic Commission for Africa

The countries of Africa had the lowest levels of life expectancy and considered poor health and low life expectancy to be their most serious population problems. The Governments of these countries were more dissatisfied with their current levels of morbidity and mortality than were the Governments in any other area. Only two countries considered their average level of life expectancy at birth to be acceptable in the prevailing economic and social circumstances, while 49 countries considered it to be unacceptable. Some 37 countries in the ECA area had levels of life expectancy under 50 years, while another 12 countries had levels in the range of 50-61 years—below the average level of life expectancy of 62 years recommended by the World Population Plan of Action.

Although many countries in the ECA area of responsibility will not achieve a mortality reduction of the dimension recommended by the World Population Plan of Action, many Governments reported that they did have as their goal to achieve substantial progress. Quantitative mortality targets had been identified by a number of countries, including Botswana, Burundi, Egypt, Ethiopia, Kenya, Madagascar, Morocco, the Niger, Nigeria, Senegal, Seychelles, Sierra Leone, Somalia and Togo. Egypt, a country with relatively good demographic data, had identified precise targets: to reduce the crude death rate from 14.2 to 13 per 1,000 and the infant mortality rate from 119 to 80 per 1,000 live births by 1982. Kenya expressed its target in terms of increasing life expectancy at birth: from 49 to 60 years by the year

[8] Leo A. Kaprio, *Primary Health Care in Europe*, EURO Reports and Studies No. 14 (Copenhagen, World Health Organization Regional Office for Europe, 1979).

[9] Ministry of Social Affairs and Health, National Board of Health, *Primary Health Care in Finland* (Helsinki, 1978).

[10] *Report on the World Social Situation, 1978—Supplement, Patterns of Government Expenditure on Social Services* (United Nations publication, Sales No. E.79.IV.3), p. 35.

2000. A number of countries reported that they could not identify quantitative targets—or be at all specific concerning prevailing mortality trends because of major inadequacies in the available data.

Since a number of the Governments of countries in the ECA area considered poor health and high mortality their most serious population problem, a special content analysis of the health policy objectives of 45 countries was undertaken by the Population Division and is presented in tables 13 and 14. The objective of this study was to determine to what extent the principles being articulated in international forums were actually being incorporated into recent plans and programmes of developing countries in Africa and to see how they were likely to interact with population policies concerning fertility, mortality and migration.

The training of health workers was rated as a policy priority by all the countries studied, which reflected a great shortage in the area (see table 13). The control of endemic diseases, sanitation efforts, immunization, and maternal and child health were recognized as a policy priority by more than 90 per cent of the countries. Efforts to promote potable drinking-water and the extension of health coverage, often to rural areas, was also an overwhelming priority. Nutrition, food and health education were recognized as priority health areas by about three quarters of the countries studied. The first category included food subsidies and agricultural policies, as well as the nutritional education measures most often found in connection with maternal and child health care measures. Particular attention was given to the nutrition of children and of pregnant and lactating women. Health education was another high priority area; sometimes it involved specifically targeted adult education programmes, but often it was emphasized as a part of the family health strategy which included immunization, maternal and child health, nutrition and family planning.

About two thirds of the countries expressed some interest in the concept of community involvement in health; in some cases, that meant the community would employ health workers and assist in establishing the priority of measures to be undertaken within the village. The concept of the village or community health worker was articulated as a priority by more than half the countries, and it often represented a strategy of decentralization of medical services and in some cases a method of incorporating the traditional birth attendants and paramedical workers into a referral network. Twenty countries, 47 per cent, mentioned family planning services as a health policy objective. The emphasis in this aspect was usually for contraceptives in order to space births or for family health reasons and it was often integrated with maternal and child health programmes. More countries might actually have been supporting family planning but only 20 Governments indicated they were doing so as part of their priority health objectives. The provision of essential drugs was mentioned as a priority by only 19 countries, or 44 per cent. Since that number appears to be rather low, it might be that such measures were subsumed in other programmes, perhaps in the control of endemic diseases and immunization, and thus might have actually been considered more important by the Governments.

The aim of this examination was to see the extent to which specific population and primary health care measures were included in the formulation of government policies. The notes to table 14 show that efforts to control malaria were an important and widespread policy objective. Also of special attention were efforts to modernize hospitals, research and training facilities, and so forth.

This content analysis found that the principles of primary health care were at least being adopted by the Governments themselves in the formulation of their most recent health policies, which itself was a significant change from past strategies, even though their vigorous implementation was a reality in only a few countries. The investigation of stated objectives shows a striking move towards some of the prin-

TABLE 13. ANALYSIS OF HEALTH POLICY OBJECTIVES OF GOVERNMENTS OF SELECTED COUNTRIES OF AFRICA, AS ASSESSED IN JULY 1980

	Priority		*Not a priority*		*Total*	
Health objective	*Number of countries*	*Percentage*	*Number of countries*	*Percentage*	*Number of countries*	*Percentage*
Health education	32	74	11	26	43	100
Nutrition and food	33	77	10	23	43	100
Drinking-water	38	88	5	12	43	100
Sanitation	40	93	3	7	43	100
Maternal and child health	39	91	4	9	43	100
Family planning	19	44	24	56	43	100
Immunization	39	91	4	9	43	100
Control of endemic disease	42	98	1	2	43	100
Provision of essential drugs	19	44	24	56	43	100
Extension of health coverage[a]	38	88	5	12	43	100
Community involvement in health	28	65	15	35	43	100
Village health workers	26	60	17	40	43	100
Training of health workers	43	100	—	—	43	100

Source: Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat, "Study of health and mortality policy objectives in Africa".

[a] Especially in rural areas.

TABLE 14. ANALYSIS OF HEALTH POLICY OBJECTIVES, SELECTED COUNTRIES OF AFRICA, 1980; AND RELATED DATA ON PUBLIC HEALTH EXPENDITURES AND INFANT MORTALITY RATES

Country	Health education	Nutrition and food	Drinking-water	Sanitation	Maternal and child health	Family planning[a]	Immunization	Control of endemic diseases	Provision of essential drugs	Extension of health coverage[b]	Community involvement in health	Village health workers	Training of health workers	Public expenditures on health per capita, 1976 (dollars)	Infant mortality rate, 1980 (per 1,000)
Angola	x	x	x	x	x	(3)	x	x	—	x	—	x	x	3	155
Benin	x	—	x	x	x	(2)	x	x	—	x	—	—	x	3	155
Botswana[c]	x	—	x	x	x	(4)	x	x	x	x	x	x	x	10	83
Burundi[d]	—	x	x	x	—	(2)	x	x	x	—	—	—	x	1	122
Cape Verde	—	x	—	—	x	(4)	—	—	x	x	—	—	x	. . .	82
Central African Republic[e]	x	x	x	x	x	(2)	x	x	—	—	—	—	x	2	149
Chad[f]	x	x	x	x	x	(1)	x	x	—	x	x	x	x	1	149
Comoros[g]	—	x	x	x	x	(2)	x	x	—	x	x	x	x	. . .	93
Congo[h]	x	x	x	—	x	(4)	x	x	x	x	x	—	x	10	129
Equatorial Guinea	—	—	x	x	x	(1)	—	x	—	x	—	x	x	3	143
Ethiopia[i]	x	—	x	x	x	(3)	x	x	x	x	x	—	x	1	146
Gabon[j]	—	x	x	x	—	(1)	x	x	—	x	x	—	x	57	117
Gambia[k]	x	—	x	x	x	(3)	—	x	—	x	x	x	x	4	198
Ghana[l]	—	x	x	x	x	(4)	x	x	—	x	x	x	x	10	103
Guinea[m]	—	x	x	x	x	(2)	x	x	x	x	x	x	x	4	165
Guinea-Bissau[n]	x	x	—	x	x	(3)	x	x	x	x	x	—	x	. . .	127
Ivory Coast[o]	x	x	x	x	x	(2)	x	x	—	x	x	—	x	9	127
Kenya[p]	x	x	x	x	x	(4)	x	x	x	x	x	x	x	4	87
Lesotho[q]	—	x	x	x	x	(4)	x	x	x	x	—	x	—	2	115
Liberia[r]	x	x	x	x	x	(4)	x	x	—	x	x	x	x	7	154
Madagascar[s]	x	x	—	x	x	(3)	x	x	—	x	—	—	x	4	71
Malawi[t]	x	x	x	x	x	(1)	x	x	—	x	x	x	x	2	172
Mali[u]	x	x	x	x	x	(4)	x	x	—	x	x	x	x	2	155
Mauritania	x	x	x	x	x	(2)	x	x	—	x	x	x	x	3	143
Mauritius[v]	x	x	—	x	x	(4)	x	x	—	x	x	x	x	17	35
Mozambique	x	x	x	x	x	(4)	x	x	x	x	x	x	x	1	115
Namibia[w]	—	—	—	—	—	—	—	—	—	—	—	—	—	. . .	120
Niger	x	x	x	x	x	(2)	x	x	x	x	x	x	x	1	146
Nigeria	x	x	x	x	x	(3)	x	x	x	x	x	x	x	3	135
Reúnion[x]	x	—	x	x	x	—	x	x	—	—	—	—	x	. . .	20
Rwanda[y]	—	x	x	x	x	(4)	x	x	x	—	x	—	x	1	107
Sao Tome and Principe[z]	—	x	x	x	x	(2)	x	x	—	x	—	x	x	. . .	. . .
Senegal[aa]	—	x	x	x	x	(4)	x	x	—	x	x	x	x	4	147
Seychelles	x	—	—	x	x	(4)	x	—	—	—	x	—	x	. . .	. . .
Sierra Leone[bb]	x	x	x	x	x	(3)	x	x	—	x	—	—	x	3	208
Saint Helena[cc]	—	—	—	—	—	—	—	—	—	—	—	—	—	. . .	. . .
Swaziland[dd]	x	—	x	x	x	(4)	x	x	—	x	—	x	x	10	135
Togo[ee]	x	—	x	x	—	(3)	x	x	—	x	—	—	x	3	109
Uganda[ff]	x	x	x	x	x	(4)	x	x	x	x	x	x	x	3	97
United Republic of Cameroon	x	x	x	x	x	(3)	x	x	x	x	x	—	x	3	109
United Republic of Tanzania	x	x	x	x	x	(4)	x	x	x	x	x	x	x	3	103
Upper Volta	x	x	x	x	x	(2)	x	x	—	x	—	x	x	1	211
Zaire	x	x	x	x	x	(4)	x	x	x	x	x	x	x	1	112
Zambia	x	x	x	x	x	(4)	x	x	x	x	—	x	x	13	106
Zimbabwe[gg]	x	—	x	x	—	(4)	x	x	x	x	x	—	x	. . .	74

(See footnotes on following page.)

(Footnotes to table 14.)

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat; World Health Organization, Regional Office for Africa, "Proposed programme budget, 1982-1983", WHO/AFR/RC 30/2, Thirtieth Session of the Regional Committee, Brazzaville, 1980; World Health Organization, *The Work of WHO in the African Region, 1977-1978,* Biennial Report of the Regional Director for public expenditures, World Bank, *Health,* Sector Policy Paper, 2nd ed. (Washington, 1980); and Ruth Leger Sivard, *World Military and Social Expenditures, 1979* (Leesburg, Virginia, World Priorities Inc., 1979); and for infant mortality rates, computer print-out of the Population Division.

[a] Numbers in parentheses refer to Governments' policies with respect to provision of support for effective individual fertility regulation: (1) access limited; (2) access not limited, but no support provided; (3) access not limited and indirect support provided; (4) access not limited and direct support provided.

[b] Especially in rural areas.

[c] Special emphasis on a new hospital at Francistown and on occupational health.

[d] Special emphasis on hospital development.

[e] Special emphasis on modernizing existing hospital facilities.

[f] Special emphasis on malaria control.

[g] Special attention to malaria control and oral rehydration services.

[h] Special attention to integration of curative with traditional services and into over-all development efforts, and to the development of hospitals, health surveillance and malaria control.

[i] Special attention to malaria control programmes.

[j] Special attention to hospitals, research and training, and to malaria control programmes.

[k] Special attention to malaria control programmes.

[l] Special attention to medical research, health surveillance and malaria control programmes.

[m] Special attention to the development of hospitals, laboratory services and research, and to malaria and parasitic control programmes.

[n] Special attention to the development of laboratory services and health surveillance and professional health training.

[o] Special attention to malaria control programmes and health surveillance.

[p] Special attention to development of hospitals and health research, and to the integration of health services into other ministries.

[q] Special emphasis to upgrade curative facilities for national self-sufficiency.

[r] Special attention to the further development of health infrastructure and of laboratory and x-ray services.

[s] Special emphasis on occupational health, hospitals, and malaria and parasitic disease control.

[t] Special emphasis on diagnostic, therapeutic and rehabilitation services.

[u] Special emphasis on the integration of health activities with other ministries, especially agriculture, water and education; and the development of health statistics.

[v] Special emphasis on district hospitals and malaria control.

[w] Under illegal occupation by South Africa. The World Health Organization was providing health care support for Namibians in Angola and Zambia, and health assistance through the South West Africa People's Organization (SWAPO).

[x] Special emphasis on the control of malaria and parasitic diseases.

[y] Special emphasis on hospital development and the integration of health and social services.

[z] Special emphasis on malaria control, school health services and the development of laboratory services.

[aa] Emphasis on health research and development.

[bb] Emphasis on the development of laboratory services and health surveillance.

[cc] Emphasis to maintain existing high standards. Universal access to medical coverage.

[dd] Special emphasis on rehydration facilities, schistosomiasis and malaria control programmes.

[ee] Special emphasis on the integration of primary health care into rural development projects.

[ff] Special emphasis on reconstruction of hospitals and all medical facilities damaged by war.

[gg] The years of war had had adverse effects upon health. The country was currently undergoing significant reorganization of health services, including the rehabilitation of war victims.

ciples of primary health care.[11] Surprisingly little emphasis was given to curative medicines, medical research and hospital centres in the stated objectives, although most of the traditional funding had gone to that sector in the past. Analysis of government health expenditures in selected countries of Africa in the early 1970s showed that a very substantial percentage had been spent for curative care. In 1971, over 80 per cent of the health expenditure for a number of these countries had been spent on curative care, 83 per cent in Kenya and approximately 86 per cent in Tunisia; while the rest had been spent on preventive medicine, training, eradication of endemic diseases etc.[12]

A majority of countries reported that they had reviewed their development strategies in order to provide greater support for health care programmes. The diversity of the experience in Africa is interesting and reflects a basic principle of the primary health care approach: that each country determines its own health system in the light of its political, social and economic realities; and, as result, the mix of measures will necessarily vary. For example, Botswana reported that its major objectives were to reinforce primary health care services in rural and marginal urban areas and to strengthen community participation; Burundi emphasized the training of its citizens with respect to preventive medicine; Egypt planned to concentrate on maternal child health services and to provide potable water and housing in rural areas. Ethiopia placed emphasis on the construction of health care stations, health centres and rural hospitals; Gabon, on the improvement of hygiene, nutrition and rural housing; Kenya, on a rural health programme and a "basic needs" approach; Madagascar, on the training of personnel, the distribution of medicine and sanitary facilities, and a better utilization of traditional medicine; Morocco, on campaigns against infectious diseases and malnutrition, and the training of health care personnel; Nigeria, on an immunization programme; Rwanda, on an increase in the number of health care centres; Sierra Leone, on the strengthening of maternal and child health services; Somalia, as well as Togo, on campaigns against infectious diseases.

Although different countries in the ECA area of responsibility stressed different facets of the primary health care approach, their collective policies shared common principles. All of those countries which replied to the Fourth Inquiry reported measures designed to reach rural and underprivileged groups in their societies. For example, Botswana stated that it had been providing services to rural areas since 1973 and that 80 per cent of its population currently was within one kilometre of a health care facility; Egypt was emphasizing maternal child health and nutrition activities, to be delivered by health units in rural and urban areas;[13] Gabon was setting up dispensaries in isolated zones; Ethiopia was constructing health stations and hospitals in rural areas and was training village health workers;[14] the Ivory Coast was "regionalizing" its health care system and was making use of mobile health teams; Morocco was developing basic infrastructure and training sanitary personnel; the Niger was organizing village health teams; Nigeria was currently establishing a pilot National Basic Health Scheme; Rwanda was establishing health care centres throughout the country; Seychelles was sending physicians and nurses to outlying areas; Sierra Leone was extending the activities of its Endemic Disease Control Unit and was training increased numbers of middle-level personnel; Somalia was establishing mobile units to serve the nomad population, while Togo was making similar use of mobile health teams. The experience of other Governments, such as that of the United Republic of Tanzania, for example, had also made far-reaching efforts in the health care field.[15]

Among the countries of Africa, there was an observable shift towards the primary health care approach. However, there was no consensus among those Governments as to the efficacy of any one approach and some Governments had criticized the increasing reliance on paramedical personel in presentations at the Conference at Alma-Ata in 1978. Nevertheless, important new principles were being articulated in health policy in Africa; and to the extent that they are implemented, they are likely to have profound demographic consequences. Though there are many financial, administrative, political and perhaps structural constraints to the actual implementation of these health policy objectives, the new emphasis of the policies and measures will remain significant.[16]

Area of responsibility of Economic Commission for Latin America

The countries in the ECLA area of responsibility had achieved substantially higher levels of life expectancy than those in the ECA and ESCAP areas. However, progress in the further reduction of mortality had apparently slowed in a number of countries, which was causing some concern. Of the 30 countries in the ECLA area, 19 considered their level of life expectancy to be unacceptable in their prevailing economic and social circumstances. Of the 11 Governments that considered it acceptable, three had levels above 70 years of age and six in the range of 62-69 years. None of the

[11] See also Morocco, Ministère de la santé publique, Direction des affaires techniques, "Les soins de santé primaites", paper prepared for the International Conference on Primary Health Care, Alma-Ata, 1978; Libyan Arab Jamahiriya, Secretariat of Health, *Primary Health Care Concept* (1978); Ministry of Health, *The Status of Primary Health Care in Sudan* (Khartoum, 1978); Ministry of Health, *Primary Health Care Programme, Sudan 1977/78 to 1983/84* (Khartoum, Khartoum University Press, 1978).

[12] World Bank, *Health*, Sector Policy Paper, 1st ed. (Washington, D.C., 1975), p. 76. See also Peter S. Heller, *An Analysis of the Structure, Equity and Effectiveness of Public Sector Health Systems in Developing Countries: The Case of Tunisia 1960-1972*, Center for Research on Economic Development Discussion Paper No. 43 (Ann Arbor, Michigan, University of Michigan, 1975); United States Department of Health, Education and Welfare, Office of International Health, *Syncrisis: The Dynamics of Health, an Analytical Series on the Interactions of Health and Socio-economic Development*, XIV, *Zaire*, by Karen E. Lashman (Washington, D.C., 1975); and A. A. Idriss and others, "Sudan: national health programme and primary health care, 1977/78-1983/84", *Bulletin of the World Health Organization*, vol. 53 (1976).

[13] Ministry of Health, *Egyptian Experience in Primary Health Care* (Cairo, 1978).

[14] Ministry of Health, *Primary Health Care Status in Revolutionary Ethiopia* (Addis Ababa, 1978).

[15] United Republic of Tanzania, Ministry of Health, *Primary Health Care: Tanzanian Experience* (Dar es Salaam, 1978).

[16] World Health Organization, "Report of the Regional Director for Africa", ICPHC/ALA/78.4, paper prepared for the International Conference on Primary Health Care, Alma-Ata, 1978; see also Oscar Gish, "The political economy of primary care and health by the people: an historical explanation", *Issue, A Quarterly Journal of Africanist Opinion*, vol. IX, No. 3 (Fall 1979), pp. 6-13.

countries in the ECLA area had a life expectancy of 50 years or less.

A number of the countries were developing health measures along the principles of primary health care, although their implementation had yet to be evaluated.[17] All of the countries in the area reported that they had reviewed their development strategies to provide additional support to their health care programmes.

Since 1978, programmes to extend and further develop health services systems had been undertaken in many countries. In Argentina, health policies had been formulated to help integrate provincial and municipal programmes with the national health activities. Bahamas had established a network of health centres, clinics and dispensaries throughout the islands, as well as a flying physician-dentist service in more remote areas. Bolivia had made major efforts to achieve a national health service. Brazil had developed a programme for the isolated population of the northern and north-eastern parts of the country. Chile had continued with the organization of its national health system. Colombia had begun formulations for a national health plan to consolidate its local, departmental and natural levels as a part of its national development plan. It expected to improve the health of the country's population through income redistribution, tax reform and an over-all emphasis on social policies. In the short term, however, the Government's Food and Nutrition Plan, its National Health Plan and various programmes for integrated rural development were expected to extend coverage to 36 per cent of the population which was not covered by health care services. The Dominican Republic reported that it intended to regionalize health care services, to extend its programme of basic health services and to train greater numbers of paramedical personnel. It was continuing to draw up plans for consolidation of the regionalization scheme to extend services. The policy in Ecuador had a similar focus; it emphasized the extension of coverage to rural areas through the utilization of paramedical personnel and the staffing of rural centres by recent medical school graduates. El Salvador was continuing efforts towards a single national health system by extending the experiences of the eastern region to other regions. Guatemala had focused on the training of rural health technicians, had developed action plans for all operational units and had trained health personnel in 23 areas. Haiti was still reorganizing its technical and administrative units to improve operations in its health regions. Honduras was continuing the extension of its coverage in the light of its 1979-1983 national health plan, which included a programme to provide basic infrastructure to remote areas and underprivileged groups. Mexico was currently seeking to bring health care programmes to the rural populace by means of the organized participation of rural groups. Additional measures included the creation of rural medical posts in communities of from 500 to 1,500 inhabitants—which would utilize local personnel trained in a basic needs approach—the extension of social security to the country's rural areas and so on. Panama was building up an integrated health system, with auxiliary health personnel. Its preliminary 1980-1984 health sector plan was directed towards universal health care coverage by 1984, with some 90 per cent of the population already covered. Peru was constructing hospitals in rural zones, training members of rural communities to attend to basic health necessities and increasing qualified manpower in rural and marginal urban zones through the use of recent school-leavers and paramedical personnel. Its national health service system was extending coverage in the Cuzco, Huancayo, Iquitos, Piura, Puno and Tarapoto health regions. Uruguay emphasized the rehabilitation of existing facilities and other efforts to improve health care efficiency. Venezuela, in its sixth national plan, emphasized the strengthening of health care units as well as the entire national health service.

Cuba, as in the past, stood out, as it had a level of life expectancy far higher in relation to other countries in the ECLA area than its level of per capita income would suggest. It currently appeared to have one of the highest levels of life expectancy in that area. The extension of basic health services throughout the country had been noteworthy. The Cuban system as a whole had a pyramidal structure, with three hierarchical levels (central, provincial and regional) and five levels of services (national, provincial, regional, area and sector). The rural medical post was the smallest unit in the health sector; it provided basic health services to between 3,000 and 5,000 inhabitants. Community participation was considered essential to the functioning of the health care system. Extensive vaccination programmes had been carried out through mass-based organizations. A rationing system provided a minimum of 2,650 calories per day to each of the country's inhabitants.

A number of other countries in the ECLA area were formulating policies along the lines of primary health care.[18] Analysis of government health expenditures in selected countries of Latin America in the early 1970s showed that a very substantial percentage was spent for curative services. Columbia, which in 1979 had a total public expenditure in health of $203 million, spent 79 per cent on curative and 19 per cent on public or preventive health efforts. Paraguay, which in 1972 spent $10 million on health, allocated approximately 85 per cent for curative care.[19] It remains to be seen how the new policy approaches will be reflected in additional financial allocation to and within the health sector.

Area of responsibility of Economic Commission for Western Asia

The rapid economic growth in many of the countries in the ECWA area of responsibility had not yet been matched

[17] World Health Organization, "Report of the Director, World Health Organization Regional Office for the Americas/Pan American Sanitary Bureau", ICPHC/ALA/78.5, paper prepared for the International Conference on Primary Health Care, Alma-Ata, 1978; Pan American Health Organization/World Health Organization, Regional office for the Americas, *Annual Report of the Director, 1979*, Official Document No. 171, (Washington, D.C., August 1980).

[18] "Report of the Director, World Health Organization Regional Office for the Americas/Pan American Sanitary Bureau"; Ministerio de Bienestar Social, Secretariá de Estado de Salud Pública, *Atención médica rural en la Provincia de Iujing, República Argentina* (Buenos Aires, 1978); Peru, Ministerio de Salud, *Informe sobre atención primaria de la salud* (Lima, 1978); Ministry of Health and Ministry of National Planning, *Costa Rica Extension of Coverage of Health Services within the Framework of Socio-Economic Development* (Costa Rica, 1978); Ministry of Health, *Primary Health Care: The Jamaican Perspective, A Reference Manual for Primary Health Care Concepts and Approaches in Jamaica* (Kingston, 1978); Ministry of Health, *Mexico: Program to Extend Primary Health Services to the Rural Areas* (Mexico City, 1978).

[19] World Bank, *Health*, p. 76.

by corresponding primary health care implementation nor an accelerated decline in mortality. Six of the 12 countries of the ECWA area considered their average level of life expectancy at birth to be unacceptable under prevailing economic and social conditions. Four of those countries had life expectancy levels of 50 years or less.

There is, however, a strong tendency for the various countries in the ECWA area to formulate policies designed to improve the conditions of the rural population and underprivileged groups.[20] Bahrain, for example, placed an emphasis on the provision of decentralized polyvalent centres; Democratic Yemen had assigned high priority to maternal and child health in rural areas; special attention was given to the nomadic population and other inaccessible rural groups. Iraq reported that its current development plan assigned high priority to health care facilities in rural zones. Jordan, which had reported that it would upgrade basic health care services beginning in 1978, planned to focus on the expansion of preventive services for the rural and nomadic population and for lower income urban groups. Oman was concerned with the equal provision of basic services in both urban and rural zones. Saudi Arabia was focusing on the extension of health care programmes to the rural and nomadic population; and on preventive services, health education and programmes of maternal and child health. The Syrian Arab Republic reported efforts to provide rationally distributed health care institutions; furthermore, as a means of providing improved coverage of the rural population, physicians would be encouraged to work in remote and underprivileged regions. Yemen similarly had assigned priority to the establishment of preventive services in rural zones.

Area of responsibility of Economic and Social Commission for Asia and the Pacific

Of the 30 developing countries in the ESCAP area of responsibility, 23 considered their average level of life expectancy at birth to be unacceptable in the prevailing economic and social circumstances. Two of the developing countries that considered their mortality level acceptable had life expectancy levels of 70 years or more (as did the three developed countries in the area—Australia, Japan and New Zealand). On the other hand, nine countries still had unacceptable life expectancy levels of 50 years or less.

A number of countries in the ESCAP area (Bangladesh, Fiji, Iran, Pakistan, Philippines, Sri Lanka and Thailand) had identified quantitative targets for the reduction of morbidity and mortality, targets which were usually expressed in terms of reducing crude death rates and infant mortality rates by a certain number of percentage points per annum; in addition, several countries had identified targets for the reduction of malnutrition and various endemic diseases (tuberculosis, gastro-enteritis, malaria, schistosomiasis etc).

There was generally a better integration of health-related policies within over-all development plans in the ESCAP area than in the other less developed regions.[21] A number of countries emphasized that their national health policies had been fully integrated in their comprehensive development plans. Health care planning was an especially important component in the development plans of Bangladesh, China, India, the Philippines, Sri Lanka and Thailand. The countries in the ESCAP area tended to be more uniformly antinatalist than those in other less developed regions, and it is important to take note that a number of countries stressed the role that family planning had assumed in health-related programmes.

However, a number of similar difficulties with conventional health and mortality policies were identified by Governments in the area. India, for example, found its health policies to be hospital-based and disease-oriented; dependent entirely on foreign technology and therefore overly sophisticated, which made them unsuited for the needs of a rural community. Moreover, the trained personnel were unrealistic in their skills, attitudes and approaches. The system, rather than being geared to keeping the population healthy, was entirely "cure-oriented". The health services were considered to be "an end in themselves". They were physically, socially, culturally and financially inaccessible to large numbers of the people; and there was a lack of community participation in health activities. Thus, the "consumers" of the services had no influence on them.[22]

Lessons can be drawn from the efforts of India to promote delivery policies in conjunction with its primary health care programmes. The Government identified the following essential premises, which are also typical of many other developing countries:

> "That the majority of health problems of this country lie in the villages and poorer sections of the city where the vast majority of our population lives;
>
> "That the cultural factors in health and the cultural affinity of health workers to the community they serve is more important than technical expertise;
>
> "That most of the health problems at the village level can be tackled at that level, by workers appropriately trained from among the villagers.
>
> "Most common illnesses are simple to diagnose and can be treated effectively with cheap and safe drugs especially when detected early; neglected, they become complex and expensive problems;
>
> "That the medical profession by virtue of its cultural background, training and aspirations, cannot understand or function effectively in the context of village health problems;
>
> "That in a country of our size, no matter how intricate a health system is devised, the problem of adequate supervision of workers will always remain; under these conditions, the only effective supervision of workers must come from the community itself.

[20] World Health Organization, "Report of the Regional Director for the Eastern Mediterranean", ICPHC/ALA/78.6, paper prepared for the International Conference on Primary Health Care, Alma-Ata, 1978: Yemen, *Report on Basic Health Services/Primary Health Care Project* (Sana'a, 1978).

[21] World Health Organization, "Report of the Regional Director for South-East Asia", ICPHC/ALA/78.8; and "Report of the Regional Director for the Western Pacific", ICPHC/ALA/78.9, papers prepared for the International Conference on Primary Health Care, Alma-Ata, 1978.

[22] Ministry of Health and Family Welfare, *Primary Health Care in India* (New Delhi, 1978), pp. 6-7.

"In order to play the above role effectively, the community must become fully aware of its health problems and understand the roles of the various workers who will be responsible to the members of the community.

"The public, as well as the medical profession, confuse illness with health. The two are diametrically opposite. The ancient belief that health is a positive state of physical, social and mental well-being which is so well emphasized in our indigenous systems of medicine must be revived."[23]

In response to these and similar problems, the countries in the ESCAP had placed increased emphasis on a primary health care approach. Afghanistan planned to expand its 120 rural Basic Health Centres to 197 centres over a five-year period in an attempt to provide direct access to health care to a larger proportion of the remote and isolated population. Bangladesh was continuing its efforts to strengthen rural health services. Some 10,600 family welfare workers had been trained and there were plans to train 18,000, or one per 4,000 population. Those community health workers, supported by *thana* health complexes and union centres, would provide the basis for the national programme for primary health care. Bhutan was converting its dispensaries into integrated basic health units. Burma was strengthening the infrastructure of basic health services in 24 townships, which consisted of rural health centres, maternal and child health centres and health subcentres; the goal was to cover half the townships in four years, with 5,240 community health workers and 3,200 auxiliary midwives. In the Democratic People's Republic of Korea, efforts had been made to distribute adequate services within easier reach of the population. India was giving a higher priority to health needs of the underserved and underprivileged population, especially those who lived in rural areas. Some 5,380 primary health centres and 38,000 subcentres had been established to serve a rural population of 438 million in 5,247 community development blocks. The community health worker formed the basis of the rural health scheme and India planned to have 580,000 health workers. The provision of health care to vulnerable groups, such as children, pregnant women and lactating mothers was being emphasized in the Minimum Needs Programme, which also gave preferential treatment to the tribal areas which had previously been neglected. Indonesia placed an emphasis on the further development of the health services in the rural areas, where 85 per cent of the population lived. It was hoped that some 20,000 villages would be included in the Village Community Health Development programme by the end of the third five-year plan (1979-1984). Maldives was emphasizing the integrated health care approach with primary health workers at Male and in the atolls. The Government was diverting resources from disease-control efforts to community health programmes and was training workers to run health centres on each of the 19 atolls. Mongolia had given high priority to the provision of health services in the rural areas. It had provided relatively advanced services, and new attention was being given to people in inaccessible areas where mobile health units are being employed. Nepal had given priority to the expansion of health care in the rural areas where over 90 per cent of the population lived. The Philippines was currently reorganizing its total health delivery structure, was setting up a barrio health system and was providing additional midwives in rural areas. Sri Lanka placed strong emphasis on the strengthening of health services in the rural areas through support of both traditional and Western systems. Thailand was continuing to expand and strengthen its integrated rural health services; and efforts had been made with the Lampang Health Development Project, the Korat Project, the Samerng Project and the Songkhla Project.[24]

As an example of progress in this field, Kerala State in India had substantially reduced both mortality and fertility levels through various broad-based programmes even though its level of economic growth had not been great.[25]

The case of Sri Lanka is especially important because it had achieved dramatic progress in reducing levels of mortality and morbidity without rapid economic growth. A country with a highly structured health care programme, Sri Lanka reported that it provided free medical care to its entire population. The locational aspects of health care programmes had been given important consideration and, on average, a person did not have to travel more than 3 miles to reach a free public health facility. Anaemia and malnutrition had been treated through what the Government termed a "package type of family programme". Nutritional supplements were an important part of the Government's health care programme and some 50 per cent of the population received a subsidized food ration which provided up to half of their daily caloric and protein intake.

The health policies of China were particularly impressive. Within the context of a profound social revolution, self-reliant, community-based health efforts had been extended across the world's largest population and had resulted in very substantially reduced mortality and morbidity. That remarkable effort had served as an impetus to the primary health care efforts in many other countries; and adaptations of the Chinese "barefoot doctor", in particular, are being reflected in village health worker programmes throughout the developing countries.[26]

C. Emerging policy trends, issues and problems

Among the developed countries, concern continued over the substantial differentials in mortality of various groups and social classes. Of particular concern was the excess mortality of adult males and the gap between male and female mortality at the older ages. New preventive measures were being instituted in this regard to reduce deaths associated with tobacco smoking, excessive alcohol consumption, over-nutrition, insufficient exercise and stress.

[23] *Ibid.*, p. 17.

[24] Ministry of Public Health, *Primary Health Care in Thailand* (Bangkok, 1978); and Ministry of Public Health, "Lampag Health Development Project", Bangkok, 1978.

[25] See John Ratcliffe, "Social justice and the demographic transition: lessons from India's Kerala State", *International Journal of Health Services*, vol. 8, No. 1 (1978).

[26] World Health Organization and United Nations Development Programme, "Study Tour on the Training and Utilization of Barefoot Doctors in Community Health Services in the People's Republic of China", Technical Completion Report INT/78/034, Geneva, 1978.

A curative approach, with its high technology and the required advanced medical training, had contributed to a rapid escalation of health costs. In many developed countries, such costs had risen more rapidly than those of any other sector. Partially as a result of that increase, some of the principles of primary health care which were being adopted in developing countries were being adapted to the developed countries as well. In that connection, there was also a greater interest in the utilization of paramedical personnel; more attention was given to involving the consumer to participate, both collectively and individually, in the planning and implementation of health care; and greater attention was given to integration of health care with the preventive, primary and social service efforts.

There are extremely complex links between changes in health conditions and changes in governmental expenditure. Moreover, changes in levels of living are much more likely to be reflected in changing health conditions than are changes in the proportion of the gross domestic product spent on health services. Health and medical care are often financed by expenditures of individuals and/or private institutions. As mentioned above, among the developed countries with a market economy, government expenditure on health services averaged 2 per cent of gross domestic product in the mid-1970s, although some countries spent 5 per cent or more.[27] In the developed centrally planned economies, health services were generally granted free of cost for the individual. The USSR, as well as a number of other European countries, had long practised many of the health policies that were currently being formulated by the developing countries. In general, they were implemented without demographic rationale, although it was expected that an accelerated decrease in mortality would contribute to the desired level of the population growth.

The actual implementation of primary health care was expected to produce profound changes in many developing countries. There was widespread dissatisfaction with earlier approaches and a broad new consensus was emerging, with many countries supporting the concepts and principles of primary health care.[28] Such policies, in addition to their possible explicit demographic objectives, are likely to have profound demographic consequences even if they are only partially implemented.

Countries in all regions were formulating new principles to incorporate into their national policies and development strategies. Relevant, low-cost and accessible health care provided by a high degree of community participation and promoted within integrated social and economic efforts was unanimously supported by the International Conference on Primary Health Care held at Alma-Ata in 1978.

A significant impetus for the primary health care movement had come from the international recognition of the successful efforts of the Chinese in that field. Their community-based health efforts, their self-reliance principles and their idea of "barefoot doctors" were being adapted and adopted in many parts of the less developed regions. Of course, those measures had occurred within the context of a profound social revolution and their success, both the implementation and the health impact, must be judged in that light. Thus, the success of China in implementation and impact had come from a fundamental social restructuring, a profound redistribution of income and agricultural land and substantial mobilization to improve environmental health, as well as specific health care measures.

The United Nations Water Conference held at Mar del Plata, Argentina, in 1977, which designated the 1980s as the International Drinking Water Supply and Sanitation Decade and urged the ambitious goal of safe drinking-water and hygienic conditions for all by 1990, also focused attention on environmental health efforts. It is estimated that current investments in drinking-water and sanitation must be nearly doubled in urban areas to attain those goals. The investments could be considerable; tube-wells and standpipes might cost an average of $10 per person in rural areas; and with house connections, the costs could range from $75 to $150 per person. Sanitation facilities in rural areas are estimated to cost about $5 per person, while in urban areas the cost could range from $15 to $200 with sewer systems. The necessary infrastructure must also be developed to maintain these services at the community level. Without substantial mobilization of domestic and international resources, safe drinking-water and hygienic conditions for all will be an unattainable objective in the developing countries. However, the new recognition of its crucial importance within environmental health strategies, as well as over-all development efforts, is certainly significant. Even a partial implementation of these programmes may have a significant demographic impact.

Declines in infant mortality may have slowed or halted in some developing countries. Progress in the further reduction of mortality had been less than satisfactory and there was overwhelming evidence that infants and children under 5 years of age, from the lowest income groups, suffered the greatest mortality loss.[29] The high infant mortality rates were in large part a result of gastro-enteritis and diarrhoeal diseases which were not being effectively treated by traditional public health and curative-medicine practices. In many rural and urban settings, environmental health conditions were being viewed as a prerequisite of a substantial reduction of mortality.

The 1979 International Year of the Child focused widespread attention on children's health and well-being, especially in developing countries. Concern that infants and children represented the largest proportion of deaths in the

[27] *Patterns of Government Expenditure on Social Services*, p. 35.

[28] Primary health care has been defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. . . ." It "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly; . . . [and] includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". See the "Declaration of Alma-Ata", *Primary Health Care: Report on the International Conference on Primary Health Care*, pp. 3-4.

[29] Davidson R. Gwatkin, "The end of an era: recent evidence indicates an unexpected early slowing of mortality declines in many developing countries", Washington, D.C., Overseas Development Council, 1979.

developing countries led to some national evaluations of efforts undertaken on their behalf. Issues were raised in many countries about the quality, level and coverage of maternal and child health services. But broader questions were also raised about the quality of children's environmental health, their nutrition and nutritional practices; and their access to safe water, sanitation, elementary education and housing. Thus, in many countries, the activities relating to the International Year of the Child gave additional emphasis to the primary health care movement.

The World Population Plan of Action recommends that:

> ". . . health and nutrition programmes designed to reduce morbidity and mortality be integrated within a comprehensive development strategy and supplemented by a wide range of mutually supporting social policy measures; special attention should be given to improving the management of existing health, nutrition and related social services and to the formulation of policies to widen their coverage so as to reach, in particular, rural, remote and underprivileged groups".[30]

The World Plan of Action also recommends the reduction of infant and child mortality, particularly by means of improved nutrition, maternal and child health care, and maternal education".[31]

There is an accumulation of scientific evidence of important links between poverty, nutrition of pregnant and lactating women, family planning, breast-feeding practices, sanitary and supplemental infant feeding, birth intervals, and child mortality associated with diarrhoea and lower respiratory tract infections.[32]

The principles of primary health care policies are, to a large extent, scientifically based. Although there are debates about the mix of measures, which vary greatly according to the health situations of particular countries and communities, many of the basic principles share an uncommonly wide support among health scientists. Programmes to control communicable diseases, including cholera and malaria, have contributed to higher levels of life expectancy in developing countries. But the conditions of environmental health, poverty, malnutrition, poor sanitation and hygiene are more intractable. Modern drugs and curative medicine may be very effective in providing immediate relief, and in some cases an eventual cure; but often when a patient returns to a disease-ridden area, re-infection is likely. The environmental health conditions challenge the limits of curative medicine even when the services do reach the population.

Although there is strong scientific support for many of the principles of primary health care and widespread support by the international health community, there is often insufficient political support for these programmes to be fully implemented. Perhaps in no other area of policies affecting population is there such unanimity of principles among the scientific community and the international community, as well as Governments themselves. Nevertheless, the degree of commitment from many Governments remains relatively small; and, therefore, the political dimensions of health strategies—how they are formulated, financed and implemented—is of increasing importance.

The over-emphasis on individual curative medicine, with its relatively high cost and low health benefits, has been attributed to the professional bias of physicians; to the political power of the urban élite who have already met their own environmental health needs; and to the nearly universal and immediate demand for curative medicine when it is needed. The over-capitalization in curative hospital services has also reflected past domestic and international interests for visible national symbols. In any case, the access of a population to medical care is severely reduced by both economic barriers and by the uneven geographical distribution of such services.

Currently, only a very limited proportion of the population in the developing countries has access to public health services, clean drinking-water, adequate nutrition, sanitation, and other environmental and preventive health measures. However, a new emphasis is emerging which targets primary health care to high-risk groups, especially to children, to women of reproductive ages and to the underprivileged in both rural and urban areas. Priority is being placed upon environmental health efforts and to the non-medical determinants of health. New consideration is being given to the importance of potable water, proper nutrition, improved sanitation, health education, maternal and child health care, including family planning, as well as other measures to immunize against the major infectious disease and to control locally endemic diseases. This spirit also involves the greater use of paramedical personnel in simpler decentralized services where the health needs are greatest. The United Nations monitoring of health, morbidity, mortality and population policies showed an interesting new mix of measures in different countries which reflected a diversity of health conditions, as well as social, economic and political realities. But a basic shift in health care philosophy was being articulated in all the less developed regions, and despite the many constraints and difficulties in implementing such measures, the widespread recognition of their necessity is significant.

There was a growing recognition by Governments that many of the most important determinants of health and mortality are non-medical and fall outside the traditional activities of the Ministries of Health. The new awareness that health policies should be integrated within over-all socio-economic development plans was articulated by many countries that were formulating health and mortality programmes in education, food and agriculture, water and sanitation, community and rural development, and other related areas. The synergistic benefits of a unified integrated approach were being appreciated.

[30] *Report of the World Population Conference, 1974, Bucharest, 19-30 August 1974* (United Nations publication, Sales No. E.75.XIII.3), p. 10, para. 25.

[31] *Ibid.*, p. 12, para. 32 (a).

[32] Robert N. Grosse, "Interrelation between health and population: observations derived from field experiences", background paper prepared for the Conference on Health and Population in Developing Countries, Bellagio, Italy, 18-21 April 1979, sponsored by the Rockefeller Foundation; Harald Hansluwka, "Health, population and socio-economic development", *Population Growth and Economic Development in the Third World*, Léon Tabah, ed. (Dolhain, Belgium, Ordina Editions for International Union for the Scientific Study of Population, 1975), vol. 1, pp. 191-249; and Beverly Winikoff, "Nutrition, population and health: some implications for policy", *Science*, vol. 200 (May 1978), pp. 895-902.

However, the institutional, political and economic constraints to such integrated policy approaches can also be substantial. Integrating these approaches in sectoral and national development plans, though not insurmountable, often does involve competing institutions, departments and ministries whose traditional activities and interests frequently compete for priority. At the local level, operational problems arise concerning the way in specific health programmes, such as maternal and child health care and family planning, can be effectively integrated with community and rural development projects. In many ways, these integrated policies are more efficient; but, on the other hand, the benefits of specialization are sometimes lost by such steps. In some countries, the delivery systems are being overloaded with long agendas of projects. The integration of these programmes is often easier at the national level than at the village level.

A number of Governments were designing programmes to allow greater local initiative, control and supervision of village health workers. Increasingly, the community, rather than national or regional supervision of local health projects, is seen as a more effective method of obtaining responsive and caring services. Their involvement in both the formulation and the implementation of health activities and in the determination of community needs was often being given greater importance. In many countries, a greater reliance was being placed on community resources to help support those programmes. An increasing number of countries were involving traditional practitioners, whose effectiveness varied widely, by giving them elementary training, supplies and referral systems. As mentioned earlier, recent experiences gained from the Indian efforts to promote health delivery policies in conjunction with their primary health care programmes had identified a number of essential premises which were found to be typical of many countries.

The use of community health workers has been shown to be feasible not only in China but in such countries as Botswana, Brazil, India, Iran, Jamaica and the United Republic of Tanzania. However, there could be considerable difficulty in administering such as infrastructure, especially in training and recruitment, in supervision and the provision of supplies. The balance among the levels of the health care systems, the community activities, referral services and hospital facilities; among primary, preventive and curative approaches, will continue to be important issues with financial, administrative and political dimensions.

Poor nutrition is an underlying or associated factor in many of the deaths from infectious diseases among children. In one study of infant and childhood mortality in Latin America, half of the cases were associated with malnutrition.[33] Food subsidy programmes have contributed to reductions in mortality. In Sri Lanka, for example, when the effort was reduced in 1974, there was a temporary increase in deaths until food became more plentiful in 1977. Food subsidies for the general population, while potentially effective in reducing mortality, can be very expensive to maintain, especially as it may not be politically acceptable nor administratively feasible to restrict subsidies to those most undernourished. Experimental projects for supplementary feeding schemes for young children and for pregnant and lactating mothers have also proved to be relatively expensive.[34] The most important policies affecting malnutrition remain those which reduce poverty and increase food production per person. It is in this sense that one of the main underlying causes of death is fundamentally related to the process and structure of development. According to one analysis, the past increases of life expectancy in developing countries between the periods 1935-1940 and 1965-1970 are attributed roughly equally to public health efforts and to social and economic development.[35]

Actual implementation of primary health care programmes in the developing countries will require the mobilization of substantial domestic and international resources. Currently, over-all government health expenditures in developing countries are not great; they amount to less than 2 per cent of the gross national product, although private expenditure may be much higher. The greatest proportion of these public funds is spent on curative medicine which is reaching only a narrow segment of the population. Policy analysis is needed to assess the cost effectiveness and feasibility of various specific policy interventions and the relationships between those policies aimed at fertility, morbidity and mortality.[36] One report states:

> "In most developing countries, the bulk of the deaths are of children under five years of age. In general, the higher the overall mortality in a country, the larger the proportion of deaths are of children of such ages. . . . Significantly, it is precisely in this age-group that reductions in mortality have been relatively slow while the causes of mortality remain largely preventable at fairly low cost."[37]

A number of specific policy measures already exist which could have a significant impact on infant and child mortality, but they still require certain investments in infrastructure to be effective. Oral rehydration techniques can inexpensively reduce the infant and child deaths related to diarrhoea. However, the rehydration mixtures themselves require potable water as a pre-condition of effective use; thus, the cost effectiveness of these measures may be related

[33] Ruth Rice Puffer and Carlos V. Serrano, *Patterns of Mortality in Childhood: Report of the Inter-American Investigation of Mortality in Childhood;* Scientific Publication No. 262 (Washington, D.C., Pan American Health Organization/Pan American Sanitary Bureau/World Health Organization, Regional Office for the Americas, 1973).

[34] C. E. Taylor and others, *Malnutrition, Infection, Growth and Development: The Narangwal Experience, Final Report* (Washington, D.C., World Bank, 1978).

[35] Samuel H. Preston, "Causes and consequences of mortality declines in less developed countries during the twentieth century", paper presented to the National Bureau of Economic Research Conference on Population and Economic Change in the Less Developed Countries, Chicago, Illinois, 30 September-2 October 1976, pp. 21-25.

[36] Jean-Pierre Habicht and Peter Berman, "Planning primary health services from a body count?", background paper prepared for the Conference on Health and Population in Developing Countries, Bellagio, Italy, 18-21 April 1979; Peter Morrison, *The Future Demographic Context of the Health Care Delivery System,* A Rand Note, (Santa Monica, California, Rand Corporation, 1979); and Peter Kunstadter, "Interactions of child mortality with maternal parity: some implications for population and public health policy", 1978 (mimeographed).

[37] Robert N. Grosse, "Health and population in developing countries: background paper prepared for the Conference on Health and Population in Developing countries, Bellagio, Italy, 18-21 April 1979, p. 15.

to hygienic practices and drinkable water. Many infant and child deaths could be eliminated by immunization programmes, especially measles vaccinations. These are simple techniques and inexpensive measures that could be undertaken by paramedical personnel and could have significant potential demographic impact. However, to be most effective, the vaccines must be kept in constant refrigeration from the supplier to the infant; and because they often are not, many children are being immunized with ineffective vaccines. Maintaining a continual cold chain thus requires a sufficient infrastructure to reach the underserved rural populations and again underscores the fundamental pre-conditions of even the most simple medical techniques.

A study analysing pilot projects in Guatemala, India, Iran, Jamaica, Nigeria, Peru and Turkey suggests that efficiently administered nutrition and primary health care programmes can "reduce infant and child mortality rates by one-third to one-half within one to five years".[38] Some estimates suggest that such programmes could be widely implemented at a cost of 1-2 per cent of the gross national product per capita, a figure similar to the current expenditure by Governments on health services.

Arguments are emerging for a more selective interim strategy on primary health care, involving the establishment of priorities for disease control based on their prevalence, mortality and morbidity, and on the feasibility of control. Instead of attempting to achieve comprehensive health services for all, some are calling for a narrow interim concentration on a few important diseases with selective crucial intervention.

Table 15 represents one recent effort to assign priorities for disease control in developing countries upon the criteria of prevalence, mortality, morbidity and feasibility of control.[39] No doubt there will be disagreement with the priority ranking of disease control efforts, but the general framework should provide a methodology by which alternative priorities can also be advocated and their reasons specified.[40] While recognizing the importance of regional variations among developing countries, the Walsh and Warren study assigns the highest over-all priority to the control of the following diseases: diarrhoeal disease, measles, malaria, whooping cough, schistosomiasis, and neonatal tetanus.

Table 16 presents the estimated annual costs of different systems of health intervention on a per capita basis and by their estimated cost per averted infant or child death. Their selective primary health care interventions are designed for

TABLE 15. PRIORITIES FOR DISEASE CONTROL IN DEVELOPING COUNTRIES, BASED ON PREVALENCE, MORTALITY, MORBIDITY AND FEASIBILITY OF CONTROL

	Priority group	*Reasons for assignment to category*
I.	High priority	High prevalence, high mortality or high morbidity, effective control
	Diarrhoeal disease	
	Measles	
	Malaria	
	Whooping cough	
	Schistosomiasis	
	Neonatal tetanus	
II.	Medium priority	
	Respiratory infections	High prevalence, high mortality, no effective control
	Poliomyelitis	High prevalence, low mortality, effective control
	Tuberculosis	High prevalence, high mortality, control difficult
	Onchocerciasis	Medium prevalence, high morbidity, low mortality, control difficult.
	Meningitis	Medium prevalence, high mortality, control difficult
	Typhoid	Medium prevalence, high mortality, control difficult
	Hookworm	High prevalence, low mortality, control difficult
	Malnutrition	High prevalence, high morbidity, control complex
III.	Low priority	
	South American trypanosomiasis (Chagas' disease)	Control difficult
	African trypanosomiasis	Low prevalence, control difficult
	Leprosy	Control difficult
	Ascariasis	Low mortality, low morbidity, control difficult
	Diphtheria	Low mortality, low morbidity
	Amebiasis	Control difficult
	Leishmaniasis	Control difficult
	Giardiasis	Control difficult
	Fialariasis	Control difficult
	Dengue	Control difficult

Source: Julia A. Walsh and Kenneth S. Warren "Selective primary health care, an interim strategy for disease control in developing countries", *The New England Journal of Medicine*, vol. 301, No. 18 (1 November 1979), p. 969.

the priorities of disease control given in table 15. Walsh and Warren search for the least expensive interventions, both on a per capita basis and in regard to the cost per infant/child death prevented. They attach especially high priority to a target population of children up to 3 years of age and women of reproductive ages. Specific health interventions upon which they place highest priority are: child vaccinations for measles and diptheria-pertussis-tetanus (DPT); tetanus toxoid for all women of reproductive ages; health education for long-term breast-feeding; wide dissemination of chloroquine for young children subject to episodes of malaria fever; and a programme for the instructions and distribution of oral rehydration packets. They estimate that if half of all children and their mothers and half of the pregnant women were included in such a programme, deaths from measles would decline by 50 per cent, whooping cough by 30 per

[38] Davidson R. Gwatkin, "Toward a population strategy for the 1980s", Washington, D.C., Overseas Development Council, May 1979 (mimeographed), p. 3; and Davidson R. Gwatkin, Janet R. Wilcox and Joe D. Wray, "Can interventions make a difference? The policy implications of field experiment experience", report to the World Bank, March 1979 (mimeographed).

[39] Julia A. Walsh and Kenneth S. Warren, "Selective primary health care, an interim strategy for disease control in developing countries", *The New England Journal of Medicine*, vol. 301, No. 18 (1 November 1979), p. 973.

[40] Ralph H. Henderson and Jacobus Keja, "Selective health care for developing countries: to the editor", *The New England Journal of Medicine, vol. 302, No. 13 (27 March 1980), p. 758.*

TABLE 16. ESTIMATED ANNUAL COSTS OF DIFFERENT SYSTEMS OF HEALTH INTERVENTION

Type of intervention	*Cost per capita (dollars)*	*Cost per infant and/or child death averted (dollars)*
Base primary health care[a]		
Range	0.40–7.50	144–20 000 (infant)
Median	2.00	700 (infant)
Mosquito control for malaria	2.00	600 (infant)
Onchocerciasis control programme	0.90	Few infant and child deaths
Mollusk control for schistosomiasis	3.70	Few infant and child deaths
Community water supplies and sanitation	30–54	3 600–4 300 (infant and child)
Narangwal nutrition supplementation	0.75	213 (infant) 3 000 (child)
Selective primary health care[b]	0.25	200–250 (infant and child)

Source: Julia A. Walsh and Kenneth S. Warren, "Selective primary health care, an interim strategy for disease control in developing countries", *The New England Journal of Medicine,* vol. 301, No. 18 (1 November 1979), p. 973.

[a] Delivered by village workers.

[b] In this case, delivered by mobile units.

cent, neonatal tetanus by 45 per cent, diarrhoea by 25-30 per cent and malaria by 25 per cent.

The challenge of these mortality policies lies not in their formulation but in their implementation, a broad-based policy may be most effective in reducing mortality, but it may also be the most difficult to implement. An emphasis on the rural areas and urban underprivileged is clearly called for because it is there that the health demand is greatest. But the infrastructure, the training and management of personnel, and the cost of delivering services to remote areas and of developing them where few exist are difficult. There are substantial overhead costs to these structures which must be maintained over time. Fortunately, many of these problems are being anticipated in the formulation of the policies.

The implementation of these programmes will require substantial funding. Questions arise as to whether these funds will be raised from existing revenues and to what extent the funds will be transferred within the health sector or from other sectors. Analysis of government health expenditures in selected countries shows that in the early 1970s, Colombia, Kenya, Paraguay, Tunisia and Venezuela all spent more than 75 per cent of their government health expenditures on curative care and only a small fraction on primary care.[41] New efforts are being made to measure the financial allocation both to and within the health sectors of many countries.[42] to determine the degree of commitment and implementation of these policies; other indicators are also being developed to measure the progress towards these health policy objectives.[43]

The implementation of comprehensive primary health care is in many respects resting on the pre-conditions of development and the alleviation of poverty. The alleviation of poverty has often proved most difficult for powerful economic, social and political reasons. As the non-medical determinants of health receive higher priority, additional support may be given to the provision of these fundamental needs. But often there are significant financial, administrative, political and structural constraints to the provision of the non-medical determinants of health. However, China, Cuba, Sri Lanka, and Kerala State in India, to name a few, have had a spirit of broad-based environmental health efforts which have contributed to a substantial decrease in mortality and fertility. These countries have also experienced varying degrees of social restructuring, and mortality and fertility levels are apparently responding favourably to these synergistic effects. Since primary health care is only a part of an egalitarian strategy of development in these countries, it is less likely to become a dual system of health care, with low-quality services for the poor and high-quality services for the rich.

CONCLUSION

Population policies are closely related to measures that affect health and mortality. Policies that lessen morbidity and mortality will increase the natural rate of population growth and affect fertility in various ways. Over time, there are complex interrelationships among, for example, infant mortality and fertility, and the rate of population growth, which are complemented by the often close relationships among population policies, health policies, and the level and distributive character of development efforts. Also of particular importance are the overlapping high-risk target groups—infants and women of reproductive ages—who are of concern in relation to the measures on family health, and maternal and child health care, including family planning. These policies are linked with the emerging principles of primary health care, with its emphasis on the non-medical determinants of health and the widening of the population's access to better environmental health conditions. Policies affecting the spatial distribution of the population may also complement the decentralization of medical services as well as the extension of health programmes to the rural areas.

Although average life expectancy in the developed countries had reached unprecedented levels in 1980, nine of the 39 countries still considered their levels unacceptable in their prevailing, economic and social circumstances. Concern over mortality differentials among various groups and

[41] World Bank, *Health,* 1st ed., p. 76; and World Bank, *Health,* Sector Policy Paper, 2nd ed. (Washington, D.C., 1980).

[42] World Health Organization, *Financing of Health Services,* Report of a WHO Study Group, Technical Report Series No. 625 (Geneva, 1978); Dieter K. Zschock, *Health Care Financing in Developing Countries,* International Health Programs Report No. 1 (Washington, D.C., American Public Health Association, 1979); and United States of America, Department of Health, Education and Welfare, Office of International Health, *An Approach to the Study of Health Sector Financing in Developing Countries: A Manual* (Washington, D.C., 1978).

[43] Davidson R. Gwatkin and James P. Grant, "Using targets to help improve child health", paper prepared for the Fifth International Health Conference: Child Health in a Changing World, New York, 14-17 May 1978, organized by the National Council for International Health in conjunction with Columbia University.

social classes and the excess mortality among adult males was reflected in various preventive health measures.

In the developing countries, mortality levels had improved considerably over the past few decades, but they still lagged far behind the levels of the developed countries in 1980. Of the 126 developing countries, 98 considered their level of life expectancy to be unacceptable even in their prevailing economic and social circumstances. Mortality levels were seen as least acceptable in the ECA area (49 out of 51 countries), followed by the ESCAP area, the ECLA area and the ECWA area.

Major changes are occurring in the formulation and implementation of health policies among developing countries and a broad consensus is emerging which supports the principles of primary health care. Although many of these programmes were not explicitly motivated for demographic purposes, they are likely to have profound demographic consequences to the extent that they are actually implemented. Many of the newly stated objectives are ambitious, facing formidable financial, administrative, and political constraints closely linking them to the structure of development; while others are seeking more selecting crucial interventions based on priority rankings of disease control efforts and then feasibility.

Chapter XXII
FERTILITY

The fertility trend over the past few years has been marked by two characteristics of vital interest in the field of population policies. In the developed countries, the decline in fertility has continued to the point where the number of births is below the number of deaths; furthermore, net reproduction rates lower than unity have become quite usual in those countries. In the developing countries, practically two thirds of the population have entered upon a process of fairly rapid decline in fertility. Only one third of the population in those countries still has high and stable fertility levels.

The perceptions of Governments in regard to fertility can be examined from two standpoints: first, that of their overall effect on the levels and trends of the rate of natural increase; and secondly, that of their effect on the well-being of families and individuals, which can be termed the "individual" fertility criterion.

The way in which Governments perceive "individual" fertility may be regarded from several angles. Those viewpoints are, first, the health aspect, especially the health of the mother and its repercussions on the general well-being of the family; secondly, the question of personal rights, particularly the right of individuals to decide freely on the spacing and the number of children they wish to have; thirdly, the social and socio-legal aspect, which includes both the rights and the social and socio-legal obligations of the parents, the children and the family in general; and fourthly, the relationship between fertility and the status of women.

The way in which Governments perceive the global aspect of fertility, as in the case of the natural growth rate, is dependent on the net balance of advantages and disadvantages to be expected from an aggregate fertility level. However, although this perception is fairly similar to that adopted with respect to the rate of natural increase, they do not necessarily coincide, because what is involved in the first view is the evaluation of a process comprising several components. Obviously, there is a close relationship between "individual" fertility and "aggregate" fertility: the progressive polarization of "individual" behaviour around certain reproduction norms can lead to "aggregate" fertility levels that may be regarded as unsatisfactory by Governments. The crystallization of these perceptions determines, in the final analysis, the adoption of a policy (or otherwise) and its implementation. In regard to fertility, the degree of importance given to individual well-being, rather than to the demographic aspect, largely determines the type of measures adopted.

Before turning to an analysis of perceptions and policies by level of development and by area of responsibility of the regional commissions, the situation at world level with respect to fertility trends is briefly discussed. At the world level, one finds that the net reproduction rate amounted to 1.54 in 1980. The decline in that measure had been steep—in 1975, it had still been 1.61—and the rate in 1980 was essentially due to the decline in fertility in the developing countries during that period. The fertility rate had remained steady at 0.95 in the developed countries, whereas it had fallen from 1.86 to 1.74 in the developing countries. Among the major areas, in Africa, the rate had not only remained high but that was the only area in the world in which it was rising: between 1975 and 1980, it had risen from 2.24 to 2.27. In Asia as a whole and in each of the regions, the rate was below 2.0. The decline was particularly marked in East Asia; the rate had fallen from 1.32 to 1.09 in the period 1975-1980. In Latin America, the decline had been slower and the situation was more heterogeneous: the rate in 1980 was still 2.56 in Middle America; but it had fallen to 1.30 in Temperate South America.

In Europe, the rate had decreased still further, but the decline was levelling off: it had dropped from 0.93 to 0.92 between 1975 and 1980. Western Europe, with a level that appeared to be stable at 0.78, had the lowest rates in the world. There had been a slight rise in the rates for Northern America, from 0.86 to 0.92; whereas it was stable at 1.10 in the Union of Soviet Socialist Republics.

In 1980, half the countries declared themselves satisfied with their fertility rates (84 out of 165); of the other half, 22 regarded their rates as too low and 59 regarded them as too high.[1]

Among the developed countries, 8 out of 39 considered their fertility level to be too low, 31 considered it satisfactory, and no country regarded it as too high. In the developing countries, the situation was virtually the reverse: 14 countries out of 126 regarded fertility as too low; 53 regarded it as satisfactory; and 59 considered it too high (see table 17). Very few Governments had altered their perception since 1978. The number of countries that were satisfied with the existing rate was the same; as was the number of countries not satisfied because they considered the rate too low. The increase in the number of countries that regarded fertility as unduly high was owing mainly to the inclusion in that group of most of the countries that became independent during the period under review. However, the view that the situation was not satisfactory did not imply that the Governments had decided to intervene and change it. At the world level, 17 of the 22 countries that regarded their fertility rate as too low were intervening to change it, as were 38 of the 59 countries that regarded it as too high. Among the 84

[1] For views of individual Governments concerning fertility, see tables 41-44.

TABLE 17. GOVERNMENTS' PERCEPTIONS AND POLICIES WITH RESPECT TO THE CURRENT FERTILITY LEVEL AND THE DESIRABILITY OF INTERVENTION TO CHANGE IT, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

(Number of Governments)

Area of responsibility of regional commission, region and level of development	*Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it*						
	Rates not satisfactory; too low: higher rates desirable		*Rates satisfactory*		*Rates not satisfactory; too high: lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented II*	*But incentives and disincentives implemented to maintain rates III*	*Intervention not appropriate; neither incentives nor disincentives implemented IV*	*Intervention not appropriate; neither incentives nor disincentives implemented V*	*Intervention to lower rates appropriate, and incentives and disincentives implemented VI*	*Total*
ECA area							
Eastern Africa	—	—	1	6	5	4	16
Middle Africa	1	2	—	5	1	—	9
Northern Africa	1	—	—	1	1	3	6
Southern Africa	—	—	—	—	—	4	4
Western Africa	1	—	7	4	3	1	16
TOTAL	3	2	8	16	10	12	51
ECE area							
Eastern Europe	2	—	3	1	—	—	6
Northern Europe	—	—	2	5	—	—	7
Southern Europe	1	—	2	6	—	—	9
Western Europe	4	1	1	3	—	—	9
Cyprus, Israel and Turkey	1	1	—	—	—	—	1
Northern America	—	—	—	2	—	1	2
USSR	—	—	3	—	—	—	3
TOTAL	8	2	10	18	—	1	39
ECLA area							
Caribbean	—	—	—	1	4	6	11
Middle America	—	—	1	1	2	3	7
Temperate South America	2	1	—	—	—	—	3
Tropical South America	1	—	1	7	—	—	9
TOTAL	3	1	2	9	6	9	30
ECWA area							
Western South Asia[b]	1	—	5	4	2	—	12
TOTAL	1	—	5	4	2	—	12
ESCAP area							
China	—	—	—	—	—	1	1
Japan	—	—	—	1	—	—	1
Other East Asia	—	—	2	—	—	1	3
Eastern South Asia	2	—	2	1	—	4	9
Middle South Asia	—	—	—	2	1	6	9
Australia-New Zealand	—	—	—	2	—	—	2
Melanesia	—	—	—	—	1	1	2
Micronesia-Polynesia	—	—	2	—	1	3	6
TOTAL	2	—	6	6	3	16	33
Developed countries	7	1	10	21	—	—	39
Developing countries	10	4	21	32	21	38	126
TOTAL	17	5	31	53	21	38	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 41.

[b] Excluding Cyprus, Israel and Turkey.

countries that found the rate satisfactory, 31 intervened to maintain it at its current level.

In the developed countries, seven of the eight countries that regarded fertility as too low were intervening; in the developing countries, 10 of the 14 countries with a similar perception were doing so. Ten out of 31 developed countries intervened to maintain a rate regarded as satisfactory at its existing level; and 21 out of 53 developing countries did so. None of the developed countries considered the rate to be too high, but 38 developing countries out of 59 were taking action to reduce it. Although few countries had changed their perceptions since 1978, many countries had, nevertheless, decided to take action to maintain or adjust the level of fertility. Those changes are discussed below in connection with the analysis of the situation of countries by level of development.

A. DEVELOPED COUNTRIES[2]

None of the developed countries had changed its perception of fertility since 1978 (see table 18). Eight countries out of 39 still regarded the levels and trends of the fertility rate as too low.[3] That group included two Eastern European

[2] The developed countries include all the countries, except Cyprus, Israel and Turkey, in the area of responsibility of the Economic Commission for Europe (ECE); and Australia, Japan and New Zealand in the area of responsibility of the Economic and Social Commission for Asia and the Pacific. For list of countries in the ECE area, see annex table 41.

[3] In 1978, Argentina, Chile and Uruguay had belonged to that group; in 1980, they were classified as developing countries.

TABLE 18. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE CURRENT FERTILITY LEVEL, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR EUROPE, JULY 1978–JULY 1980

	Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
	Rates not satisfactory; too low: higher rates desirable		*Rates satisfactory*		*Rates not satisfactory; too high: lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented* VI	*Total*
Number of countries in each category in 1978	8	2	11	17	—	1	39
Changes in perception							
Countries that left a category	—	—	Poland Czechoslovakia	Belgium	—	—	—
Countries that entered a category	—	—	Belgium	Poland Czechoslovakia	—	—	—
Number of countries in each category in 1980	8	2	10	18	—	1	39

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

countries—Bulgaria and the German Democratic Republic; one Southern European country—Greece; and five Western European countries—France, the Federal Republic of Germany, Liechtenstein, Luxembourg and Monaco. All of them except the Federal Republic of Germany were anxious to intervene to increase the growth rate, and a series of measures had been adopted to attain that goal. In 1980, as in 1978, none of the developed countries regarded the fertility level as too high, and 31 countries (80 per cent) found the existing level satisfactory. Nevertheless, 10 of them had taken steps to maintain the level. Most of those countries were in Eastern Europe or the USSR: Czechoslovakia, Hungary, Romania, Byelorussian SSR, Ukrainian SSR and USSR. The other four were Albania, Belgium, Finland and Ireland.

Thus, a total of 17 developed countries out of 39 (44 per cent) had policies designed to adjust or maintain the level of fertility. As mentioned above, those policies might have as their primary purpose, on the one hand, action in respect of a rate of natural increase judged to be unsatisfactory; and, on the other hand, priority concern for the well-being of individuals and families. Or again—and this objective is no doubt that pursued by most of the developed countries—the policies might attempt to reconcile the two objectives simultaneously. It is not always easy to discern in practice which of the objectives is given special attention by Governments. However, if one considers the countries that had taken action to increase the fertility level, one finds that six of them (Greece was the exception) simultaneously applied comprehensive intervention policies to increase their growth rate. Their action in regard to fertility was thus mainly directed towards an increase in the natural growth rate. The 10 countries that implemented policies designed to maintain fertility at its existing level all had at the same time a policy of partial support to increase the growth rate (Byelorussian SSR, Ukrainian SSR and the USSR) or to maintain it at its current level (the other seven countries). The policies of those countries would therefore appear to envisage simultaneously the well-being of the individual and action on the growth rate without any apparent predominance of the one objective over the other. Although, on the whole, the perceptions and policies with respect to fertility coincided with those adopted in regard to natural increase, they may be divergent in so far as the perception of the rate of natural increase might result from a process in which several demographic components converge and intervention in the form of action on international migration (e.g., in Greece) can take place.

Next to be considered are the measures introduced by Governments of developed countries and designed to influence the level of fertility and the well-being of individuals and families. This type of action can be divided into three main categories: legal measures designed to enable couples to exercise their right to reproduce; economic measures intended to offset the burdens of family life or to provide a graduated series of benefits in return for desirable reproductive behaviour; and measures for coping with the contradictions inherent in the development of women's occupations and maternity.[4]

Legal provisions

The legal provisions that related to access to contraceptives (see table 19) had evolved, in the large majority of cases, in the direction of liberalization, independently of the demographic objectives envisaged by Governments (see table 20). In 33 of the 39 countries, access to modern methods of contraception was authorized and supported by the Government either directly (25 countries) or indirectly (eight countries). Access was authorized but not supported by the Government in Greece, Ireland, Liechtenstein and San Marino, while the Governments of the Holy See and Malta continued to prohibit access. Since 1978, Greece, Ireland and Spain had taken legal steps to liberalize access to contraceptives. Ireland currently authorized them but did

[4] C. Alison McIntosh, "Population policy in the liberal democracies: a comparative study of France, Sweden and West Germany", unpublished doctoral dissertation, Ann Arbor, Michigan, University of Michigan, Center for Population Studies, 1980.

TABLE 19. GOVERNMENTS' POLICIES WITH RESPECT TO EFFECTIVE USE OF MODERN METHODS OF FERTILITY REGULATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

(Number of Governments)

Area of responsibility of regional commission, region and level of development	*Access limited (1)*	*Access not limited*			*Total*
		No support provided (2)	*Indirect support provided (3)*	*Direct support provided (4)*	
ECA area					
Eastern Africa	1	3	3	9	16
Middle Africa	3	2	2	2	9
Northern Africa	1	—	—	5	6
Southern Africa	—	—	—	4	4
Western Africa	—	6	5	5	16
TOTAL	5	11	10	25	51
ECE area					
Eastern Europe	—	—	—	6	6
Northern Europe	—	1	—	6	7
Southern Europe	2	2	2	3	9
Western Europe	—	1	5	3	9
Cyprus, Israel and Turkey	—	1	—	2	3
Northern America	—	—	—	2	2
USSR	—	—	—	3	3
TOTAL	2	5	7	25	39
ECLA area					
Caribbean	—	—	1	10	11
Middle America	—	—	—	7	7
Temperate South America	1	1	—	1	3
Tropical South America	—	3	1	5	9
TOTAL	1	4	2	23	30
ECWA area					
Western South Asia[b]	1	5	2	4	12
TOTAL	1	5	2	4	12
ESCAP area					
China	—	—	—	1	1
Japan	—	—	—	1	1
Other East Asia	—	—	—	3	3
Eastern South Asia	2	1	—	6	9
Middle South Asia	—	1	—	8	9
Australia-New Zealand	—	—	1	1	2
Melanesia	—	—	—	2	2
Micronesia-Polynesia	—	—	—	6	6
TOTAL	2	2	1	28	33
Developed countries	2	4	8	25	39
Developing countries	9	23	14	80	126
TOTAL	11	27	22	105	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 42.

[b] Excluding Cyprus, Israel and Turkey.

not provide government support; they were sold in pharmacies on presentation of a physician's prescription. That procedure also applied in Greece, where contraceptives were sold freely, while the Government of Spain provided indirect support for the publicizing of contraception. The only countries that implemented policies with a view to the increase or maintenance of the level of fertility were Greece and Liechtenstein, where the Governments authorized access to contraceptive methods but did not provide any support.

Table 21 provides information on the legal circumstances in which abortion would be authorized. Of the 34 countries for which information was available, 13 authorized abortion "on request"; 16 countries authorized it for socio-economic reasons; and 28 authorized it for medical reasons, in the broad sense of the term. All countries authorized abortion when the life of the mother was in danger, 23 did so when there was a danger of an abnormal birth, and 18 did so for juridical reasons, such as incest or rape. In 10 countries, abortion also would be authorized for a variety of reasons, particularly for reasons connected with the age of the mother (when she was too young or too old).

There had been little change in legislation concerning abortion since 1978. France had ratified the law brought into force in 1975, for a trial period of five years; while Greece (partially), Yugoslavia (Croatia), Italy and Luxembourg (in those two instances, within the framework of a comprehensive law concerning contraception) had liberalized their legislation. However, in Northern Europe, Finland had introduced a number of restrictions to the law in force and had reduced the time-limit during which abortion would be authorized "on request".

TABLE 20. GOVERNMENTS' POLICIES WITH RESPECT TO EFFECTIVE USE OF MODERN METHODS OF FERTILITY REGULATION, ACCORDING TO THE PERCEPTIONS OF GOVERNMENTS CONCERNING THE CURRENT FERTILITY LEVEL, BY LEVEL OF DEVELOPMENT, JULY 1980[a]

(Number of Governments)

Governments' perceptions and policies concerning the current fertility level	*Government policies on access to modern methods of contraception*				
		Access not limited			
	Access limited	*No support provided by Government*	*Indirect support provided by Government*	*Direct support provided by Government*	*Total*
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented					
Developed countries	—	2	1	4	7
Developing countries	5	4	—	1	10
World	5	6	1	5	17
Intervention not appropriate; neither incentives nor disincentives implemented					
Developed countries	—	—	1	—	1
Developing countries	1	2	—	1	4
World	1	2	1	1	5
Rates satisfactory					
Incentives and disincentives implemented to maintain rates					
Developed countries	—	1	1	8	10
Developing countries	1	9	1	10	21
World	1	10	2	18	31
Intervention not appropriate; neither incentives nor disincentives implemented to maintain rates					
Developed countries	2	1	5	13	21
Developing countries	2	7	7	16	32
World	4	8	12	29	53
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented					
Developed countries	—	—	—	—	—
Developing countries	—	—	—	38	38
World	—	—	—	38	38
Intervention not appropriate; neither incentives nor disincentives implemented					
Developed countries	—	—	—	—	—
Developing countries	—	1	6	14	21
World	—	1	6	14	21
Total					
Developed countries	2	4	8	25	39
Developing countries	9	23	14	80	126
World	11	27	22	105	165

Source: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action", and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 42.

In Europe, the laws on abortion were relatively liberal, but the situation was far from homogeneous, which makes it necessary to consider each region independently. In Eastern Europe, three countries authorized abortion "on request" (Bulgaria, the German Democratic Republic and Hungary); and five did so for socio-economic reasons (the three countries listed above, plus Czechoslovakia and Poland). In Romania, however, abortion was no longer authorized for those reasons. At the same time, revision of the legal provisions actually had restricted access to abortion considerably in Bulgaria (Act of 1974), Czechoslovakia (1973), Hungary (1973) and Poland (1969).

In Bulgaria, abortion was authorized "on request" if the woman had at least one child living or for socio-economic reasons, such as the fact that she was a widow, divorced or separated; or had a child living and was over 40 years of age. In Czechoslovakia, it was not granted "on request" but only in certain socio-economic circumstances considered to involve hardship, for example: when the woman was over 40 years of age; when she had three or more living children; when she was unmarried, separated, divorced or a widow, or in poor health; or again if her housing or income was insufficient.

In Hungary, abortion would be granted "on request"; however, a committee had to give its consent in advance. The consent was automatic if the woman was unmarried,

TABLE 21. LEGAL GROUNDS FOR GRANTING ABORTION: BREAKDOWN OF COUNTRIES BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, 1980[a]

(Number of countries)

Area of responsibility of regional commission, and level of development	*Circumstances in which abortion was authorized*							*Number of countries having information*	*Number of countries not having information*	*Total*
	On request	*Socio-economic factors*	*General risk to health of mother*	*Life of mother in danger*	*Risk of abnormal birth*	*Juridical factors*	*Other*			
ECA area										
Eastern Africa	—	1	5	14	2	3	1	14	2	16
Middle Africa	—	1	2	7	—	1	—	7	2	9
Northern Africa	1	—	3	6	2	—	—	6	—	6
Southern Africa	—	—	3	4	1	1	—	4	—	4
Western Africa	—	—	6	14	1	1	2	14	2	15
TOTAL	1	2	19	45	6	6	3	45	6	51
ECE area										
Eastern Europe	3	5	6	6	6	6	4	6	—	6
Northern Europe	3	6	6	7	6	5	3	7	—	7
Southern Europe	2	1	4	7	3	1	1	7	2	9
Western Europe	2	2	6	8	4	3	1	8	1	9
Cyprus, Israel and Turkey	—	1	2	3	3	3	1	3	—	3
Northern America	1	—	2	2	—	—	—	2	—	2
USSR	1	—	1	1	1	—	—	1	2	3
TOTAL	12	15	27	34	23	18	10	34	5	39
ECLA area										
Caribbean	1	1	7	10	1	—	—	11	—	11
Middle America	—	—	2	7	1	2	—	7	—	7
Temperate South America	—	1	1	3	—	2	—	3	—	3
Tropical South America	—	—	3	8	—	4	—	8	1	9
TOTAL	1	2	13	28	2	8	—	29	1	30
ECWA area										
Western South Asia[b]	—	—	1	8	—	—	—	8	4	12
TOTAL	—	—	1	8	—	—	—	8	4	12
ESCAP area										
China	1	—	—	—	—	—	—	1	—	1
Japan	—	1	1	1	1	1	—	1	—	1
Other East Asia	—	1	3	3	2	2	—	3	—	3
Eastern South Asia	1	—	2	7	1	2	—	7	2	9
Middle South Asia	1	1	3	7	2	1	—	7	2	9
Australia-New Zealand	1	1	2	2	2	2	1	2	—	2
Melanesia	—	—	1	2	—	—	—	2	—	2
Micronesia-Polynesia	—	1	2	5	1	1	—	5	1	6
TOTAL	4	5	14	27	9	9	1	28	5	33
Developed countries	13	16	28	34	23	18	10	34	5	39
Developing countries	5	8	46	108	17	23	4	110	16	126
TOTAL	18	24	74	142	40	41	14	144	21	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat; United Nations Fund for Population Activities, *Survey of Laws on Fertility Control* (New York, 1979); and *International Digest of Health Legislation*, vol. 30, No. 3 (1979).

[a] For countries in each category, see annex table 43.

[b] Excluding Cyprus, Israel and Turkey.

separated or divorced, or a widow, over 40 years of age, or had at least three children. It was also granted for reasons regarded as socio-economic in nature, if pregnancy was the result of failure of an intra-uterine device (IUD) or if the woman had two children and had previously had an obstetrical operation.

In Poland, abortion was authorized for socio-economic reasons, such as difficult living conditions that were likely to be aggravated by the birth of a child. In Romania, abortion was not permitted either "on request" or for socio-economic reasons. Only women over 45 years of age or those who had four dependent children could obtain authorization to have an abortion. In the German Democratic Republic, where the law was more liberal, abortion was authorized "on request" and on economic grounds.

In Northern Europe, abortion was authorized "on request" in Denmark, Norway and Sweden; and for socio-economic reasons, in a very broad sense, in Finland, Iceland (where conditions were somewhat stricter) and the United Kingdom. Ireland was the only country in the region where the law was extremely strict: abortion was permitted only if the life of the mother was in danger. In 1978, however, Finland had reduced the length of the period of pregnancy during which abortion "on request" would be authorized, from 16 to 12 weeks.

In Southern Europe, the legislation was decidedly more restrictive. Only Italy (Acts of 1977 and 1978) and Yugoslavia would grant abortion "on request". In Greece, although the law was still fairly restrictive, abortion was currently authorized for reasons of danger to the mental health of the mother (1978 amendment).

In Western Europe, Austria (Act of 1974) and France (1979) authorized abortion "on request", while the Federal Republic of Germany and Luxembourg (1978) did so for

socio-economic reasons. In Austria, however, although the law authorized abortion "on request", it would appear that in practice the reluctance of many physicians and hospital managements made it somewhat difficult to obtain. On the other hand, in Belgium (Act of 1867) and the Netherlands (1881), where the very restrictive ancient laws had not been repealed, the penalties provided by the law were not applied and abortion was in practice very widespread, especially in the Netherlands, where many clinics (specialized, non-profit-making organizations) operated throughout the country.

Lastly, in the United States of America, although the legislation varied from one state to another, abortion was liberally granted "on request". It would also be granted "on request" in the Soviet Union; but because of its pro-natalist policies, the Government did not encourage abortion. Thus, as shown above, many countries in the area of responsibility of the Economic Commission for Europe (ECE) authorized abortion "on request" or for socio-economic reasons, even though their legislation embodied a certain number of regulations that at times made access to it more difficult.

In the United States, abortion was authorized up to the end of the second trimester of pregnancy;[5] in the other countries, the length of pregnancy during which abortion was authorized was very much shorter, usually 12 weeks. Bulgaria, France and Yugoslavia even stipulated 10 weeks, while Sweden permitted abortion until the eighteenth week.

A number of countries would only grant authorization to perform an abortion on the advice of a medical panel or following a consultation with a health or welfare centre (e.g., the countries of Eastern Europe, France and Italy). Furthermore, in the two last-named countries, a "cooling-off" period (in France, one week) for reflection was imposed following the initial request to have an abortion.

As a rule, the health insurance or social security systems covered the expense of legal abortion, even though there were variations from one country to another. In the German Democratic Republic, for example, abortion was placed on the same footing as any other medical operation; the cost was therefore reimbursed by the health insurance fund and sick leave was granted. In Czechoslovakia, on the other hand, the cost of abortion was borne by the insured person, whereas medical services generally were free. Abortion was free of charge in Sweden, the United Kingdom and Yugoslavia. In Denmark and Hungary, the charges were determined by law. In France, the costs that arose from a therapeutic abortion were covered by social security.

Table 22 provides information on the absolute figures for abortion and on the abortion rate—in relation to total population and to women of reproductive ages—for a number of countries. The years chosen for information purposes take account, in so far as possible, of the enactment of new legislation (as in France) or of amendments to previously existing legislation (as in some Eastern European countries).

[5] During the second trimester, some states in the United States of America might apply special legal provisions to regulate abortion with a view to protecting the health of the mother.

In general, the statistics available on abortion are relatively incomplete, first of all because for a long time and in a large number of countries abortion had been practised illegally; and secondly, because the countries where abortion was currently legal frequently only registered abortions carried out in public or government hospitals. Only during the past few years had some countries begun to register abortions carried out in private institutions; but operations to end pregnancy that were performed by physicians in their private surgeries were often ignored unless the law made a report obligatory and controlled it very strictly.

In the Eastern European countries, abortion had previously been practised very widely as a method of birth control. For example, the abortion rate in Romania in 1965 had been 252 per 1,000 women. However, amendments to the law in several countries had reduced the rates very considerably. The most striking example was that of Romania, where the rate had dropped from 252 per 1,000 in 1965 to 46 per 1,000 in 1967; it had subsequently risen to 81 per 1,000 in 1973. Thus, it would appear that the Government had applied the law very strictly at the outset and had later adopted a more liberal attitude. The rates had been falling in all the Eastern European countries, but they still remained at a level distinctly higher than those in the other countries in the ECE area of responsibility.

In the countries of Northern Europe, there had been a slow rise in the rates between 1970 and 1976-1977, followed in the past few years by a stagnation and even a decrease, for example, in Denmark, Finland, Norway and Sweden. In the other European countries covered in table 22, the rates were still fairly low, but account should no doubt be taken of the restrictions indicated above in regard to the registration of abortions.

In Canada and the United States of America, the rate was rising; that in the latter country was more or less on the same level as those in the Eastern European countries.

Many of the developed countries had not yet enacted definitive legislation with respect to sterilization, although the Committee of Ministers of the Council of Europe had recommended in 1975 that Governments should take the legislative measures necessary to liberalize sterilization and to regard it as a means of regulating births. Table 23 indicates that five of the 34 countries for which information is available regarded sterilization as illegal. Of the other 29 countries, 16 authorized it "on request"; two for socio-economic reasons; two as a means of birth regulation; nine for medical reasons; and five for reasons of hereditary malformation.

It was mainly in the Northern European countries that voluntary sterilization had been liberalized by recent legislation (excluding Ireland). In Denmark (Act of 1973), sterilization was authorized "on request" from the age of 25, unconditionally. Not even the consent of the spouse was necessary. Below that age, however, the conditions were stricter. The legal provisions were almost identical in Iceland (Act of 1975), Norway (1977) and Sweden (1975). Finland was more restrictive and only authorized sterilization for socio-economic or medical reasons, and when there was a risk of hereditary or other malformation, or pregnancy could not be avoided by other contraceptive means. But the

TABLE 22. NUMBER OF LEGAL ABORTIONS AND ABORTION RATE, SELECTED DEVELOPED COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR EUROPE, VARIOUS RECENT YEARS

Region and country	Year	Number of abortions	Abortion rate (per 1,000)	
			Population as a whole	Women aged 15-44 years
Eastern Europe				
Bulgaria	1970	120 900	14.2	64.0
	1971	132 500	15.5	70.2
	1972	133 600	15.6	70.9
	1973	115 400	13.4	61.2
	1974	125 000	14.4	66.4
	1975	123 700	14.2	65.8
	1976	121 100	13.8	64.5
Czechoslovakia	1970	99 800	6.9	32.3
	1971	97 300	6.8	31.4
	1972	91 300	6.3	29.2
	1973	81 200	5.6	25.9
	1974	83 100	5.7	26.4
	1975	81 700	5.5	25.9
	1976	84 600	5.7	26.8
	1977	89 000	...	...
German Democratic Republic	1973	110 800	6.5	32.2
	1974	99 700	5.9	28.8
	1975	87 800	5.2	25.2
	1976	81 900	4.9	23.3
Hungary	1970	192 300	18.6	83.5
	1971	187 400	18.1	81.1
	1972	179 000	17.2	77.5
	1973	169 600	16.3	73.5
	1974	102 000	9.7	44.3
	1975	96 200	9.1	41.9
	1976	94 700	8.9	41.5
	1977	89 100	8.4	39.2
Poland	1969	212 933	...	...
	1970	214 034	...	...
	1971	203 619	...	...
	1972	204 562	...	...
	1973	210 682	...	...
	1974	214 387	...	...
	1975	212 101	...	...
	1976	215 368	...	...
	1977	213 911	...	...
Romania	1965	1 115 000	58.6	252.3
	1966	973 000	50.5	218.7
	1967	206 000	10.6	46.0
	1968	220 000	11.1	48.0
	1969	258 000	12.9	56.9
	1970	292 000	14.4	63.9
	1971	330 000	16.2	71.9
	1972	381 000	18.5	82.7
	1973	376 000	18.1	81.3
Northern Europe				
Denmark	1970	9 400	1.9	9.4
	1971	11 200	2.2	11.1
	1972	13 000	2.6	12.9
	1973	16 500	3.3	16.2
	1974	24 900	4.9	24.2
	1975	27 900	5.5	27.0
	1976	26 800	5.3	25.8
	1977	25 700	5.0	24.4
Finland	1970	14 800	3.2	13.8
	1971	20 400	4.4	18.9
	1972	22 200	4.8	20.4
	1973	23 400	5.0	22.4
	1974	22 800	4.9	21.8
	1975	21 500	4.6	20.4
	1976	19 800	4.2	18.6
Norway	1970	7 900	2.0	10.9
	1971	10 400	2.7	14.1
	1972	12 200	3.1	16.4
	1973	13 700	3.5	18.2
	1974	15 200	3.8	20.0
	1975	15 100	3.8	19.7

TABLE 22 *(continued)*

Region and country	Year	Number of abortions	Abortion rate (per 1,000)	
			Population as a whole	Women aged 15-44 years
Northern Europe *(continued)*				
Norway *(continued)*	1976	14 800	3.7	19.0
	1977	15 500	3.8	19.7
Sweden	1970	16 100	2.0	10.2
	1971	19 300	2.4	12.2
	1972	24 200	3.0	15.2
	1973	26 000	3.2	16.3
	1974	30 600	3.8	19.2
	1975	32 500	4.0	20.2
	1976	32 400	3.9	20.0
	1977	31 200	3.8	19.2
United Kingdom[a]	1968	24 900	...	...
	1969	58 200	...	...
	1970	86 600	...	...
	1971	133 000	...	...
	1972	167 500	...	...
	1973	174 600	...	...
	1974	170 400	...	...
	1975	147 000	...	...
	1976	135 900	...	...
	1977	140 700	...	...
Western Europe				
France	1976	133 416	...	...
	1977	150 149	...	...
	1978	150 246	...	...
Germany, Federal Republic of	1970	4 900	0.08	0.4
	1971	6 900	0.11	0.6
	1972	8 600	0.14	0.7
	1973	13 000	0.21	1.1
	1974	17 200	0.28	1.4
	1975	21 200	0.34	1.7
	1976	...	...	...
	1977	54 300	0.88	4.1
Netherlands	1970	10 000	0.8	3.7
	1971	15 000	1.1	5.5
	1972	21 000	1.6	7.6
	1973	20 000	1.5	7.1
	1974	17 000	1.3	6.0
	1975	16 000	1.2	5.5
	1976	16 000	1.2	5.5
Northern America				
Canada	1970	11 200	0.5	2.6
	1971	30 900	1.4	6.6
	1972	38 900	1.8	8.2
	1973	43 100	2.0	8.8
	1974	48 200	2.1	9.5
	1975	49 300	2.2	9.5
	1976	54 500	2.4	10.3
	1977	57 600	2.5	10.6
United States of America	1973	744 600	3.5	16.6
	1974	898 600	4.2	19.6
	1975	1 034 200	4.8	22.1
	1976	1 179 300	5.5	24.5
	1977	1 270 000	5.9	25.8

Sources: Demographic Yearbook, 1977 (United Nations publication, Sales No. E/F.78.XIII.1); *Demographic Yearbook, 1978* (United Nations publication, Sales No. E/F.79.XIII.1); Christopher Tietze, *Induced Abortion: 1979*, 3rd ed., A Population Council Fact Book (New York, The Population Council, 1979); and for France, "Neuvième rapport sur la situation démographique de la France", *Population* (Paris), vol. 35, No. 4-5 (July-August 1980), pp. 759-812.

[a] Not including Northern Ireland

TABLE 23. LEGAL GROUNDS FOR GRANTING STERILIZATION: BREAKDOWN OF COUNTRIES BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, 1980[a]

(Number of countries)

Area of responsibility of regional commission, region and level of development	Circumstances in which sterilization was authorized					Juridical status			
	On request	Socio-economic factors	Birth control	Medical reasons	Hereditary and other malformations	Illegal	Legal or not clearly defined	Number of countries not having information	Total
ECA area									
Eastern Africa	2	1	—	3	—	5	7	4	16
Middle Africa	—	—	—	—	—	6	1	2	9
Northern Africa	2	—	1	2	2	3	2	1	6
Southern Africa	2	—	2	1	—	—	4	—	4
Western Africa	1	—	—	1	—	4	10	2	16
TOTAL	7	1	3	7	2	18	24	9	51
ECE area									
Eastern Europe	2	—	—	3	1	1	5	—	6
Northern Europe	4	1	2	1	1	—	7	—	7
Southern Europe	2	—	—	2	—	4	3	2	9
Western Europe	5	1	—	1	1	—	8	1	9
Cyprus, Israel and Turkey	—	—	—	2	1	3	—	—	3
Northern America	2	—	—	—	—	—	2	—	2
USSR	—	—	—	1	—	—	1	2	3
TOTAL	15	2	2	10	4	8	26	5	39
ECLA area									
Caribbean	5	—	—	1	1	1	6	4	11
Middle America	3	1	—	1	1	1	6	—	7
Temperate South America	—	—	—	1	—	2	1	—	3
Tropical South America	3	—	—	2	2	3	5	1	9
TOTAL	11	1	—	5	4	7	18	5	30
ECWA area									
Western South Asia[b]	1	—	—	5	5	9	2	1	12
TOTAL	1	—	—	5	5	9	2	1	12
ESCAP area									
China	1	—	—	—	—	—	1	—	1
Japan	—	—	—	1	1	—	1	—	1
Other East Asia	—	—	1	—	—	2	1	—	3
Eastern South Asia	1	2	2	2	1	1	6	2	9
Middle South Asia	5	—	1	—	—	1	6	2	9
Australia-New Zealand	1	—	—	—	—	—	2	—	2
Melanesia	—	—	—	—	—	—	1	1	2
Micronesia-Polynesia	1	—	—	—	—	—	1	5	6
TOTAL	9	2	4	3	3	4	19	10	33
Developed countries	16	2	2	9	5	5	29	5	39
Developing countries	27	4	7	21	13	41	60	25	126
TOTAL	43	6	9	30	18	46	89	30	165

Sources: Compiled from "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat; United Nations Fund for Population Activities, *Survey of Laws on Fertility Control* (New York, 1979); and Jean-Paul Sardon, "La stérilisation dans le monde. II. Données statistiques", *Population* (Paris), vol. 34, No. 3 (May-June 1979), pp. 607-636.

[a] For countries in each category, see annex table 44.

[b] Excluding Cyprus, Israel and Turkey.

law in the United Kingdom was that most slanted towards birth control: sterilization was considered an excellent method of contraception. It was allowed without any age limit for contraceptive reasons and was performed free of charge by the National Health Service.

In Southern Europe, only Italy (Act of 1978) and Yugoslavia (Acts of 1977 and 1978) authorized sterilization "on request". In Yugoslavia, however, the person concerned must be at least 35 years old.

In Western Europe, the legal situation in regard to voluntary sterilization was not very clearly defined, but it would appear that a certain laxness permitted it in practice. In Austria, sterilization "on request" was legal; but as in the case of abortion, it was opposed by many physicians and hospitals. It was authorized, likewise, "on request" in Belgium, France (where, in the absence of clear-cut legislation, the decision was regularly taken by joint agreement between physician and patient), the Netherlands and Switzerland. The Federal Republic of Germany authorized it for serious social reasons.

In Eastern Europe, voluntary sterilization was legal in Bulgaria, Czechoslovakia and Poland, but was subject to certain restrictions: persons of "a certain age" in Bulgaria; and women of 35 years with at least three children in Czechoslovakia. However, sterilization was not encouraged in the countries of Eastern Europe and hence was rarely utilized.

Sterilization "on request" was authorized in Canada, subject to discussion with the physician; and in the United States, without any restriction provided the person was 18

or 21 years of age, according to the state in question. Sterilization was not legal in the USSR and hence was not practised to regulate births.

In recent years, the number of couples who used voluntary sterilization as a means of contraception had increased considerably in the developed countries. The number of couples who had been sterilized was estimated at 12 million in the United States (compared with 3 million in 1970), 10 million in Europe (3 million in 1970) and 1 million in Canada (0.5 million in 1970). In the developed countries, therefore, sterilization represented some 25 per cent of that practised throughout the world (63 per cent of all cases took place in China and India alone). In 1970, the proportion had been higher (32 per cent); but at that time, China had not yet instituted its vast sterilization campaign, which is discussed in a later section.[6]

Economic incentives

A second type of measure taken by Governments to adjust the levels of fertility or to ensure individual well-being consists of economic benefits granted by the State to families. These benefits actually represent a fairly considerable taking-over of the costs occasioned by the arrival of a child and its upbringing. Thus, they perform two functions—which cannot easily be distinguished—a social function, that of protecting the income of families (in all the countries studied); and a second function, that of providing a demographic stimulus (in pro-natalist countries).

These economic measures take the form of direct and indirect benefits. The direct benefits are financial. They may consist either of income-tax reliefs or of allowances, the two systems at times existing simultaneously.[7] In the former instance, the system is based on the principle that the portion of the income devoted to bringing up a child should not be taxed. Consequently, a lump sum, or a progressive amount based *pro rata* on the number of dependent children, is deducted from the taxable earnings. That system, however, which was in force in several countries, appeared to be losing ground in favour of family allowances,[8] which are dealt with in greater detail in this report.

The system of family allowances consists of the payment of a sum of money, subject to tax or otherwise, during pregnancy, on the birth of a child (childbirth bonus) and for its upbringing (monthly or quarterly family allowances), together with the payment in some countries of holiday allowances, new school-year bonus (holiday pocket-money, beginning-of-term allowances), etc. Indirect benefits, such as cheap fares on public transport and housing allowances, are also given at times. The amount of these family allowances is, as a rule, independent of income, but this was not always found to be the case. In Denmark, for example, families in a high income bracket did not receive them. In many countries, the amount of the childbirth bonus and family allowances depended upon the birth order of the child. In others, the amount of the allowances varied with the age of the child so as to make up more fully for the rising cost of upbringing and education.

Table 24 gives information for the member countries of the Organisation for Economic Co-operation and Development (OECD) concerning the percentage of national budgets devoted to social expenditure and, in particular, to family allowances in the period 1970-1975. The gap between the various countries was fairly wide. Australia, Canada, Finland and especially Japan devoted less than 1 per cent of their gross domestic product to family allowances, while others allocated between 1 and 2 per cent; and some countries, such as Belgium and France, more than 2 per cent. However, certain countries gave preference to relief from income tax rather than to family allowances to make up the family income. Table 25 indicates the proportion of the gross income of a worker of average level with two children that represented family allowances and the whole range of family benefits, including income-tax reliefs, in 1972. One finds a decided gap between the various countries—Australia, Japan, the United States and the Northern European countries formed a group in which family benefits represented approximately 5 per cent of gross income (2.0 per cent in Japan and 7.0 per cent in Sweden); on the other hand, that proportion was nearly 14 per cent in Austria, 15 per cent in Belgium and nearly 17 per cent in France.

Table 26 gives information on the levels of family allowances and supplementary benefits paid as of 1 July 1978, according to the birth order and age of the child. Allowances at that time were payable, as a rule, up to 16 or 18 years of age; but in some countries, the payments were continued up to the ages 25 and even 27 years if the child was engaged in studies and thus remained a dependant vis-à-vis his parents. However, as between one country and another, the amount of the allowances and supplements based on the birth order of the child in the family varied. The amount was modest in Denmark, Italy and the United Kingdom, where each child in the family received the same amount; the amount increased progressively up to the third child in the Federal Republic of Germany, Ireland and Luxembourg; up to the fifth child in Belgium and France; and up to the eighth child in the Netherlands.

Comparisons between the amounts allocated must take into account both the basic amount (the one granted for the first child) and the scale of progression according to the birth order of the child. Thus, in Iceland, the allowance paid out for the third child was double that for the first child, but the amount was small, from 3.4 to 7.25 European Units of Account (EUA). In Belgium, the amount payable for the first child was the highest among all the countries covered, and that amount was doubled for the third child (34.60 EUA

[6] C. P. Green, *Voluntary Sterilization: World's Leading Contraceptive Method*, Population Reports, Series M, Special Topics, No. 2 (Baltimore, Maryland, Johns Hopkins University Press, January 1979); and Reimert T. Ravenholt, "Prospects for voluntary sterilization", *Voluntary Sterilization: A Decade of Achievement*, Proceedings of the Fourth International Conference on Voluntary Sterilization, Seoul, Republic of Korea, 7-10 May 1979, Marilyn E. Schima and Ira Lubell, eds. (New York, Association for Voluntary Sterilization, 1980), pp. 99-102.

[7] In the case of France, see, for example, Gérard Calot, "Niveau de vie et nombre d'enfants: un bilan de la législation familiale et fiscale française de 1978, *Population* (Paris), vol. 35, No. 1 (January-February 1980), pp. 9-55.

[8] Kenneth Messere and Jeffrey Orvens, "The treatment of dependent children under income tax and social welfare systems", paper submitted to the meeting of the International Social Security Association Group of Experts on the Relationship between Social Security and Fiscal Systems, Jerusalem, Israel, 12-14 December 1978.

TABLE 24. PUBLIC EXPENDITURE ON INCOME MAINTENANCE PROGRAMMES AND FAMILY ALLOWANCES, COUNTRIES MEMBERS OF THE ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

Country	*Public expenditure on income maintenance programmes as a percentage of gross domestic product (trend)*[a]	*Proportion of income maintenance expenditure devoted to family allowances in the national social welfare budget*[a]	*Public expenditure on family allowances as a percentage of gross domestic product (trend)*[a]
Australia	4.0	14.8	0.59
Austria	15.3	11.4	1.74
Belgium	14.1	21.9	3.09
Canada	7.3	8.0	0.59
Denmark	9.9	15.5	1.29
Finland	9.9	7.3	0.65
France	12.4	20.0	2.49
Germany, Federal Republic of	12.4	2.7	0.34
Ireland	6.4	12.9	0.90
Italy	10.4	11.2	1.17
Japan	2.8	2.5	0.07
Netherlands	14.1	15.1	1.85
New Zealand	6.5	27.5	1.80
Norway	9.8	15.6	1.30
Sweden	9.3	14.0	1.08
United Kingdom	7.7	7.1	0.56
United States of America	8.0	—	—

Source: Organisation for Economic Co-operation and Development, *Public Expenditure on Income Maintenance Programmes,* Studies in Resource Allocation (Paris, 1976).

[a] The comparative figures cover different years for each country, but all refer to the period 1970–1975.

TABLE 25. FAMILY WELFARE ALLOWANCES AND TOTAL FAMILY BENEFITS FOR A TWO-CHILD FAMILY, AS A PERCENTAGE OF THE GROSS INCOME OF A WORKER OF AVERAGE LEVEL, COUNTRIES MEMBERS OF THE ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, 1972

Country	*Total benefits, including income-tax relief*	*Of which: family allowances*
	(percentage of gross income)	
Australia	4.3	1.7
Austria	13.9	9.1
Belgium	15.2	13.6
Canada	3.8	1.8
Denmark	5.5	5.5
Finland	6.2	3.8
France	16.6	13.8
Germany, Federal Republic of	4.0	[a]
Ireland	7.8	1.4
Italy	8.4	7.9
Japan	2.0	—
Netherlands	8.6	7.3
New Zealand	8.2	7.6
Norway	6.0	6.0
Sweden	7.3	7.3
United Kingdom	8.5[b]	2.6
United States of America	3.5	—

Source: Organisation for Economic Co-operation and Development, *Public Expenditure on Income Maintenance Programmes,* Studies in Resource Allocation (Paris, 1976).

[a] Family allowances were paid only to persons with income below a certain ceiling, which is exceeded in the example given.

[b] Since family allowances were taxable, the total amount was reduced by 1 per cent in the example given here.

for the first child and 75.20 for the third); after the third child, the increase in the allowance was much smaller (76.70 EUA for the fourth child and 77.25 for the fifth). In the Netherlands, both the amount and the increase according to the child's birth order were less, in comparison with Belgium or Luxembourg. In France, the amount was on a rising scale up to the third child, after which it decreased from the fourth up to the fifth. The amount payable for the third child in Belgium was higher than that payable in any of the other countries for any child, whatever its birth order.

In several countries, a supplementary family allowance was payable according to the age of the child. In Belgium, the age scale comprised three groups: children from 6 to 10 years; from 10 to 14; and from 14 onward. The amount of the supplement for the oldest group was three times that payable for children aged from 6 to 10 years. In other countries, the age scale comprised only two groups: over 10 years and over 15 years in France; over 6 years and from 12 years onward in Luxembourg etc. In the Netherlands, the basic amount of the allowance might be doubled or tripled according to the age of the child, subject to certain conditions. There might also be other family benefits to add to an already complex system. In Italy, an allowance was payable to the family if the mother had no income; and in France, if the family had a child under 3 years of age or if there were at least three children in the family (family complement). Some countries granted other family allowances, again in the form of a pre-natal allowance; a childbirth bonus, decreasing in amount according to the child's birth order (in Belgium) or at a fixed level (in France and Luxembourg); holiday bonuses (in Belgium); or a bonus payable at the beginning of the school year. In France, however, the childbirth bonus payable for a child third in rank in the family was recently increased substantially, with a view to encouraging the birth of a third child in families.

In the Eastern European countries, the amount of family allowances had traditionally been high and in 1980, depending upon the number of children, it could represent an extremely large portion of the income—in Hungary, from 17 per cent of the monthly earnings of a worker or employee with two children to 54 per cent for one with five children;

TABLE 26. AMOUNT OF FAMILY BENEFITS AND SUPPLEMENTARY ALLOWANCES PAYABLE, ACCORDING TO AGE OF CHILD AND BIRTH ORDER, SELECTED EUROPEAN COUNTRIES, 1 JULY 1978

Country	Age limit (years)			Amount of allowance[a]		Supplementary allowance based on age
	Normal	Extended for study purposes	Handicapped child			
Belgium	16	25	No limit	First child:	34.60	6-10 years: 263.25 Belgian francs
				Second child:	54.90	10-14 years: 464.25 Belgian francs
				Third child:	75.20	14 years and over: 751.50 Belgian francs
				Fourth child:	76.70	
				Fifth child:	77.25	
Denmark	16	—	—	Each child:	21.35	Up to 16-17 years, maximum: 7 700 per annum if parents' income does not exceed 7 000 kroner
France	16	20	20	Second child:	34.90	From second child onward:
				Third child:	57.70	Over 10 years: 76.50 French francs
				Fourth child:	56.15	Over 15 years: 136 French francs
				Fifth child:	53.10	
Germany, Federal Republic of	18	27	No limit	First child:	19.40	—
				Second child:	31.0	
				Third child:	58.15	
Ireland	16	18	18	First child:	3.40	—
				Second child:	6.10	
				Third child:	7.25	
Italy	18	26	No limit	Each child:	9.30	—
Luxembourg	18	25	No limit	First child:	28.40	From 6 years onward, 115 Luxembourg francs
				Second child:	28.40	
				Third child:	73.20	From 12 years onward, 375 Luxembourg francs
Netherlands	16	27	18	First child:	19.80	Under 16 years, amount doubled if child is not living at home for educational or health reasons
				Second and third child:	41.40	
				Fourth and fifth child:	55.25	Between 16 and 27 years, amount trebled if child is not living at home for educational reasons and is still dependent on parents
				Sixth and seventh child:	61.15	
				Eighth child and more:	67.60	
United Kingdom	16	19	—	Each child:	14.90	—

Source: Commission of the European Communities, Comparative Table of the Social Security Systems in the Member States of the European Communities, Situation at 1 July 1978, 10th ed. (n.d.).

[a] The amounts of the allowances are shown in European Units of Account (EUA): the conversion rates used were: 1 EUA = 40.6585 Belgian francs; 7.02342 Danish kroner; 5.60086 French francs; 2.57941 deutsche mark; 1 061.46 Italian lire; 40.6585 Luxembourg francs; 2.7758 Netherlands guilders; 0.6692 pound sterling.

and in Czechoslovakia, from 18 per cent (two children) to 64 per cent (five children) (see table 27). It will be noted that it is with the advent of the second and third child that the family allowance would become really substantial (Bulgaria, Romania, Czechoslovakia). It may have been observed in the course of this discussion that two systems of family allowances exist side by side in the developed countries: those on a rising scale; and those at a fixed amount. The rising scale of allowances has often been cited as the criterion distinguishing family policies with a demographic objective from those with a social objective, on the assumption that a rising scale of family allowances was sufficient to classify a family policy in the pro-natalist category. The example of countries like the Netherlands, where allowances in 1978 were on a sharply rising scale, makes it clear that this criterion may be necessary, but certainly not sufficient, to place the country in the pro-natalist category. Indeed, it may be recalled that this country found its rate of fertility satisfactory and currently was not applying any measures to modify it.

In addition to direct financial benefits, there may also be indirect benefits, such as payments to offset education costs, going as far as entirely free schooling; priority in access to low-cost housing and to loans and subsidies for the acquisition of dwellings; cheap fares on public transport (in Belgium, those were granted to all members of families after the birth of the third child); etc. In Czechoslovakia,[9] for example, the cost of placing children in day nurseries and kindergartens, school meals, and purchase of clothes and of other goods and services needed for the education and upbringing of the child were taken over by the State by means of *pro rata* payments based on the income of the parents. In government housing, reductions in rent could amount to 50 per cent, according to the number of dependent children. Low-interest loans up to a maximum of 30,000 koruny were granted to young couples under 30 years of age for the purchase of furniture (interest rate, 2.5 per cent) and dwellings (interest rate, 1 per cent). The amount to be repaid was reduced by 2,000 koruny on the first birthday of the first child and by 4,000 koruny on the first birthday of each of the other children. There was a similar measure in the German Democratic Republic: the repayment of housing loans was progressively cancelled out

[9] Tomáš Frejka, "Fertility trends and policies: Czechoslovakia in the 1970s", Population Council Working Paper No. 54, New York, February 1979.

TABLE 27. PROPORTION OF AVERAGE MONTHLY EARNINGS REPRESENTING BENEFITS, ACCORDING TO NUMBER OF CHILDREN IN FAMILY, SELECTED EUROPEAN COUNTRIES

Country and currency unit	Average monthly earnings of a manual or white-collar worker in government service	Year	Proportion of average monthly earnings representing benefits (percentage)				
			First child	Second child	Third child	Fourth child	Fifth child
Bulgaria (lev)	148	1976	3.4	13.5	37.2	40.5	44.0
Czechoslovakia (koruna)	2 369	1976	3.8	18.2	37.2	54.0	64.2
German Democratic Republic (mark)	713	1969	2.8	5.6	9.8	18.2	28.1
Hungary (forint)	2 976	1976	43.4	16.8	32.3	43.0	54.1
Poland (zloty)	3 969	1976	4.0	10.3	18.9	25.5	37.0
Romania (leu)	1 964	1976	8.2	16.8	26.5	36.2	45.8
Yugoslavia (dinar)	1 592	1972	1.7	3.2	4.5	5.7	6.3

Source: Valentina Bodrova, "The family as an object of demographic policy in the socialist countries of Europe", paper submitted to the Fourth European Population Seminar, Athens, 2-5 September 1979.

as each child was born; and by the birth of the third child, the debt was liquidated.[10]

At the same time, although the financial aid given to families was not negligible, the growth of that aid had not been sufficient in some countries to maintain the purchasing power of the family. Since real income and wages had increased more rapidly, families found themselves relatively worse off. Thus, in France, the family allowances index in 1975 stood at 638.8 (base: 1946 = 100) for a family of two children and at 1,376.6 for a family of five; but the hourly wage index at that time stood at 3,169.3 (base: 1946 = 100) and the price index at 1,190.8.

Some countries had also given priority to other social problems whose solution was regarded as more urgent (old-age pensions, unemployment benefits etc.). Thus, again in France, the index of social benefits stood at 232.3 in 1973 (base: 1962 = 100), but the index of family allowances then stood at only 141.9.[11]

Family allowances were not always equitably allocated according to the level of earnings of the family. Not all allowances evolved at the same rate and they were not always granted under the same conditions to all families. For example, in France, calculating in absolute values the benefits granted to a typical family according to its income level, one finds that the relative amounts, which were high for persons with entitlement in a low income bracket, decreased when medium earnings were reached, but again increased for those with higher incomes.[12] France was chosen as an example because it illustrates the present discussion. It should be pointed out, however, that much effort has been expended by the Government of France to correct those "disparities".[13]

[10] Jacqueline Hecht, "La politique de population de la République démocratique allemande, mai 1979", Paris, Institut national d'études démographiques (mimeographed).

[11] Nicole Questiaux and Jacques Fournier, "France", *Family Policy: Government and Families in Fourteen Countries*, Sheila B. Kamerman and Alfred J. Kahn, eds. (New York, Columbia University Press, 1978), pp. 117-182.

[12] Jacques Fournier and Nicole Questiaux, *Le pouvoir du social*, Economie en liberté series (Paris, Presses universitaires de France, 1979). The total amount of family benefits granted to a family with three children on a single wage amounted in 1976 to 12,626 French francs for a worker's family; F 8,966 for a middle-class family; and F 12,209 for a family in the higher brackets.

[13] France, "Rapport de synthèse des travaux du Haut comité de la population", submitted to the Ministre de travail et de la participation, Paris, June 1980.

Measures designed to reconcile maternity and employment

A third type of intervention consists of an entire series of measures designed to reconcile participation by women in the labour force with maternity. In the countries of Eastern Europe, action on those lines had developed on a large scale, owing to the fact that those countries had found themselves confronted by a problem of shortage of manpower at a time when recourse to foreign immigration was limited and large numbers of women had jobs. Therefore, the only solution for the long-term problem was to raise fertility and at the same time allow women to continue with their occupations. For that purpose, they had to be offered favourable conditions which would enable them to play their roles as mothers and workers simultaneously. Thus, in Czechoslovakia, the German Democratic Republic and Hungary, day nurseries and kindergartens were set up to enable the mothers of families to reconcile their work with the rearing of young children. Leave for study purposes was granted to women to enable them to improve their skills. In addition to maternity leave, paid leave was also introduced for the education of the child: in the German Democratic Republic, such leave (known as the "babyjahr") was granted to mothers after the birth of the second child and later children, from the end of the maternity leave until the child was one year old. The arrangement entitled the woman to payment, for the period of a year, of an indemnity calculated on the basis of the sickness allowance (a minimum of 300 mark per month for two children and 350 mark for three children or more). In addition, the weekly working hours for mothers of families were reduced without any reduction in wages.[14]

In Czechoslovakia,[15] maternity leave had been extended from 18 to 26 weeks (35 weeks if the mother was alone) and the mother received virtually her full wages during that period. Furthermore, the Government had established a system of childbirth allowances designed to enable the mother to prolong her maternity leave beyond the statutory period. Thus, a working woman who wished to remain at home in order to bring up a child under 2 years of age, provided she had at least one other child of school age, was entitled to a monthly allowance varying from 500 to 1,200

[14] J. Hecht, *op. cit.*

[15] T. Frejka, *op. cit.*

koruny, with the amount determined on the basis of the number of dependent children under 2 years of age.

Hungary had a similar arrangement: at the end of her maternity leave (20 weeks on full pay), a working woman who wished to remain at home to bring up her child herself could do so for a period of three years. During that period, she would receive an allowance equivalent to approximately one third of the average pay of a working woman.[16]

The countries of Western Europe also were beginning to adopt provisions of that type, although the pro-natalist objective of those measures was distinctly less marked. Sweden recently set up a system of child education leave under which the father or mother could be the beneficiary, without any prior demographic conditions.[17] In Norway also, the parents of a new-born child were entitled to share a leave of one year, of which six weeks were mandatorily reserved for the mother.[18] Other Western European countries had transformed maternity leave into what was really educational leave, by continuous extensions. Thus, in the Federal Republic of Germany, maternity leave had been increased from four to six months; and during that time, the wage that the woman must relinquish would be refunded by the State up to an amount of 750 deutsche mark per month.[19] In Italy, as of 1978, maternity leave covered five months, but supplementary leave[20] of six months could be granted.[21] In France, in 1980, maternity leave was four months, but it was extended to six months with the advent of a third child.[22]

Despite these various types of intervention by the State, the fact remains that the burden of educating and rearing a child involves a lowering of the level of living of families. In France, for example, a recent study[23] shows that in the first place, when the spouse had no job, the decline in the level of living was in direct proportion, given equal earnings, to the number of children; and when the number of children was equal, the drop in the level of living was proportionally less when the earnings became higher (at any rate reckoned from a certain threshold of earnings which increases with the number of children).

In another direction, when the spouse had an occupation that was interrupted when the children were young, the lowering of the level of living was much more marked than that when the spouse chose not to carry on an occupation. In other words, the existing legislation genuinely penalized women who had an occupation and would like at the same time to begin a family.

Reference has already been made to certain obstacles encountered by developed countries in their concern about fertility levels which they considered too low and had decided to take action to change. Some general consequences of the choice of those policy options are discussed below. As is well known, couples tend increasingly to have the number of children they desire and no more. In addition, the growing polarization of choice in favour of the two-child family corresonds at the macro-demographic level to the adoption of a population model showing a slightly downward curve. Pro-natalist policies, which are intended to attain a situation of a slightly upward or even a stationary trend in population growth, must emphasize privileges to encourage families to have at least three children. The emphasis on three-child families, justified on grounds of demographic efficacy, is, however, to some extent at variance with the very strong trend towards equality in the burden of fertility, as expressed in the almost universal acceptance of the family norm of two children.

However, recent trends in fertility in several developed countries would actually seem to weaken the case here: in Austria, Belgium, France, the Federal Republic of Germany, Sweden, the United Kingdom and the United States of America, one finds an upswing in the birth rate.[24] The question is whether that increase is the outcome of government policies or quite simply a confirmation of the theory of long-term fertility cycles. Only extensive observations over several years will make it possible to decide.

The demographic history of Europe in the twentieth century shows that the burden of generation replacement has long been taken over—and indeed without government intervention in most instances—by a minority of fertile families situated at both ends of the social spectrum. Even if the State became wholeheartedly involved in a policy of support, it is not certain today that such inequality in the distribution of the burden of fertility would be acceptable to those same categories of population, bearing in mind the undoubted fact that the legitimacy of social action by the State is now based on strictly egalitarian expectations.

B. Developing countries

Almost half the developing countries, 59 out of 126 (47 per cent) wanted to have a lower fertility rate; a more or less identical proportion, 53 countries (42 per cent), declared themselves to be satisfied with the existing level; and only 14 countries (11 per cent) wanted to attain a higher fertility rate (see table 17). There had been few changes in perception since 1978, although, on the other hand, a large number of countries had decided to implement policies designed to adjust the fertility rate or to maintain it at its existing level. Those changes are discussed later.

At the regional level, the countries in the area of responsibility of the Economic and Social Commission for Asia and the Pacific (ESCAP) were the largest group to express a desire for a lower fertility rate: 63 per cent of those countries did so. Next were those in the area of the Economic Commission for Latin America (ECLA), with 50 per cent; those in the area of the Economic Commission for Africa (ECA),

[16] Egon Szabady, "Effects of child care allowance on fertility", paper submitted to the Fourth European Population Seminar, Athens, 2-5 October 1979.

[17] Murray Gendell, *Sweden Faces Zero Population Growth*, Population Bulletin, vol. 35, No. 2 (Washington, D.C., Population Reference Bureau, Inc., June 1980).

[18] *Women at Work* (Geneva), No. 1 (1979).

[19] *Le Monde*, 17 May 1979.

[20] Optional supplementary leave could be requested by the father if the mother did not claim it or if the father took charge of the child alone.

[21] Commission of the European Communities, *Comparative Table of the Social Security Systems in the Member States of the European Communities*, Situation at 1 July 1978, 10th ed. (n.d.).

[22] *Le Monde*, 14 July 1980.

[23] G. Calot, *loc. cit.*

[24] Jean Bourgeois-Pichat, "The demographic situation in Europe, with emphasis on fertility, development and urbanization", paper submitted to the Beijing International Round Table Conference on Demography, organized jointly by the United Nations and the Government of China, Beijing, 20-27 October 1980.

with 43 per cent; and those in the area of the Economic Commission for Western Asia (ECWA), with a mere 16 per cent. In terms of population, the countries in the ESCAP area again were the least satisfied. The proportion of countries that would like to have a higher fertility rate was approximately the same in the various areas: 13 per cent in the ECLA area; 10 per cent in the ECA area; 8 per cent in the ECWA area; and 7 per cent in the ESCAP area. On the other hand, the proportion of countries that found the rate satisfactory varied considerably from one area to another. The ECWA area led—75 per cent of the countries considered the fertility rate to be satisfactory. That area was followed by the ECA area, with 47 per cent; the ECLA area, with 37 per cent; and the ESCAP area, with 30 per cent.

With regard to policies as such, most of the countries that were not satisfied with the rates were taking measures to change the situation: 10 countries out of 14 had policies to raise the rate; and 38 out of 59 had policies to reduce it. Of the countries that found the rate satisfactory, only 21 out of 53 were taking steps to maintain the level. At the level of the areas of responsibility, the countries in the ESCAP area were again the most numerous in taking action to change rates considered to be too high. In that area, 16 out of 19 countries intervened to reduce the rates; as did nine countries out of 15 in the ECLA area and 12 countries out of 22 in the ECA area. In the ECWA area, none of the countries was intervening.

The following discussion deals with the way in which the countries in each area perceived their level of fertility, what changes had taken place since 1978 and what types of measures were being applied by the countries that had decided to take action. Under each area of responsibility, the various measures are divided into the following categories: legal measures (access to contraception, abortion, sterilization and age at marriage); technical and administrative measures (integration of birth control programmes within the health services, basic communities etc.); incentive and disincentive economic measures (bonuses paid at the time of sterilization, annulment of the income-tax reliefs after the birth of the *n*th child etc.); psychological measures (publicity and educational campaigns etc.); and action in respect of the socio-economic factors that determine fertility (education, improvement of the status of women, distribution of earnings etc.).[25]

The context in which such measures are taken is also indicated: (*a*) pro-natalist or anti-natalist policies; and (*b*) policies for individual well-being in countries that were satisfied with the existing rates. In most instances, the pro-natalist countries wanted to attain a higher rate of fertility, although some of them found the existing rates satisfactory. The anti-natalist countries, as a rule, wanted to see a lower fertility rate, but some of those countries might also have found their rates satisfactory; while countries that took action to improve individual well-being were on the whole satisfied with their rates, even though some of them might have desired a lower or a higher rate.

[25] Bernard Berelson, W. Parker Mauldin and Sheldon J. Segal, "Population: current status and policy options", Center for Policy Studies Working Paper No. 44, New York, The Population Council, May 1979.

As stated above in regard to the developed countries, it is not always easy to determine the primary purpose of fertility policies implemented by Governments, whether an action is designed first and foremost to change the fertility rate or rather to ensure the well-being of individuals and families. Whereas in most of the developed countries it would appear that Governments attempted to reconcile those two objectives and to keep them in balance, in the developing countries the emphasis appeared, as a rule, to be more definitely on one or the other of the two objectives. That situation was more particularly the case in the countries of Asia, where government policies in regard to fertility were implemented first of all for their incidence on growth rates. On the other hand, the situation was not always so clear-cut in many of the countries of Africa and Latin America, where at times the measures taken differed very little, regardless of whether the Governments had adopted a pro-natalist or an anti-natalist position.

Area of Responsibility of Economic Commission for Africa

In 1980, five out of 51 countries in the ECA area of responsibility expressed a wish for a higher rate and 22 for a lower rate, while 24 countries declared themselves satisfied with the existing rates. Few changes had taken place since 1978. The United Republic of Cameroon, which formerly had regarded its fertility rate as too low, currently considered it to be too high. Algeria, which in 1978 had been satisfied with the rate, also regarded it as too high in 1980. Those two countries were at the same time anxious for a lower growth rate, but they had not yet adopted any specific measures. Several countries that were satisfied with the rate had decided to implement a policy designed either to maintain the rate at its current level or to improve the conditions of individual well-being (see table 28). Thus, on an over-all basis, three out of five countries wanted to attain a higher rate and were consequently taking measures, as were the 14 countries out of 22 that preferred to see a lower rate. Among the countries that found the rate satisfactory, eight out of 24 were implementing policies to maintain it at its existing level.

All the countries that wanted to attain a higher fertility rate would at the same time welcome a higher growth rate. Only one, the Ivory Coast, stated that it was satisfied with the fertility level, but would like to see a higher growth rate—and it was hoping to attain that goal by action on components other than fertility, namely, mortality and migration. The fertility policies implemented by the former countries were thus directed towards an increase of the population, whereas the Ivory Coast had a double objective—to improve individual well-being and to take action on the components of growth.

Legal measures

One primary category of measures that Governments can put into action consists of legal measures in regard to access to modern methods of contraception, abortion and sterilization. Tables 19 and 20 indicate that 35 countries authorized and supported (25 countries directly and 10 countries indirectly) access to modern methods of contraception in 1980. Among those countries, 21 were anti-natalist countries and 14 were satisfied with the current rate. One Government,

TABLE 28. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE CURRENT FERTILITY LEVEL, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR AFRICA, JULY 1978–JULY 1980

	Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
	Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented* VI	*Total*
Number of countries in each category in 1978	3	3	2	23	7	12	50
Changes in perception							
Countries that left a category	—	United Republic of Cameroon	—	Algeria, Benin, Mali, Mauritania, Niger, Togo, Upper Volta	Rwanda	—	
Countries that entered a category	—	—	Benin, Mali, Mauritania, Niger, Togo, Upper Volta	—	Algeria, United Republic of Cameroon	Rwanda, Zimbabwe[a]	
Number of countries in each category in 1980	3	2	8	16	8	14	51

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a]Country that became independent during the period 1978–1980.

that of Comoros, although anti-natalist, authorized the distribution of contraceptives but provided no support. Five countries restricted access to contraceptives and 11 countries authorized it without the provision of any government support. Among the former five countries, three had a pro-natalist policy (Equatorial Guinea, Gabon and the Libyan Arab Jamahiriya), while two were satisfied with the rate—Chad (as of 1978) and Malawi. Of the 11 others, two were pro-natalist countries (the Central African Republic and Guinea) and nine found the rate satisfactory. Thus, there is no doubt that the pro-natalist countries restricted access to contraception while the anti-natalist countries favoured it. Those countries which found their rates satisfactory may be divided into two almost equal groups, which either favoured or restricted the distribution of contraceptives, and thus gave priority to the incidence of their policy on growth in the one case and on individual well-being in the other.

In the countries of the ECA area, the legal provisions in regard to abortion remained very restrictive. One single anti-natalist country, Tunisia, had authorized abortion "on request" since 1973; while only two others, Zambia since 1972 and the Congo in practice (both of them were satisfied with the rate), had authorized abortion for socio-economic reasons in the interests of individual well-being (see table 21). In Zambia, the law provided that pregnancy could be terminated if its continuation risked injuring the physical or mental health of children already born. Any request for abortion on socio-economic grounds or to protect the physical or mental health of the mother was invariably considered in the light of such factors as her age and the material conditions (current or future) of the family. In the Congo, where the law dated from 1810 and was no longer in application (a new bill was under discussion and abortion was practised frequently), abortion was authorized on the advice of a social worker if any further birth was likely to create difficult living conditions for the mother or her family.

In general, in the countries of Africa, legal provisions that authorized abortion in the case of danger to the mental health of the mother or risk of an abnormal birth, or for legal or juridical reasons, were rarely mentioned. On the other hand, all those countries, i.e. the 45 countries about which information is available, authorized abortion in order to save the life of the mother; and about 20 countries did so to preserve her physical health.

The penalties envisaged by the codes in the event of transgression of the law were, as a rule, very severe; but it is difficult to asertain whether they were actually applied. The penalties imposed for those who performed an abortion extended, on average, from two to 10 or 14 years in prison, with or without a fine. If the person who performed the abortion was a physician or a member of one of the medical professions, the penalties were still more severe and often involved suspension from professional activities, sometimes for life (e.g., in Chad). The penalties laid down for women who had abortions were less severe: imprisonment that extended from a few days (a fortnight in the United Republic Cameroon) to five or seven years. In one country, Liberia, under a law of 1979, abortion brought about by the pregnant woman herself was no longer a criminal offence, nor was any method she used to prevent nidation of the fertilized ovum. By way of example, it may be mentioned that in Tunisia the number of abortions was not high—21,000 in 1977, but the rate of abortion had risen from 3 per 1,000 women aged 15-44 years to 10.9 per 1,000

in the year following the liberalization of abortion (1974), and by 1977, it had reached 16.8 per 1,000.[26]

Voluntary sterilization was still very little practised in Africa; and as of 1980, few countries had liberalized it. In 1978, the number of couples who had been sterilized for contraceptive reasons was estimated at 1 million, as against 0.5 million in 1970.[27] With regard to voluntary sterilization, seven countries authorized sterilization "on request", one only for socio-economic reasons and three for reasons of birth control (see table 22).

Sterilization was authorized "on request" in Ethiopia, a country which was satisfied with its growth rate, and also in Uganda, an anti-natalist country; but the legal provisions were extremely restrictive. In Ethiopia, the mother must be over 35 years of age, she must already have at least five children living, and her social and economic conditions must involve hardship. In Egypt, an anti-natalist country, although the legal situation was not clearly defined, sterilization was in practice authorized "on request", if the woman was at least 35 years old and had at least three children living, including one male child. In Tunisia, likewise an anti-natalist country, the Government encouraged sterilization and had declared it to be an acceptable means of limiting the family. It was authorized "on request" if the woman had at least four children. The number of couples sterilized in Tunisia was estimated in 1965 at 3,000 and in 1977 at 40,500. In 1965, 2.7 per cent of those who had accepted family planning services used sterilization as a means of contraception; and the proportion had risen to 11.3 per cent in 1976, after having reached a peak of 21.2 per cent in 1974.[28] In Southern Africa, sterilization was authorized "on request" in Botswana and in another anti-natalist country, South Africa. The legal provisions in both those countries required that applicants must give their full consent, must have reached maturity, and must provide full information on the outcome of the operation. Most Governments that had liberalized abortion or sterilization, or that authorized them in practice were anti-natalist. A few, however, were countries that were satisfied with their growth rate (the Congo, Ethiopia and Zambia), but none of them was pro-natalist.

Other legal measures that could have a significant effect on fertility had also been taken by a number of Governments, particularly in anti-natalist countries. Mention may be made of changes in the legal minimum age at marriage, particularly of women, which was 17 years in Tunisia (since 1974), 16 in Lesotho (1974), 15 in Mauritius (1976) etc.[29] Another type of legal measure taken by certain countries was the prohibition of polygamy, as in Tunisia, or at any rate its discouragement.

Technical measures

As stated above, in the countries of the ECA area, legal measures constituted a valuable tool in the hands of Governments. Up to 1980, only a few countries had introduced other types of measures, technical measures in particular. In the pro-natalist countries, especially those faced with subfertile population problems (for example, in the equatorial and western areas of Africa), policies were geared to improvements in health conditions and rural development, as in the Congo and Gabon. On the other hand, in the United Republic of Tanzania, where the goal of the fertility policy was to improve the well-being of families, a vast programme of "village settlement" had been undertaken to bring a dispersed population together and to settle the people in villages and thus to give them an administrative, economic and cultural infrastructure. Each village had a maternal and child health service, which was responsible, among other things, for improving conditions of hygiene and nutrition, and also for all other questions relating to birth control.[30]

In the anti-natalist countries, birth control programmes were as a rule integrated into the health services, particularly the maternal and child health services. Table 29 shows, for selected countries in various years, the proportion of the national budget represented by the budget of the Ministry of Health; and the proportion that the Ministry devoted to birth control programmes. It may be noted that in Mauritius, 10 per cent of the national budget was earmarked for the Ministry of Health, which spent 5 per cent of that sum on birth control programmes. On the other hand, in the United Republic of Tanzania, the proportion of the budget earmarked for those programmes was extremely low.

Governments are tending more and more to give local communities the responsibility for the implementation of birth control programmes, for publicizing the idea of smaller families, for recruiting acceptors, for distributing contraceptives etc. Social groups, associations, the industrial sector and other bodies are playing a similar role. In Tunisia, large firms, such as the railways, included family planning as part of the social programme devised for the benefit of their personnel; and the law required small firms that grouped together for that purpose to include a birth control clinic in their dispensaries.[31]

In several countries, the responsibility for birth control services was entrusted to paramedical personnel, especially midwives, who, on the whole, had the full confidence of the women, especially in rural areas. In the United Republic of Cameroon, Ghana,[32] Kenya, Liberia, Senegal[33] and Sierra

[26] Christopher Tietze, *Induced Abortion: 1979*, 3rd ed., A Population Council Fact Book (New York, The Population Council, 1979); and *Demographic Yearbook, 1978* (United Nations publication, Sales No. E/F.79.XIII.1).

[27] C. P. Green, *op. cit.*; and R. T. Ravenholt, *op. cit.*

[28] Jean-Paul Sardon, "La stérilisation dans le monde. I. Aperçus médicaux et législatifs: revue et synthèses; II. Données statistiques", *Population* (Paris), vol. 32, No. 2 (March-April 1977), pp. 411-437; and vol. 34, No. 3 (May-June 1979), pp. 607-636, respectively.

[29] Alice Henry and Phyllis T. Piotrow, *Age at Marriage and Fertility*, Population Reports, Series M, No. 4 (Baltimore, Maryland, Johns Hopkins University, November 1979).

[30] *National Experience in the Formulation and Implementation of Population Policy: United Republic of Tanzania, 1960-1976* (ST/ESA/SER.R/28).

[31] The way in which local communities and some private community groups were associated in the government birth control programmes is what is known as "community participation" in the programmes. Margaret Wolfson, *Changing Approaches to Population Problems* (Paris, Organisation for Economic Co-operation and Development, Development Centre, 1979).

[32] *National Experience in the Formulation and Implementation of Population Policy: Ghana, 1970-1976* (ST/ESA/SER.R/27).

[33] *Population Policy Compendium: Senegal*, situation as assessed in, a joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities (New York, 19):

TABLE 29. PROPORTION OF THE NATIONAL BUDGET EARMARKED FOR HEALTH AND BIRTH CONTROL PROGRAMMES, SELECTED DEVELOPING COUNTRIES

(Percentage)

Country	*Year*	*Proportion of national budget earmarked for birth control programmes*	*Proportion of Ministry of Health budget earmarked for birth control programmes*	*Proportion of national budget earmarked for Ministry of Health*
Bangladesh	1976	2.4	...	...
Bolivia	1976	0.0001	0.12	1.1
Dominican Republic	1977	0.17	1.2	14.4
El Salvador	1977	0.7	6.2	11.2
India	1978	0.52	11.1	4.7
Indonesia	1978	0.2	23.2	1.0
Malaysia	1978	0.11	...	...
Mauritius	1978	0.6	5.2	10.9
Philippines	1978	0.4	11.8	3.6
Republic of Korea	1978	0.18	16.1	1.11
Singapore	1979	0.1	1.5	4.8
United Republic of Tanzania	1977	0.05	0.77	6.4

Source: Dorothy L. Nortman and Ellen Hofstatter, *Population and Family Planning Programs: A Compendium of Data through 1978,* 10th ed., A Population Council Fact Book (New York, 1980).

Leone, programmes had been set up, in some cases on a simple experimental basis, but in others on a country-wide scale, with a view to utilizing the services of midwives as agents of the birth control services.[34] Egypt had made a valiant effort to extend the network for the distribution of contraceptives through commercial and non-commercial outlets.

Economic incentives and disincentives

Economic measures designed to encourage or dissuade were being little used in the ECA area, especially if one compares that area with the ESCAP area. Some of the pro-natalist countries had introduced incentives of a financial type, comparable to those found in the developed countries. For example, in Gabon (Act of 1975) and in the Congo (1956), family allowances were granted to workers, with a special system for government employees. Family allowances were paid for children up to 16 years of age (17 if they were apprentices or 20 if they were students), together with pre-natal allowances and childbirth bonuses.[35] But in most countries where such allowances were paid, they were perceived to have social rather than demographic significance, unlike the situation in the developed countries, where demographic and social justice goals were distinctly more marked. In anti-natalist countries, the simplest type of incentive—and also the oldest—was the free distribution of contraceptives; and government subsidies, full or partial, for the cost of abortion and sterilization, in those countries which authorized such measures.

Table 30 indicates, in respect of a number of countries, the services offered free of charge or at a low cost. As can be seen, most countries did not charge for the insertion of an intra-uterine device or for the distribution of condoms, while contraceptive pills were sold at very low prices. Few countries in Africa authorized voluntary sterilization, as mentioned above. In addition to free or low-cost services, many countries offered a cash bonus to those who agreed to practise contraception, in order to encourage them to accept it and to persevere in its use. Some countries (e.g., Botswana and Tunisia) also offered a cash bonus to those who distributed contraceptives and even to those who supplied contraceptive products. In Mauritius, a bonus was being offered to agents who distributed birth control devices, but the bonus was paid in two instalments with a six-month gap; the second instalment was forthcoming only if the person recruited persevered in the use of contraceptives.

Along with those incentives, some Governments employed disincentive measures. In Tunisia, for example, the family allowance system was restricted and on a descending scale from the first to the fourth child, with 18 per cent of the wage for first child, then 16 per cent, 14 per cent and 12 per cent for the fourth child.[36]

Psychological measures

Several anti-natalist countries of Africa had initiated publicity campaigns designed to influence the motivation of couples in favour of smaller families. Educational programmes also had been launched for the benefit of adults and young people, through the formal and informal education systems. The problems of the interrelationship between population and economic and social development, health, environment etc. formed part of the school curriculum in Egypt, Kenya and Tunisia.[37]

Action in respect of socio-economic determinants of fertility

One final approach is action on the socio-economic factors that determine fertility, such as education, health, employment, the distribution of income and improvement in the status of women. Efforts to integrate programmes into the general strategy of development had been undertaken by

[34] May-Ling Simpson-Hebert and others, *Traditional Midwives and Family Planning*, Population Reports, Series J, No. 22 (Baltimore, Maryland, Johns Hopkins University, May 1980).

[35] United States of America, Department of Health and Human Services, Social Security Administration, Office of Policy, Office of Research and Statistics, *Social Security Programs throughout the World, 1979*, Research Report No. 54 (Washington, D.C., 1980).

[36] *Ibid.*

[37] M. Wolfson, *op. cit.*

TABLE 30. DIRECT FINANCIAL INCENTIVES OFFERED TO PERSONS USING CONTRACEPTIVE METHODS, SELECTED DEVELOPING COUNTRIES

Area of responsibility of regional commission and region	*Contraceptive methods*			
	Intra-uterine device	*Pill*	*Sterilization*	*Condoms and other devices*
ECA area				
Botswana	F	LC	LC	LC
Egypt	F, I	LC, I	NP	LC
Ghana	F	LC	NP	LC
Kenya	F	F	NP	F
Mauritius	F, I	F, I	NP	F
Morocco	F	F	NP	F
Tunisia	F, I	F	F, I	F
ESCAP area				
Bangladesh	F, I	F	F, I	F
China	F	F	F	F
Fiji	F	LC	F	LC
India	F, I	...	F, I	F
Indonesia	F	F	F	F
Iran	F	F	F	F
Malaysia	F	LC	F	F
Nepal	F, I	F	F, I	F
Pakistan	F	LC	F	LC
Philippines	F	F	...	F
Republic of Korea	F, I	LC	F, I	LC
Singapore	LC	LC	LC	F
Sri Lanka	F	LC	F	LC
Thailand	F	F	LC	F
Turkey	F	...	...	...
ECLA area				
Colombia	F	F	...	F
Dominican Republic	F	F	...	F
El Salvador	F	F	...	F
Guatemala	LC	LC	...	...
Jamaica	F	LC	...	...
Mexico	F	F	...	F

Source: Chai Bin Park, "Incentives and disincentives in population programmes", *The Role of Incentives in Family Planning Programmes,* A Report of UNFPA/EWPI Technical Working Group Meeting on the Role of Incentives in Family Planning Programmes, East-West Center, Honolulu, Hawaii, 15-16 May 1979, Policy Development Studies No. 4 (New York, United Nations Fund for Population Activities, 1980), table 1, pp. 32-33.

Note: F = free programme; LC = low-cost services provided; NP = no programme; I = incentives to accept the programme.

several countries, and some—for example, Egypt and Tunisia—had set up for that purpose a national population committee directly under the authority of the Prime Minister or the Minister of Planning. In Egypt, integration had been carried a considerable way. One strategy consisted of introducing, at the local level, the population component in all economic and social development activities. The Egyptian Population and Family Planning Committee had identified nine variables on which action should be taken with a view to the improvement of living conditions and the reduction of fertility, two closely interdependent goals. Among those variables, mention may be made of the socio-economic level of the family, female labour, mechanization of agriculture and industrialization, reduction of child mortality, education etc., and family planning services as an integral element in the social services in general.

Area of responsibility of Economic Commission for Latin America

In 1980, four out of 30 countries in the ECLA area of responsibility wanted a higher fertility rate and 15 desired a lower rate, while 11 countries stated that they were satisfied with the existing level. Little change had occurred since 1978. Chile had changed its perception of the natural growth of the population: in 1978, it had regarded the fertility rate as too high; and in 1980, it considered it too low. During the same period, some countries had decided to introduce policies either with a view to maintaining the rate at its current level or improving conditions of individual well-being, or in order to modify the rate because it was too high (see table 31). In 1980, three countries out of the four that wanted a higher rate and 13 of the 15 that desired a lower rate, as well as two countries out of the 11 that expressed satisfaction with the rate,[38] had introduced policies on the subject.

The four countries that were seeking a higher fertility rate were at the same time anxious to have a higher growth rate. Paraguay was the only country in the ECLA area that would like to increase the growth rate while at the same time it stated that it was satisfied with the fertility rate; it relied on other demographic variables, such as international migration, to attain its goal.

[38] Valeria Ramírez and Fernando Toro, under the supervision of Gerardo González, "La política de población en América Latina, 1974-1978", Santiago, Chile, Latin American Demographic Centre (CELADE) (mimeographed).

TABLE 31. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE CURRENT FERTILITY LEVEL, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR LATIN AMERICA, JULY 1978–JULY 1980

	Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
	Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented* VI	*Total*
Number of countries in each category in 1978	3	—	—	11	5	8	27
Changes in perception							
Countries that left a category	—	—	—	Panama Colombia	Bahamas Costa Rica Chile	—	
Countries that entered a category	—	Chile	Panama Colombia	—	—	Bahamas Costa Rica Dominica[a] Saint Lucia[a] Saint Vincent and the Grenadines[a]	
Number of countries in each category in 1980	3	1	2	9	2	13	30

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Country that became independent during the period 1978-1980.

Legal measures

Tables 19 and 20 show that 25 Governments authorized and supported (24 countries directly and one indirectly) access to and distribution of contraceptive devices. Of those countries, 15 were anti-natalist and nine were satisfied with the current rate. Chile was the only pro-natalist country that authorized and supported access to modern methods of contraception. Although Peru desired a lower growth rate, it had, nevertheless, recently withdrawn its direct support of modern contraceptive methods, which were only dispensed in government centres. Of the pro-natalist countries, Uruguay restricted access to contraceptives, and Argentina and Bolivia authorized it but without government support. The same attitude was held by Guyana and Suriname, both of which found the rate satisfactory. The Governments of the countries of Latin America, like those of Africa, thus used legal measures to support their policies. The anti-natalist countries authorized and supported access to contraceptive devices, while the pro-natalist countries limited or did not support the distribution of contraceptives.

Legislation on abortion was still very restrictive, whatever the general trend in the fertility policy, whether it was anti-natalist, pro-natalist or otherwise (see table 21). Cuba, a country satisfied with its rate of fertility, authorized abortion "on request". The Bahamas, an anti-natalist country, and Uruguay, a pro-natalist country, both authorized it for socio-economic reasons, although those reasons were interpreted in a fairly restrictive manner. Virtually all the countries of Latin America authorized abortion in order to save the life of the mother, but only 13 countries did so for reasons of risk to health.

However, the penalties laid down in the law were, on the whole, distinctly less severe than those in Africa: from one to three years imprisonment, and often less. In addition, a variety of extenuating circumstances could reduce the penalties still further—in order to save the reputation of a woman who had become pregnant as a result of illicit relations (adultery) in Mexico, or of criminal relations (incest or rape) in Colombia; or where abortion was required for reasons of serious economic hardship, as in Uruguay. In some countries, the penalties were adjusted according to the length of pregnancy. In Costa Rica, for example, the penalty laid down for the person who induced an abortion or the aborting woman was imprisonment for from one to three years, but the penalty was reduced to from six months to two years if the foetus was under six months. By way of example, it may be mentioned that in Cuba, there had been 121,000 abortions in 1976, or an abortion rate of 61 per 1,000 women aged 15-44 years. The abortion rate had constantly increased up to 1974, when the figure was 69.5 per 1,000, but it appeared to have been decreasing since then.[39]

Voluntary sterilization had been liberalized on a far wider scale than abortion, especially in the anti-natalist countries of the Caribbean and Middle America. Table 22 indicates that 11 countries authorized it "on request", and one did so for socio-economic reasons. In the Caribbean region, five countries—Barbados, Cuba, the Dominican Republic, Jamaica, and Trinidad and Tobago—authorized voluntary sterilization "on request". However, in Cuba and Jamaica, the legal provisions were restrictive. In Cuba, the woman must be 32 years of age and must have several children; and in Jamaica, she should preferably be at least 35 years of age. It

[39] C. Tietze, *op. cit.*

would appear that in Jamaica, sterilization was becoming increasingly common. In any event, it was encouraged, as tubal ligations performed in government hospitals were free of charge. In the Dominican Republic, the law provided for a very explicit adjustment of the conditions—the woman must be at least 40 years of age with at least one child, or 35 with at least three children, 30 with at least five children, or 25 with at least six children.

In Middle America, voluntary sterilization was legal in all countries but Nicaragua; and on the whole, there were relatively few restrictions. In Tropical South America, five countries out of nine authorized sterilization (Brazil, Colombia, Ecuador, Guyana and Peru), but the law also imposed restrictions in some of those countries. In Colombia, the woman must be 35 years of age and have more than two children, at least one of each sex; in Ecuador, she must be 25 years of age and have at least three children. All the pro-natalist countries (Argentina, Bolivia, Chile and Uruguay) prohibited voluntary sterilization. In Latin America as a whole, 4 million couples had been sterilized for contraceptive reasons as of 1978, as against 0.5 million in 1970.[40] There had been, for example, 21,000 sterilizations in Colombia (1977), 70,000 in El Salvador (1977), 3,000 in Guatemala (1977) and 55,000 in Mexico (1976).

The relative incidence of sterilization, as compared with other means of contraception, varied from one country to another and within the same country from one year to another. Thus, in Costa Rica in 1976, 6.9 per cent of the persons who accepted the family planning services were sterilized, as compared with 1.1 per cent in 1973. In Jamaica, the increase had been constant, from 4.8 per cent in 1972 to 11.8 per cent in 1975. In Puerto Rico, the proportion was 16.9 per cent in 1975; and in El Salvador, 27.5 per cent. In Panama, on the other hand, the proportion fell from 23.9 per cent in 1972 to 5.3 per cent in 1975.[41]

With regard to other legal measures that can have a significant effect on fertility, some countries had changed the minimum legal age at marriage or had codified it. In Barbados, for example, the age had been fixed in 1976, at 16 years for males and 14 years for females.[42]

Having examined the way in which legal measures fit into the sometimes contradictory perspectives on pro-natalist or anti-natalist policies, the discussion now turns to the other types of measures instituted by Governments to alter or to maintain the fertility level.

Technical measures

Some of the anti-natalist countries in the ECLA area implemented a broad range of technical measures. Several countries were trying to integrate birth control programmes; and as in the other areas, the responsibility for the management and publicizing of programmes fell to the Ministry of Health. Table 29 indicates that in El Salvador, for instance, the Ministry of Health received 11 per cent of the national budget in 1977; and over 6 per cent of that budget (0.7 per cent of the national budget) was devoted to birth control programmes.

In comparison with that example, the share of the budget received by the Ministry of Health in the Dominican Republic, a country that was satisfied with its fertility rate, was higher than that of El Salvador, but the proportion devoted to birth control programmes was lower (1.2 per cent). Similarly, in Costa Rica, all the activities and birth control programmes were entrusted to the Maternal and Child Health Division of the Ministry of Health.[43] In Haiti, the President stated in April 1979 that the Government would like to see small families and that birth control programmes were a priority in the national health plan.[44] In Mexico, that type of programme integration was one of the goals of the 1977-1982 development plan. All the public health services were required to include birth control programmes in their activities. The Government, which was anxious to provide the public with access to modern methods of contraception, encouraged local communities to participate actively in the birth control programmes.[45] The Government was also endeavouring to introduce the practice of contraception in community groups, such as the army, and government and semi-government institutions. As another technical measure, several countries were making efforts to "de-medicalize" contraception, and were tending more and more to hand over the responsibility for birth control services to paramedical staff. Midwives, specially trained for the purpose, were used as staff by those services in Costa Rica, El Salvador, Haiti and Mexico.[46]

The distribution or sale of contraceptives through non-commercial and commercial outlets, modern or traditional, was another aspect of intervention by Governments. In Mexico, the Government had undertaken a vast campaign for the marketing of contraceptives so as to make them accessible everywhere in the country at low prices. A fleet of trucks was used to distribute them to retail shops, such as supermarkets, grocery stores, state emporium and general stores in country areas.[47] Contraceptives were provided to military personnel, railway workers, the staff of the Federal Electricity Commission, the National Petroleum Company etc.[48]

Colombia provides another good example of diversification of the distribution networks for contraceptive products.[49] The Ministry of Health and Profamilia, a private family planning organization, shared between them 90 per cent of the birth control and contraceptive supply services. Medical practitioners and the commercial sector coped with the rest, especially in urban centres. Since 1965, contraceptives had been generally available in the towns and the coffee plantation regions.

[40] C. P. Green, *op. cit.*; and J.-P. Sardon, *loc. cit.*
[41] J.-P. Sardon, *loc. cit.*
[42] A. Henry and P. T. Piotrow, *op. cit.*

[43] Dorothy L. Nortman and Ellen Hofstatter, *Population and Family Planning Programs: A Compendium of Data Through 1978*, 10th ed., A Population Council Fact Book (New York, The Population Council, 1980).
[44] *Ibid.*
[45] International Planned Parenthood Federation, *Family Planning in Mexico: A Profile of the Development of Policies and Programmes* (London, n.d.).
[46] M.-L. Simpson-Hebert, *op. cit.*
[47] International Planned Parenthood Federation, *op. cit.*
[48] *National Experience in the Formulation and Implementation of Population Policy, 1960-1976: Mexico* (ST/ESA/SER.R/18).
[49] Dorothy L. Nortman, "Factors influencing government provision of family planning services", New York, The Population Council, unpublished document.

Economic incentives and disincentives

The pro-natalist developing countries encouraged fertility by means of incentives in the form of direct and indirect economic benefits. In Argentina, for example, direct benefits consisted of the grant of bonuses payable on marriage and on the birth of children (or adoption of a child). Family allowances were paid to families whose children attended school up to secondary level, and the allowances varied with the number of children—there was a supplement from the third child onward. Among the indirect benefits may be mentioned housing facilities for families, day nurseries and kindergartens for working mothers, flexibility in working conditions to make them compatible with maternity, etc.[50] Brazil, which stated that it was satisfied with the rate and officially desired to maintain it at its current level, was taking action to protect individual well-being and freedom.[51] The Ministry of Health had set up a programme to improve the medical conditions surrounding childbirth and birth control services had been devised and integrated into nutrition programmes. Contraceptive devices were available, but they were subject to control (the pill was obtainable for the period of a year on medical prescription).[52]

Several of the anti-natalist countries in the region provided free distribution of contraceptives and subsidized, entirely or in part, the cost of abortion and sterilization, where those methods were legally authorized. Table 30 gives some details about this type of direct financial incentive, which can also be used by countries satisfied with their rates, in order to ensure individual well-being. That use applied, among the countries used as examples, to Colombia, the Dominican Republic and Guatemala. It should be noted that the State virtually assumed the cost of IUD insertions and the distribution of the pill and condoms. As has already been mentioned, few countries in the region authorized sterilization.

Psychological measures

Some Governments, Mexico in particular, had launched psychological persuasion campaigns, and education and publicity programmes addressed to young people and adults with a view to encouraging them to have fewer children. The appeal of the Government of Mexico for "responsible parenthood" reflected the State's demographic concern and at the same time forced parents to consider their responsibilities as educators.[53] A programme for training and guidance in regard to birth control had been established for medical practitioners, midwives, nurses and paramedical personnel. It was also intended for social workers, community development experts, civil servants etc. The Ministry of Education was working with the other ministerial departments responsible for rural matters and had taken over, in particular, the task of preparing the necessary materials. It was also responsible for preparation of a special programme for the benefit of young people, to be publicized through the formal education system.

Action taken in regard to socio-economic determinants of fertility

Relatively few countries in the ECLA area had explicity considered the potential effects of intervention on the socio-economic factors that determine fertility. Several countries had introduced policies intended to improve health conditions, nutrition and health in general. Others concentrated on education and rural development, while some were also trying to improve the status of women (e.g., Mexico).[54] Cuba, a country that was satisfied with its growth rate, had geared its policy essentially to the establishment of social and economic conditions calculated to influence reproductive behaviour, e.g., improvement of standards of education (compulsory for children), through special programmes for adults; the urbanization of rural zones through the establishment of social services and development projects; the development of small urban communities; the reduction of discrepancies between earnings in towns and in the country; improvement of the status of women and an increase in their participation in the economy through educational programmes, political mobilization and voluntary participation; legalization of the family code, free access to birth control methods, and more recently the admission of women into the labour force. In addition to those measures, there was the introduction of a vast government programme in the field of health, including a national campaign for education in maternal and child care (the health aspect that derives from birth control) and easier access to contraceptives and abortion. In 1977, the legal abortion ratio, which measures the proportion of pregnancies ending in legal abortions,[55] was 420 per 1,000 pregnancies, the highest rate recorded anywhere in the world during the 1970s.[56]

Area of responsibility of Economic Commission for Western Asia

As is shown in table 32, no country in the ECWA area of responsibility had changed its perception since 1978. Thus, the situation remained as follows: only one country (Iraq) wanted to see a higher rate; two countries (Bahrain and Jordan) desired a lower rate, and the other nine countries said that they were satisfied with the current fertility rate. Iraq and five other countries that found the rate satisfactory had introduced policies with a view to modifying or maintaining the level of fertility, while the two countries that would like to see a lower rate did not propose to take action at that time. Yet, Iraq was satisfied with its growth rate, whereas Oman, Qatar, Saudi Arabia and the United Arab Emirates expressed satisfaction with the fertility level, but wanted to see a higher growth rate.

[50] *Population Policy Compendium: Argentina*, situation as assessed in January 1979, a joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities (New York, 1979).

[51] It would appear, however, that the Government recently has been expressing some concern about the effects of a high current fertility level, but the official attitude has remained the same to date.

[52] D. L. Nortman and E. Hofstatter, *op. cit.*

[53] M. Wolfson, *op. cit.*

[54] International Planned Parenthood Federation, *op. cit.*

[55] The number of legal abortions per 1,000 pregnancies (abortions plus live births occurring during the 12-month period beginning six months after the year in which the abortions were registered).

[56] Paula E. Hollerback, "Recent trends in fertility: abortion and contraception in Cuba", Center for Policy Studies Working Paper No. 61, New York, The Population Council, September 1980.

TABLE 32. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE CURRENT FERTILITY LEVEL, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR WESTERN ASIA, JULY 1978–JULY 1980

	Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
	Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented* VI	*Total*
Number of countries in each category in 1978	1	—	5	4	2	—	12
Changes in perception							
Countries that left a category	—	—	—	—	—	—	
Countries that entered a category	—	—	—	—	—	—	
Number of countries in each category in 1980	1	—	5	4	2	—	12

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

Legal measures

Access to and distribution of means of contraception, the primary type of legal measures at the disposal of Governments, were authorized and directly supported by four countries in the ECWA area and indirectly by two (see tables 19 and 20). Two of those countries were anti-natalist and four were satisfied with their rate. Saudi Arabia, which was satisfied with its rate, was the only country in the area to prohibit access to contraceptive methods. Among the five countries that authorized it but did not provide any support, Iraq was pro-natalist and the other four countries found the rate satisfactory. Thus, in the countries of the ECWA area, as in those of the ECA and ECLA areas, restrictions on access to and distribution of means of contraception were used as a measure by the pro-natalist countries, whereas the anti-natalist countries authorized and supported the use of contraceptive methods. Half the countries that expressed satisfaction with the rate supported the distribution of contraceptives, whereas the other half simply authorized it.

Abortion and sterilization were not widespread in the ECWA area. Islamic religious law was in force practically everywhere, and it only authorizes abortion where the life of the mother is in danger (see tables 21 and 22). In Jordan, the civil law authorized abortion in the event of risk to the mother's health. Sterilization was not forbidden, but religious beliefs oppose it in practice, except for medical reasons or in the case of hereditary or other malformations of the foetus. In Lebanon, although the civil law was not particularly explicit, sterilization was encouraged by family planning associations and was practised in fact "on request", but the woman must be at least 30 years of age and have at least three children.

Other measures

Apart from very restrictive legal measures, as mentioned above, few countries in the ECWA area had introduced other measures, although one country, Iraq, desired a higher rate and two wanted a lower rate. In Iraq, family benefits were paid to families, especially wage earners: a childbirth bonus; family allowances; and maternity leave on full pay for 10 weeks, with a possible extension to nine months in the event of complications (at 75 per cent pay), for women who worked. Education and information programmes were implemented through the maternal and child health services.[57] Saudi Arabia, which wanted to maintain its current fertility level, had introduced similar measures.[58] The Syrian Arab Republic, which would like to control the spontaneous trend of the rate, encouraged the spacing of births by means of education and information programmes, development of maternal and child health services, and improvement of the status of women (by way of integration into the work-force etc.).[59]

Area of responsibility of Economic and Social Commission for Asia and the Pacific

In 1980, two of the 30 developing countries in the ESCAP area of responsibility wanted to attain a higher rate, 19 desired a lower rate, and the other nine expressed satisfaction with the current rate. There had been no major change in attitude since 1978 (see table 33). The Lao People's Democratic Republic, a pro-natalist country, applied policies designed to increase the rate,[60] while the overwhelming majority of the countries (18 out of 19) that wanted to have a lower rate did so in order to reduce it. Half of the countries that expressed satisfaction with the rate also took measures, but rather to maintain fertility at its current level or to improve individual well-being.

The Lao People's Democratic Republic, which wanted to increase its growth rate, relied on a higher fertility level to attain its goal. On the other hand, some countries that were satisfied with the current fertility rates but wanted to see a

[57] *Population Policy Compendium: Iraq*, situation as assessed in March 1980 (New York, 1980).

[58] *Population Policy Compendium: Saudi Arabia*, situation as assessed in March 1980 (New York, 1980).

[59] *Population Policy Compendium: Syrian Arab Republic*, situation as assessed in February 1980 (New York, 1980).

[60] Up to 1978, Democratic Kampuchea had wanted to attain a higher rate.

TABLE 33. CHANGES IN GOVERNMENTS' PERCEPTIONS CONCERNING THE CURRENT FERTILITY LEVEL, COUNTRIES IN AREA OF RESPONSIBILITY OF ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC, JULY 1978–JULY 1980

	Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
	Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
	Intervention to raise rates appropriate, and incentives and disincentives implemented I	*Intervention not appropriate; neither incentives nor disincentives implemented II*	*But incentives and disincentives implemented to maintain rates III*	*Intervention not appropriate; neither incentives nor disincentives implemented IV*	*Intervention not appropriate; neither incentives nor disincentives implemented V*	*Intervention to lower rates appropriate, and incentives and disincentives implemented VI*	*Total*
Number of countries in each category in 1978	2	—	3	8	1	16	30
Changes in perception							
Countries that left a category	—	—	—	Malaysia Singapore	—	—	
Countries that entered a category	—	—	Singapore Malaysia Kiribati[a]	—	—	Solomon Islands[a] Tuvalu[a]	
Number of countries in each category in 1980	2	—	6	6	1	18	33

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Country that became independent during the period 1978–1980.

higher growth rate relied on other factors to attain that end: the Democratic People's Republic of Korea and Mongolia relied on a decline in the death rate; Bhutan and Nauru relied on international migration.

Legal measures

Tables 19 and 20 show that in the ESCAP area, 26 Governments of developing countries authorized and directly supported access to and distribution of contraceptive devices. Nineteen of those countries were anti-natalist and seven were satisfied with the rate. The only two countries that restricted access were the two pro-natalist countries of the area. Malaysia and Maldives, which were satisfied with their current rate, authorized the use of contraceptives, but their Governments did not support distribution. As in the other less developed regions, access to contraceptive methods was determined by the type of government policies—pro-natalist or anti-natalist.

With regard to the legal measures relating to abortion and sterilization, there is no doubt that among the developing countries, the largest proportion of those which had liberalized abortion, and especially voluntary sterilization, were found in the ESCAP area.

Three countries—China, India and Singapore—authorized abortion "on request" (see table 21). In China, abortion was encouraged and facilitated by the Government and was practised on a broad scale as a birth control method. After an abortion, a woman had the right to 14 days of sick leave with pay (30 days if the abortion took place when she was more than three months pregnant). The legislation, which dated from 1979, was one of the rare instances in the world where abortion was encouraged beyond three months of pregnancy. In India, the law authorized abortion in the event of pregnancy that resulted from the failure of the contraceptive method used by either the man or the woman. For that reason, that type of abortion is considered here to be authorized "on request".

Three countries—the Democratic People's Republic of Korea, Fiji and Iran (in 1978)—authorized abortion for socio-economic reasons interpreted in a fairly broad manner. Ten countries authorized abortion in order to preserve the mental health of the mother, but the interpretation given to that provision would appear to be very broad. In Bangladesh, Indonesia and Pakistan, abortion had not been liberalized, even though the countries were anti-natalist. In India and in Singapore, the number of abortions was constantly growing, but whereas in the former country it was based on a method used relatively little (in 1977, there were 278,000 abortions and an abortion rate of 2.2 per 1,000 women aged 15-44 years), in Singapore, the abortion rate was 28.4 as against 4.1 in 1970.[61] In the Republic of Korea, even though abortion had not been liberalized, there were over 330,000 operations in 1970, a figure that represented an abortion rate of 50.1 per 1,000 women between 15 and 44 years of age.[62]

As already mentioned, voluntary sterilization had been liberalized on a large scale in the ESCAP area. Nine countries authorized it "on request", two for socio-economic reasons and four for birth control purposes (see table 23). In China, sterilization was essentially regarded as a means of regulating births. It was greatly encouraged by the authorities and was authorized unconditionally. A whole medical infrastructure had been set up, with mobile units and paramedical staff, to make sterilization accessible to the largest possible number.[63] The Republic of Korea likewise encouraged sterilization on a large scale as a method of birth control.[64]

[61] C. Tietze, *op. cit.*; *Demographic Yearbook, 1977* (United Nations publication, Sales No. E/F.78.XIII.1); and *Demographic Yearbook, 1978*.

[62] *Ibid.*

[63] "Population", *China News Analysis*, No. 1163 (14 September 1979).

[64] *Population Policy Compendium: Republic of Korea*, situation as assessed in November 1980 (New York, 1980).

In Eastern South Asia, voluntary sterilization was legal in Malaysia, the Philippines, Singapore and Thailand, for socio-economic and contraceptive reasons. In Middle South Asia, it was authorized everywhere except in Afghanistan and Iran.[65] It was also authorized in Fiji. In several countries of the ESCAP area, not only was the law very liberal, but measures of persuasion and dissuasion were applied to encourage couples to be sterilized. State programmes supported by vast publicity campaigns and what can really be called "action strategies" had been set up, as is shown below.

In 1978, it was estimated that 36 million couples had been sterilized in China, as against 4 million in 1970; 22 million in India, as against 7 million in 1970; and 4 million in the other countries of Asia, including 405,000 in Bangladesh (1977), 42,000 in Indonesia (1977), 27,000 in Malaysia, 39,000 in Nepal (1977), 90,000 in the Philippines (1977), 530,000 in the Republic of Korea, 48,000 in Singapore (1977), 122,000 in Sri Lanka (1976) and 395,000 in Thailand (1977).[66]

Among the acceptors of family planning services, the proportion of those who accepted sterilization was higher in the countries of Asia than anywhere else.[67] Thus, in 1976, the proportion had been 4.9 per cent in Bangladesh, 65.1 in India, 5.2 in Malaysia, 9.7 in Nepal, 0.5 in Pakistan, 7.4 in the Philippines, 25.3 in Singapore and 20 in Thailand. According to the country, the relative extent of sterilization as a means of contraception varied. In Bangladesh, Sri Lanka and Thailand, the upward trend had been constant over the preceding few years; whereas in such countries as India and Nepal, the proportion had fallen off but had been rising again more recently.

All the countries that had liberalized abortion, and sterilization in particular, were anti-natalist or were satisfied with the current fertility rate. In the two pro-natalist countries of the ESCAP area, abortion and sterilization were prohibited or no information was available. However, some anti-natalist countries, such as Bangladesh, Indonesia and Pakistan, had not liberalized abortion, as mentioned above.

As another legal measure, several countries in the ESCAP area had modified or legalized the minimum age for marriage. Nepal (in 1975) and Sri Lanka (in 1978) had established the minimum age at marriage at 18 years for males and 16 years for females.[68] More recently, China had proposed that the minimum age be fixed at 22 years for females and 23 years for males.

Technical measures

With respect to the technical measures adopted by anti-natalist countries and certain countries that were satisfied with the fertility rate but continued to take measures to reduce it further, most countries integrated their birth control programmes with the work of the Ministry of Health, as was found in the other less developed regions. Table 29 shows, for several countries in the ESCAP area, the proportion of the national budget devoted to health and to birth control programmes. In Indonesia and the Republic of Korea, the budget of the Ministry of Health represented only a modest part of the national budget, but nearly 25 and 16 per cent, respectively, of that budget was devoted to birth control programmes. In a general way, the maternal and child health services were the means used by ministries of health to publicize birth control programmes, particularly in the rural areas.

New experiments for the integration of birth control programmes into health services other than maternal and child protection services, and into projects or programmes belonging to ministries other than the Ministry of Health, were being attempted in some countries. Mention may be made of the experiments undertaken in Indonesia, Malaysia, the Philippines, the Republic of Korea and Thailand, where an effort was being made to integrate birth control programmes into services for the prevention and cure of parasitic diseases in rural areas.[69] In Sri Lanka, there was a project that associated the programmes with a food help plan; and in India, with integrated rural development projects. The Indian experiment is indeed very interesting to follow, as it is one of the first of that type. As has been pointed out, that type of "horizontal" approach derives more from a transformation of procedures and administration at basic community level than the "vertical" approach which tackles the problem simultaneously by means of birth control programmes and independent sectoral action (education, industrialization etc.).[70]

Another technical method used more and more frequently to improve the supply of birth control services, and more or less in consequence, the demand for those services, was the decentralization of programmes and their redirection towards local communities, villages, urban districts or certain community groups, associations, business undertakings etc. China had made great progress with that type of experiment.[71] The implementation of measures was decided by the Ministry of Health, which took the over-all responsibility, while the execution was entrusted to a hierarchy of administrative units in which the responsibility was delegated from one level to another down to the level of the local authorities. The organs of the Party and such humanitarian bodies as the Federation of Women operated alongside the administrative system.

Another example is that of Indonesia.[72] The Government had given the people and their basic local communities, particularly the highly structured communities (the *banjar*), the responsibility for execution of programmes, including motivation campaigns, recruitment of couples for birth con-

[65] Situation in 1978.

[66] J.-P. Sardon, *loc. cit.*

[67] *Ibid.*

[68] A. Henry and P. T. Piotrow, *op. cit.*

[69] This programme, the Joint Parasite Control/Nutrition Family Planning Project, was launched on the initiative of the Japanese Organization for International Co-operation and Family Planning and is financed in part by the International Planned Parenthood Federation and the United Nations Fund for Population Activities.

[70] B. Berelson, W. P. Mauldin and S. J. Segal, *op. cit.*

[71] Y. C. Yu, "Population policy in China", *Population Studies*, vol. XXXIII, No. 1 (March 1979), pp. 125-142; and "Population", *China News Analysis*.

[72] *Population Policy Compendium: Indonesia*, situation as assessed in May 1979, a joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities (New York, 1979).

trol programmes and distribution of contraceptives. The local development projects, which came under the responsibility of various ministries, were associated with the success of the targets fixed by the Government in regard to fertility.[73] The programmes in question had been incorporated into the development programmes: Repelita I (1963-1974); and Repelita II (1975-1979). The Philippines followed a similar policy and had transferred the responsibility for birth control programmes from the dispensaries to the local communities. Several countries similarly used industrial undertakings for the distribution of contraceptives (India, the Philippines and the Republic of Korea). In the Philippines, industrial undertakings that employed over 200 persons were required by law to include birth control methods in their health services. In the Republic of Korea, birth control programmes were associated with the health insurance schemes launched by industry. Other types of organizations also were used to publicize the programmes: sports organizations (the Philippines); youth associations (India); the border police (Thailand);[74] the army; and a new village movement that comprised 35,000 mothers' clubs (Republic of Korea).[75]

Along with those measures, a very large number of countries were tending increasingly to entrust the responsibility for birth control services to non-medical staff, in particular, midwives. Such programmes were in operation in Bangladesh, Indonesia, Malaysia, Pakistan, the Philippines, and Thailand.[76] Some countries also called in village chiefs, schoolteachers, women's organizations etc. to carry out the same functions. In the Philippines, paramedical personnel were used for distribution of the pill and for IUD insertions. In another direction, many countries had established vast programmes for the distribution or sale of contraceptives through non-commercial and modern or traditional commercial circuits.

However, those experiments are not without their dangers, especially in regard to the distribution of contraceptives with a hormone base. Some people are worried about entrusting the responsibility for distributing products with a distinct potential danger to people who do not have adequate medical training and are not competent to react properly if secondary effects should develop.[77]

Economic incentives and disincentives

Among pro-natalist countries, such as the Lao Democratic People's Republic or Mongolia, which wanted to maintain the existing level of rates, economic incentive and disincentive measures had been introduced. In Mongolia, for example a comprehensive programme of measures had been worked out when the fifth development plan (1971-1975) was drawn up. Among the incentives, mention may be made of a very comprehensive system of family allowances and a variety of benefits, such as retirement at age 50 for working women with four or more children. In the sixth development plan (1976-1980), those measures were stepped up, and new benefits were added, such as maternity leave for a period of six months with allowances representing half pay. But disincentives also existed, such as a 2 per cent tax on the income of unmarried persons from the age of 16 onward and taxes on childless couples.[78]

In anti-natalist countries, an initial incentive was the supply of contraceptives free of charge. Table 30 indicates a number of countries where contraceptive services were provided free of charge or where contraceptives were sold at low cost. It will be noted that most countries provided free IUD insertion or the distribution of condoms. Sterilization was frequently done free of charge, while contraceptive pills were sold at very reduced prices. In addition to services free of charge or at low cost, many countries also offered a cash bonus to those who agreed to practise contraception. Some countries also offered a bonus to those who publicized contraceptive devices and sometimes even to the suppliers of contraceptive products, for instance, in India and Pakistan.

In many countries that had decentralized birth control programmes, the bonuses granted by the State to persons or bodies who publicized methods of contraception very often benefited the local communities to whom that responsibility had been entrusted. The measure was applied also in certain instances for the supply of contraceptives where co-operative distribution centres had been established locally.[79]

In addition to that type of remuneration, there were graduated systems of direct and indirect incentives designed to promote a certain type of reproductive behaviour. Such remuneration could be financial, in kind or in the form of social benefits, granted immediately or deferred, for families that had complied with the family standards recommended by the Government. One or two examples may be given to illustrate the various types of measures. In Sri Lanka, on the occasion of a campaign launched in favour of male sterilization among tea plantation workers, increased maternity benefits were offered to those who agreed to allow themselves to be sterilized after the birth of the second or third child.[80] In the Republic of Korea, couples with two children were given absolute priority in obtaining new dwellings constructed by the Government, provided the woman was at least 40 years old.[81]

The payment of the remuneration was sometimes deferred in India, for example, a system of savings and retirement had been set up in favour of families who undertook to have only a limited number of children. The benefits were only payable if the number of children had not been exceeded. Along with those incentives, some Governments, especially those which had already reached an intermediate stage of development, had recourse to disincentives. Essen-

[73] Economic and Social Commission for Asia and the Pacific, *Report of the Expert Group Meeting on Socio-Economic Measures Affecting Fertility Behaviour with Special Emphasis on Actionable Programmes, Bangkok, 5-10 September 1977*, Asian Population Series, No. 41 (ST/ESCAP/31) (Bangkok, 1978).

[74] M. Wolfson, *op. cit.*

[75] *Population Policy Compendium: Republic of Korea.*

[76] M.-L. Simpson-Hebert, *op. cit.*

[77] D. L. Nortman, *op. cit.*

[78] *Population Policy Compendium: Mongolia*, situation as assessed in June 1979 (New York, 1979).

[79] M. Wolfson, *op. cit.*

[80] International Planned Parenthood Federation, *Report to Donors* (London, October 1979).

[81] United Nations Fund for Population Activities, *The Role of Incentives in Family Planning Programmes*, Policy Development Studies No. 4 (New York, 1980).

tially, their purpose was to impose financial or social penalties on families whose reproductive behaviour differed from that which the Government would like to see. In general, those measures applied to confinement expenses, paid maternity leave, priorities in obtaining employment and housing, choice of schools; and, in particular, income-tax reliefs and family allowances. One or two further examples to illustrate such measures and the way in which they were applied may be appropriate.

In Singapore, confinement costs in government hospitals rose according to the child's birth order; but if the mother agreed to allow herself to be sterilized following childbirth, the costs were waived.[82] Paid maternity leave was also cancelled with the birth of the third child and subsequent births. In the Philippines, paid maternity leave was granted only for the first four confinements. Priority in obtaining housing subsidized by the State was not given when the family was numerous; and in Singapore, when the family had a dwelling, it was not allowed to let rooms.

With regard to tax cuts, income-tax relief was limited to two children in the Republic of Korea[83] and to four dependent children in the Philippines. In China, exemption from income-tax relief was cancelled after the birth of the fourth child. In Nepal, an income-tax law had been enacted in 1975 which cancelled the income-tax relief based on the number of dependent children.[84] Some countries, such as China, had taken even more rigorous measures to persuade couples to abide by the rules established: free schooling and free medical care were withdrawn with the advent of a third child; and the earnings of the head of the family were cut by 10 per cent until the third child reached 14 years of age.[85]

Thus, the economic measures used by Governments to induce parents to limit their progeny represented in actual fact a mixed system. At the outset, and so long as couples conformed to the norms laid down, the measures constituted financial incentives. Subsequently, once the couples had exceeded the rules established, the measures involved disincentives and penalties.

Psychological measures

Most of the Governments in the ESCAP area had instituted psychological persuasion campaigns that used both traditional and modern information media. Large-scale educational programmes also had been launched for the benefit of adults and young people through the formal and informal education systems. Such publicity and education campaigns actually constitute a basic factor in any birth control strategy. Government policies will only be followed when families are convinced that they are sound. They will only be effective when couples are familiar with methods of avoiding conception and know where to obtain them. Those responsible for birth control programmes have understood this; and thus it has been established in a pilot programme,[86] based on the programmes in force in 18 countries, that the heading "information and education" represented 14 per cent of the total budgetary expenses of the programme, while the supply of contraceptives alone represented 56 per cent of the budget.

China had embarked on a vast mass mobilization campaign. Slogans, simple but persuasive, were given wide publicity: "Later, longer and fewer", a slogan that summarized the whole of the Government's strategy (marriage at a later age, longer intervals between births and fewer children).[87]

In the Philippines, the study of population problems was integrated into the curricula of schools at all levels. Information was disseminated in many countries through the media, the maternal and child health services, social and cultural bodies (mainly women's organizations), local communities (the village chief, schoolteachers and voluntary student workers), and business undertakings. Mobile teams were sent from village to village, where they used diagrams, graphs and audio-visual apparatus.[88]

Action on socio-economic determinants of fertility

One final type of measure consists in action on the socio-economic factors that determine fertility. A number of national experiments had shown effectively that improvements in living conditions brought about a drop in fertility. The most resounding successes in programmes to reduce fertility had been achieved in countries where a more advanced stage of development had already been reached, as for example, in Singapore. On the other hand, in countries where the gap between population growth and economic development was widening, Governments were realizing that birth control programmes applied without other types of action on the determinants of fertility were not sufficient. A statement by the chief of the Indian delegation to the World Population Conference at Bucharest expressed the problem neatly when he said: "The real enemy is poverty." In India, the most marked successes had been achieved in certain states, such as Kerala, where the level of education, the status of women, nutrition and equality in the distribution of earnings had reached a level distinctly higher than the national average.[89] The Philippines was resolutely steering its policies in that direction. While it was analysing the complex problem of motivation towards fertility and its determinants, policies had been set up, jointly with birth control programmes, to reduce mortality and morbidity. That was only an intermediate stage, since the Government had set itself the task of tackling all the known factors that determined fertility and not merely some of them.[90] Sri Lanka was following a similar policy.

Some of the countries in the ESCAP area were integrating birth control programmes into their general development strategies. In the Republic of Korea[91] and Thailand,[92] for

[82] Peter S. J. Chen and James F. Fawcett, *Public Policy and Population Change in Singapore* (New York, The Population Council, 1979).

[83] *Population Policy Compendium: Republic of Korea.*

[84] *Population Policy Compendium: Nepal*, situation as assessed in May 1979 (New York, 1979).

[85] "Population", *China News Analysis.*

[86] D. L. Nortman and E. Hofstatter, *op. cit.*

[87] "Population", *China News Analysis.*

[88] M. Wolfson, *op. cit.*

[89] Lester R. Brown, *Resource Trends and Population Policy: A Time for Reassessment*, Worldwatch Paper No. 29 (Washington, D.C., Worldwatch Institute, May 1979).

[90] M. Wolfson, *op. cit.*

[91] *Population Policy Compendium: Republic of Korea.*

[92] *Population Policy Compendium: Thailand*, situation as assessed in January 1979 (New York, 1979).

example, a population committee or council had been set up at high ministerial level for the purpose of co-ordinating population policies and integrating them into the other sectors of planning.

In developing countries anxious to reduce their fertility level, the debate was currently less concerned with the legitimacy of action by the State, or even with its efficacy, than with the manner and the vigour with which it is carried out. Since the World Population Conference, birth control programmes had acquired an additional measure of legitimacy from the concept of integration, which although vague, did indicate an essential direction in which action could take place: birth control programmes, if they were to be acceptable and therefore effective, should be designed as an integral part of an over-all strategy for improving levels of living. That integration appeared to be widely accepted at the level of techniques designed to improve the supply and demand for services.

On the other hand, the account deliberately taken in development strategies of the demographic effects of this or that macro-economic intervention or social measure still did not indicate any marked changes in government practice since the Conference. However, the recent establishment of dozens of population units set up to integrate demographic and non-demographic processes within planning organs should help to improve the current situation over the long term.

All in all, the expansion of economic incentives and disincentives, especially in Asia, associated with an improvement in procedures for the supply of birth control services in all the anti-natalist countries, appeared to be one of the outstanding characteristics of anti-natalist policies in the past few years. Their rapid expansion nevertheless raises serious financial problems; and there is a great temptation to have recourse to fairly strong pressure, at the outset complementing and subsequently replacing these costly economic incentives. It may be added in this connection, that most of the measures referred to above may or may not be coercive in character, in the broad sense, according to the way in which they were being applied. The Chinese authorities, for example, were well aware of the problem, because when the sixth five-year development plan (1981-1985) was submitted, they stressed the fact that only persuasion and ideological and political effort should be used in implementing birth control programmes and ruled out the coercive methods which had occasionally been used in the past.

Meanwhile, as has been shown in this chapter, a relatively small but significant number of developing countries that regarded their fertility level as either too low or satisfactory had adopted policies designed to change the levels and trends. They were, with a few notable exceptions, small countries at the early stages of demographic transition and hence they had a high mortality rate. They felt that the smallness of their current population was a major obstacle to the full use of their natural resources and a potential danger to their security. For most of them, excluding such countries as Argentina, the Democratic People's Republic of Korea or Mongolia—the pro-natalist policies were limited to legal measures, for want of national and international resources. Access to the various methods of contraception was often made difficult, abortion was more or less prohibited, the age at which marriage was authorized was relatively low, etc. Admittedly, some economic incentives, such as family allowances, maternity leave and tax benefits, did exist; but in many instances, those benefits reached only a fraction of the population, the wage earners or even at times only civil servants. Moreover, they would appear to be perceived more and more, in the socio-cultural context of the countries where they were applied, as having a social rather than a demographic significance.

Conclusion

The majority of countries, both in the more developed regions and in the less developed regions, were faced with the problems of "aggregate" fertility which was perceived as either too low or too high in 1980, or with problems that arose from the trend in "individual" fertility through the maintenance or improvement of family well-being.

Comparing the strategies to which the various groups of countries had recourse, it may be said that in the developed countries, legal measures, such as access to contraceptives, abortion, sterilization and age at marriage, tended to become independent of the population policy aims (except in the Eastern European countries). Those measures were essentially designed to ensure the well-being of the individual and to permit the person to control fertility in complete freedom. In the developing countries, on the other hand, legal measures were as a rule bound up with demographic objectives. In pro-natalist countries, and in some countries that considered their fertility rate satisfactory but wanted to maintain it at the existing level, the provisions were, on the whole, relatively restrictive, whereas in anti-natalist countries, or in some countries that were satisfied with their rate but would still like to reduce it, they had been much more liberalized. The liberalization of sterilization would appear to have advanced more rapidly than the liberalization of abortion in the latter countries, whereas in the developed countries, Governments had been concerned with abortion first and foremost.

Among the technical measures mentioned throughout this chapter, the role played by local communities and certain community groups in publicizing and sometimes in implementing modern contraceptive methods has been shown to be one of the characteristic features of the new trends in the organization of these services. This trend is at variance with that observed in the developed countries, where the right of the individual to determine his own reproductive behaviour is recognized almost universally.

Economic incentives and disincentives are a tool used by both developed and developing countries. In the former group, family allowances, tax relief, etc. make it possible first, to encourage families to have a larger number of children; and secondly, to give families some compensation for the cost of upbringing and education involved when a child is born. Among the latter countries, while a number of pro-natalist countries did have recourse to that type of measure, its significance, as noted above, was social rather than demographic. On the other hand, anti-natalist developing countries had recourse on a large scale to economic incentives and disincentives which sometimes severely penalized couples who did not abide by the family norms established by the Government.

Psychological publicity measures were used mainly in the developing countries, whereas in the developed countries the private and public media played an important role in publicizing the social norms, which undoubtedly have a considerable influence on fertility.

Lastly, although certain types of action on the socio-economic determinants of fertility have a fairly similar significance in both developed and developing countries, others have a more specific significance. For example, one of the goals of the efforts to improve the status of women in anti-natalist developing countries was to create favourable conditions for reducing fertility. In pro-natalist developed countries, measures designed to resolve the contradictions between maternity and employment were perceived as also influencing fertility. On the other hand, however, such factors as provision of education, health facilities and employment, which are intrinsic to countries where the welfare State is trying to establish the bases of an egalitarian society, cannot be further manipulated to affect fertility. In developing countries, on the other hand, those factors could be regarded as indirect methods of modifying fertility in the direction desired, and hence may be subject to manipulation in a variety of ways.

Chapter XXIII

INTERNATIONAL MIGRATION

The movement of labour across national boundaries has assumed very large proportions in the past decade. As of 1980, there were about 20 million migrant workers in the world, about 12 million of them from developing countries. The oil-producing countries of Western South Asia continued to be a major pole of attraction and were beginning to draw manpower from countries that had formerly supplied labour migrants to Western Europe, as well as from a growing number of Asian countries. In recent years, there has been a tendency for Governments to take increasingly active roles in overseeing recruitment and as recruiters themselves—both as a means of avoiding abuses and as a means of increasing the export of manpower in conformity with labour-export strategies. Among the suppliers of labour to Western South Asia, there was a growing emphasis on the "project package" approach to manpower exportation, whereby Governments would supply entire projects from design through execution. There remained, however, countries that engaged solely in manpower exportation.

In Africa, Latin America and Asia, intraregional movements of labour tend to be spontaneous and often outside government control. The major flows continued to be towards traditional poles of attraction: in sub-Saharan Africa, towards Gabon, the Ivory Coast and South Africa; in Latin America, towards Argentina and Venezuela in the southern cone; and in Eastern South Asia, towards Hong Kong and Singapore. Much of the movement was of a circular or temporary nature, or involved border movements that were really inseparable from internal flows. In all regions, including the more developed regions, illegal flows probably were increasing. Since an unknown but certainly a significant proportion of illegal migration consists of movement from poorer to richer countries, the phenomenon is likely to continue. What the long-term consequences will be—for the migrants as well as for the sending and receiving countries—is imperfectly known. An obvious corollary is that the most appropriate policies and measures are equally unknown.

In Western Europe, the former chief destination of labour migrants, the closing of the door of the large-scale migration of foreign manpower remained in force. Migration streams were increasingly mature and consisted largely of dependants admitted for family reunification purposes. There was still some immigration to meet labour force needs, although those flows were closely monitored in order to prevent further "leakage" into permanence. Although several Western European countries—notably Belgium, the Federal Republic of Germany and Switzerland—had passed legislation since 1978 that was designed to improve the position, or to facilitate the integration, of foreign workers and their dependants, there was still a wide gap in most countries between pronouncements of concern and actual policies. Other countries, such as France, sought a continuing reduction in their stock of foreign workers and had adopted legislation towards that end.

The former chief recipients of permanent immigration had adopted similar positions. In the period 1978-1980, the United Kingdom of Great Britain and Northern Ireland shifted to a position of restricting future immigration, particularly of Asians from Commonwealth countries. The United States of America, which was currently in the process of re-evaluating its immigration policy, was likely to make a number of minor adjustments, such as the abolition of its underused preference categories, although it appeared to be moving in the direction of becoming more restrictive.

At the world level, few countries desired permanent immigration. Several of those countries were not perceived as desirable migration destinations and had been unsuccessful in attracting migrants, while others had actually lost population through emigration. At the same time, few countries desired the permanent emigration of their nationals, although growing numbers desired emigration on fixed-term contracts. Virtually all countries affected by a brain or skill drain desired to reduce that flow. Although a wide variety of incentives and disincentives had been employed, few countries had been successful in the repatriation of skilled personnel.

The fact that a majority of countries desired neither immigration nor emigration is shown clearly in the summary tables on Governments' perceptions of the acceptability of current international immigration and emigration (tables 34 and 36).[1] As of 1980, only six countries with significant immigration considered it to be too low, as shown in table 34, while four additional countries, in which immigration was not significant, desired greater immigration. On the other hand, 21 countries with significant immigration considered it to be too high.

An examination of Governments' policies with respect to immigration (table 35) shows that nine countries had policies designed to achieve a higher rate of immigration; 17 countries with significant immigration had a policy intended to maintain the current rate, subject to strict control; and lastly, 25 countries with significant immigration had adopted policies to curb immigration in the near future and to maintain the already established immigrant population.

As shown in table 36, while 25 countries considered emigration to be too high, only six countries with significant emigration considered it to be too low. Three additional

[1] For views of individual Governments concerning international immigration and emigration, see annex tables 45-48.

TABLE 34. GOVERNMENTS' PERCEPTIONS OF THE DEMOGRAPHIC SIGNIFICANCE AND ACCEPTABILITY OF CURRENT LEVELS OF IMMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

Area of responsibility of regional commission, region and level of development	*Immigration significant*			*Immigration not significant*		*Total*
	Too low	*Satisfactory*	*Too high*	*Immigration desired*	*Situation satisfactory*	
ECA area						
Eastern Africa	—	2	2	—	12	16
Middle Africa	1	1	1	—	6	9
Northern Africa	—	1	1	—	4	6
Southern Africa	1	—	—	—	3	4
Western Africa	—	1	2	—	13	16
TOTAL	2	5	6	—	38	51
ECE area						
Eastern Europe	—	—	—	—	6	6
Northern Europe	—	2	1	—	4	7
Southern Europe	—	—	1	—	8	9
Western Europe	—	6	2	—	1	9
Cyprus, Israel and Turkey	1	—	—	—	2	3
Northern America	—	1	1	—	—	2
USSR	—	—	—	—	3	3
TOTAL	1	9	5	—	24	39
ECLA area						
Caribbean	—	—	1	—	10	11
Middle America	—	—	1	—	6	7
Temperate South America	1	—	—	—	2	3
Tropical South America	—	—	1	3	5	9
TOTAL	1	—	3	3	23	30
ECWA area						
Western South Asia[b]	1	4	2	1	4	12
TOTAL	1	4	2	1	4	12
ESCAP area						
China	—	—	—	—	1	1
Japan	—	—	—	—	1	1
Other East Asia	—	—	—	—	3	3
Eastern South Asia	—	—	2	—	7	9
Middle South Asia	—	1	2	—	6	9
Australia-New Zealand	1	—	—	—	1	2
Melanesia	—	—	—	—	2	2
Micronesia-Polynesia	—	1	1	—	4	6
TOTAL	1	2	5	—	25	33
Developed countries	1	9	5	—	24	39
Developing countries	5	11	16	4	90	126
TOTAL	6	20	21	4	114	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For countries in each category, see annex table 45.

[b] Excluding Cyprus, Israel and Turkey.

countries in which emigration was not significant desired greater emigration.

As shown in table 37, with respect to emigration policies, six countries had adopted policies to achieve a higher rate; 28 countries with significant emigration had a policy intended to maintain the current rate; lastly, 26 countries with significant emigration had a policy designed to curb emigration in the future.

Before beginning the discussion of international migration policies at the world level, which is organized according to the 24 geographical regions established by the Population Division, it is necessary to deal briefly with the problem of classifying migrants. In the present text, migrants have been grouped into one of four general categories: permanent; temporary; illegal; or refugees. For purposes of analysis, the first category generally refers to the more traditional type of immigration, involving the permanent immigration of persons with needed skills and family ties to the receiving country. The second category, that of "temporary" migration, refers to various types of labour migration, along a continuum from seasonal migration or border community to movements that in effect become permanent, as has commonly occurred with large numbers of "guest workers" in Western Europe. A third category, that of illegal migration, is essentially a subcategory of the second, since illegal migrants are typically labour migrants. The greatest number, however, fall somewhere in between; and under current international law, it is the prerogative of the receiving country to grant or to deny asylum.

In employing the four categories of migrants throughout this chapter, it is important to take note that the categories sometimes overlap, both as a result of the lack of a standardized definition and as a result of deliberate government policy. Lastly, it is important to mention that while the various categories of migrants are treated separately, it is often the total volume of migration that affects Governments' perceptions of international migration and related policies.

TABLE 35. GOVERNMENTS' POLICIES CONCERNING IMMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

Area of responsibility of regional commission, region and level of development	*Government policies in favour of:* Higher rate	*Maintaining current rate but subject to strict control*	*Curbing immigration in future but maintaining already established immigrant population*	*Immigration perceived to be not demographically significant or desirable or not desirable*	*Total*
ECA area					
Eastern Africa	—	3	1	12	16
Middle Africa	1	1	1	6	9
Northern Africa	—	1	1	4	6
Southern Africa	1	—	—	3	4
Western Africa	—	1	2	13	16
TOTAL	2	6	5	38	51
ECE area					
Eastern Europe	—	—	—	6	6
Northern Europe	—	—	3	4	7
Southern Europe	—	—	1	8	9
Western Europe	—	—	8	1	9
Cyprus, Israel and Turkey	1	—	—	2	3
Northern America	—	2	—	—	2
USSR	—	—	—	3	3
TOTAL	1	2	12	24	39
ECLA area					
Caribbean	—	1	—	10	11
Middle America	—	1	—	6	7
Temperate South America	1	—	—	2	3
Tropical South America	3	—	1	5	9
TOTAL	4	2	1	23	30
ECWA area					
Western South Asia[b]	1	4	2	5	12
TOTAL	1	4	2	5	12
ESCAP area					
China	—	—	—	1	1
Japan	—	—	—	1	1
Other East Asia	—	—	—	3	3
Eastern South Asia	—	—	2	7	9
Middle South Asia	—	1	3	5	9
Australia-New Zealand	1	—	—	1	2
Melanesia	—	—	—	2	2
Micronesia-Polynesia	—	2	—	4	6
TOTAL	1	3	5	24	33
Developed countries	1	2	12	24	39
Developing countries	8	15	13	90	126
TOTAL	9	17	25	114	165

Sources: Compiled from replies to "Fourth Population Inquiry Among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For names of countries in each category, see annex table 46.
[b] Excluding Cyprus, Israel and Turkey.

A. AREA OF RESPONSIBILITY OF ECONOMIC COMMISSION FOR AFRICA

Eastern Africa

One of the major refugee situations among many in Eastern Africa was the result of the continuing conflict between Ethiopia and Somalia. A number of countries were affected. For example, the presence of an estimated 25,000 refugees from Ethiopia had placed a severe strain on the economy of Djibouti because the country is arid, with inadequate domestic food production, and there was little likelihood that those refugees would be repatriated soon.[2]

The major brunt of the war between Ethiopia and Somalia had been borne by Somalia, whose refugee population had increased its total population size by about one third. As of spring 1980, Somalia was hosting more than 1.3 million refugees. Of that number, some 750,000 were living in makeshift camps; the remainder were living among the local population. A serious problem was that many of the refugees had nomadic life-styles and were not used to living in large groups; in addition, about 90 per cent of the refugees were women and children under 15 years of age.[3] Although it had been a major producer of refugees, Ethiopia had in turn provided refuge to some 11,000 refugees, mostly from the southern area of the Sudan. The country's major problem, however, was the more than 2 million displaced persons within its borders.

[2] "Assistance to refugees in Djibouti: Report of the Secretary-General" (A/35/409).

[3] "Humanitarian Assistance Programmes of the United Nations High Commissioner for Refugees in Somalia and other countries in the horn of Africa" (E/1980/44).

TABLE 36. GOVERNMENTS' PERCEPTIONS OF THE DEMOGRAPHIC SIGNIFICANCE AND ACCEPTABILITY OF CURRENT LEVELS OF EMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

Area of responsibility of regional commission, region and level of development	*Emigration significant*			*Emigration not significant*		*Total*
	Too low	*Satisfactory*	*Too high*	*Emigration desired*	*Situation satisfactory*	
ECA area						
Eastern Africa	—	4	2	1	9	16
Middle Africa	—	2	—	—	7	9
Northern Africa	1	3	—	—	2	6
Southern Africa	—	2	1	—	1	4
Western Africa	—	4	2	—	10	16
TOTAL	1	15	5	1	29	51
ECE area						
Eastern Europe	—	—	—	—	6	6
Northern Europe	—	—	2	—	5	7
Southern Europe	1	1	4	—	3	9
Western Europe	1	—	—	—	8	9
Cyprus, Israel and Turkey	1	—	1	—	1	3
Northern America	—	—	—	—	2	2
USSR	—	—	—	—	3	3
TOTAL	3	1	7	—	28	39
ECLA area						
Caribbean	—	5	2	—	4	11
Middle America	—	2	2	—	3	7
Temperate South America	—	—	1	—	2	3
Tropical South America	—	—	4	—	5	9
TOTAL	—	7	9	—	14	30
ECWA area						
Western South Asia[b]	—	2	1	1	8	12
TOTAL	—	2	1	1	8	12
ESCAP area						
China	—	—	—	—	1	1
Japan	—	—	—	—	1	1
Other East Asia	1	—	—	—	2	3
Eastern South Asia	—	2	—	1	6	9
Middle South Asia	1	2	1	—	5	9
Australia-New Zealand	—	—	1	—	1	2
Melanesia	—	—	—	—	2	2
Micronesia-Polynesia	—	1	1	—	4	6
TOTAL	2	5	3	1	22	33
Developed countries	2	1	7	—	29	39
Developing countries	4	29	18	3	72	126
TOTAL	6	30	25	3	101	165

Sources: Compiled from replies to "Fourth Population Inquiry Among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For names of countries in each category, see annex table 47.
[b] Excluding Cyprus, Israel and Turkey.

In addition to the countries affected by the Ogaden conflict, many countries in the region had granted asylum to large numbers of refugees. For example, Burundi had been assisting some 50,000 refugees from neighbouring countries and was encouraging those without skills to move to designated rural settlements. Similarly, the United Republic of Tanzania had provided assistance to large numbers of refugees from various countries in Southern Africa. A number of those refugee settlements had become self-reliant communities; they produced their own food and sold cash crops sufficient to meet their other expenses. In some cases, those refugee settlements had already been passed over to the Government for normal administration, on the same terms as the other villages and development schemes in the country.

While the United Republic of Tanzania had been relatively successful in its refugee resettlement, many countries had experienced serious problems. In the case of Zambia, for example, the closing of its borders and the cutting-off of main travel routes had not stopped a steady stream of refugees. Although large numbers of Zimbabweans had begun to be repatriated, some 32,000 remained in Zambia as of May 1980. The drain on Zambian revenues caused by the sheltering and feeding of those refugees had become even more acute as recurring drought depleted food supplies.

Several countries in Eastern Africa had recently had successful experiences with repatriation. For example, with financial assistance from the United Nations High Commissioner for Refugees (UNHCR), Uganda had begun to resettle large numbers of returning refugees and displaced persons, including thousands of Rwandese and Zairians who had previously lived in Uganda. A large flow of Ugandans may be expected to be repatriated because the Government of Kenya revoked the refugee status of Ugandans living in

TABLE 37. GOVERNMENTS' POLICIES CONCERNING EMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

Area of responsibility of regional commission, region and level of development	*Government policies in favour of:*			*Emigration perceived to be not demographically significant and desirable or not desirable*	*Total*
	Higher rate	*Maintaining current rate*	*Curbing emigration in future*		
ECA area					
Eastern Africa	—	5	1	10	16
Middle Africa	—	2	—	7	9
Northern Africa	1	3	—	2	6
Southern Africa	—	2	1	1	4
Western Africa	—	3	2	11	16
TOTAL	1	15	4	31	51
ECE area					
Eastern Europe	—	—	—	6	6
Northern Europe	—	—	2	5	7
Southern Europe	1	1	4	3	9
Western Europe	1	—	—	8	9
Cyprus, Israel and Turkey	1	—	1	1	3
Northern America	—	—	—	2	2
USSR	—	—	—	3	3
TOTAL	3	1	7	28	39
ECLA area					
Caribbean	—	4	3	4	11
Middle America	—	2	2	3	7
Temperate South America	—	—	1	2	3
Tropical South America	—	—	4	5	9
TOTAL	—	6	10	14	30
ECWA area					
Western South Asia[b]	—	2	1	9	12
TOTAL	—	2	1	9	12
ESCAP area					
China	—	—	—	1	1
Japan	—	—	—	1	1
Other East Asia	1	—	—	2	3
Eastern South Asia	—	1	1	7	9
Middle South Asia	1	2	1	5	9
Australia-New Zealand	—	—	1	1	2
Melanesia	—	—	—	2	2
Micronesia-Polynesia	—	1	1	4	6
TOTAL	2	4	4	23	33
Developed countries	2	1	7	29	39
Developing countries	4	27	19	76	126
TOTAL	6	28	26	105	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] For names of countries in each category, see annex table 48.
[b] Excluding Cyprus, Israel and Turkey.

that country and gave them until March 1980 to return. Similarly, the newest State in Africa, Zimbabwe, was well on its way to resettling its refugees. When its guerrilla war ended, about 500,000 persons who had been held in "protected villages" by the former Government became free to move. Of the some 200,000 who fled to Botswana, Mozambique and Zambia, about 35,000 returned to Zimbabwe to vote in the February 1980 elections. In a second phase, over 5,000 persons were repatriated from Mozambique in May 1980, while mothers and children, and other vulnerable groups, were air-lifted to Zimbabwe from Zambia.[4] In a reverse flow, many of the white citizens of Zimbabwe emigrated to South Africa in 1980, as well as to Australia and to the United Kingdom. A country that wanted to encourage selective repatriation was Mozambique. In March 1980, the President delivered a plea for former Portuguese settlers who were living in other countries of Africa to return to Mozambique; he promised them special business incentives upon their repatriation.

Lastly, Rwanda was somewhat unique among countries in the region in that it had an explicit policy to promote the emigration of its nationals. As reported in its reply to the Fourth Population Inquiry in 1978, the Government desired to increase emigration as a means of "reducing demographic pressure on the land and of improving the well-being of the country's population".[5] At that time, it had been reported to be exploring the possibility of bilateral accords with potential receiving countries. Recently, there

[4] United Nations High Commissioner for Refugees, Refugee Update, 16 May 1980.

[5] "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action".

were reports that Rwanda might co-operate with the United Republic of Tanzania in a scheme to send Rwandese emigrants to populate the new capital city of Dodoma.

In addition to its policy of encouraging emigration, Rwanda had been a producer of refugees, primarily the minority Tutsi. By 1978, some 175,000 refugees had been living outside Rwanda, with considerable year-to-year movement back and forth.

Middle Africa

As was the case in Eastern Africa, refugees posed a serious problem for many of the countries in Middle Africa. In Gabon, formerly a major importer of contract labour, refugee pressures had contributed to the Government's policy shift on immigration. While the Government had reported in its 1978 reply to the Fourth Inquiry that it desired to maintain rather than to increase immigration, in 1980, due largely to an influx of refugees, it desired to decrease the rate. In mid-1979, the Government reported that Gabonese nationals would receive priority in employment; it took note that without the large number of foreigners then in Gabon, there would be no problem of unemployment among Gabonese. It further announced that the Governments of those countries who were sending labour migrants to Gabon would be asked to assist in reducing those flows. Lastly, the Government reported that a census would be taken of all foreigners in the country, and those whose situation was irregular would be repatriated to their respective countries.[6]

The refugee movement of longest standing in the region involved Equatorial Guinea, approximately one third of whose population might have taken refuge in neighbouring countries, as well as in Spain, during the 1970s. Although there was a change of government in 1979, it was not yet known whether the new administration would encourage repatriation on any significant scale.

A more recent exodus occurred in 1979, in the wake of the violent civil war in Chad, when some 100,000 refugees sought asylum in the United Republic of Cameroon. Those refugees presented a particularly serious problem, since they were concentrated in the northern province, one of the poorest in the country, and it was not yet known whether the movement would be of temporary or more permanent duration. In addition to the provision of emergency assistance to the refugees from Chad, UNHCR was assisting the United Republic of Cameroon with an information campaign directed towards encouraging the repatriation of refugees from Equatorial Guinea.

Another country in Middle Africa—Zaire—was one of the major refugee-receiving countries on the African continent. The estimated 172,000 refugees in Zaire as of 1979 were primarily nationals of Angola (especially Cabinda Province), Burundi and Uganda. Although Zaire had generated sizeable refugee flows in the past, a large-scale repatriation of Zairian refugees from Angola and other neighbouring countries followed the proclamation by the Government of Zaire of a general amnesty in June 1978. During the year-long duration of the amnesty, some 120,000-150,000 Zairian refugees returned from Angola under UNHCR auspices, in one of the largest organized border crossings in recent African history.[7]

Lastly, Angola had received from 20,000-30,000 refugees from northern Namibia (although it was not known how many of those "refugees" were non-combatants), and it had been the source of even larger flows. A large proportion of the 172,000 refugees in Zaire were from Angola. Up to 1980, however, Angola had shown no willingness to proclaim a general amnesty.

Northern Africa

The Libyan Arab Jamahiriya remained the major labour-importing country in Northern Africa. Increasing numbers of Egyptians and Tunisians had migrated there in recent years, as had nationals of a wide range of other countries, although there was evidence that the Government had been applying pressure on foreigners in the managerial ranks, in the hope that they would depart. Bilateral agreements had been increasingly important in regulating migration to the Libyan Arab Jamahiriya. The agreement between the Libyan Arab Jamahiriya and the Syrian Arab Republic was of particular importance, although bilateral agreements had also been used to obtain labour supplies from non-Arab countries, including Bulgaria, Romania and Yugoslavia. In addition to those organized flows which had resulted from bilateral agreements, the Libyan Arab Jamahiriya had received large numbers of illegal migrants, particularly across the border with Egypt.[8]

On the supply side, Egypt remained one of the major exporters of labour to the Arab countries. The Government viewed emigration as a positive benefit to the economy, and Ministry of Planning officials estimated that the number of Egyptians who were working abroad would increase to approximately 1 million by 1986. The Libyan Arab Jamahiriya and Saudi Arabia absorbed over two thirds of those Egyptian workers, while the other important receiving countries were Algeria, Kuwait, the United Arab Emirates and Yemen. Many Egyptian workers had emigrated to Jordan in recent years, due largely to a process of replacement migration, in which foreign workers had been brought into Jordan to offset the shortfall of labour caused by the departure of Jordanians. Although Egypt had no official migration policy, a number of measures had the effect of increasing emigration. Those measures included new import regulations and the creation of brokerage agencies that operated not only as facilitators of migration but as active agents to influence individuals to migrate.

Algeria, formerly one of the major suppliers of labour to France, was sending migrants to new destinations in Western South Asia. Although the Government could not renew labour emigration to France, the unprepared repatriation of hundreds of thousands of its nationals was considered to be an equally unacceptable policy alternative. Consequently,

[6] *Le Monde*, 13 March 1979.

[7] Office of the United States Coordinator for Refugee Affairs, "1979 world refugee assessment", Washington, D.C., 30 September 1979, p. 49 (mimeographed).

[8] J. S. Birks and C. A. Sinclair, *International Migration and Development in the Arab Region*, A World Employment Programme Study (Geneva, International Labour Office, 1980), p. 85.

the Government of Algeria had strongly protested the announcement by the French Secretary of Immigration that some 300,000 Algerian work permits—due to expire at the end of the 10-year period set out by a 1968 labour agreement—would not be renewed. Algeria had been urging France to extend those work permits, which were to expire in 1980, by at least one year, in order to enable Algeria to work out plans for the integration of returning migrants, a programme to which it felt the Government of France should contribute.[9]

Tunisia faced problems similar to those of Algeria, although it had been somewhat more successful in channelling migrants to new destinations. Since the mid-1970s, various oil-producing countries, rather than France, had been the chief destinations of Tunisian labour migrants. An estimated 2 per cent of the Tunisian labour force was employed abroad, chiefly in the Libyan Arab Jamahiriya; and remittances had become a significant source of income for the Tunisian economy. The situation might change, however, because some 800 Tunisian migrant workers were expelled from the Libyan Arab Jamahiriya in early 1980 and a systematic round-up of Tunisian workers was reported, largely as a result of deteriorating relations between the two countries.

In contrast to those countries which primarily export temporary labour, the situation of the Sudan was somewhat more complex. On the one hand, the emigration of a significant proportion of the labour force of the country's modern sector, to the Libyan Arab Jamahiriya and Saudi Arabia, had led to growing government concern. An additional concern had been an increase in illegal emigration. It was estimated, for example, that as many as 70 per cent of the Sudanese labourers in Saudi Arabia during 1977/78 had been employed on an illegal basis. On the other hand, in addition to a continuing influx of pilgrims, who were significant in the urban and modern-sector agricultural labour force, migrant workers from Chad and from across southern borders of the Sudan had enlarged its domestic labour market. That situation had been further complicated by a recent massive influx of refugees. As the country on the African continent with the second largest refugee population (after Somalia), the Sudan had an estimated 340,000-350,000 refugees; the largest numbers had come from Ethiopia and Uganda, and smaller numbers from Chad and Zaire. Although the Sudan had its own unemployment problems, some 80,000 refugees from rural areas had been given work on agricultural schemes or with Sudanese tenant farmers. About half of the refugees were from urban areas, however; and they had settled at Khartoum and the main towns, which was causing numerous problems in those areas.[10]

Since the partition of the former Spanish Sahara, large numbers of refugees had been generated by continued fighting. Controversy exists over the size of the population of Western Sahara and the number of Saharan refugees. A majority of the refugees had sought asylum in Algeria. There is no consensus about their numbers, however; and estimates range from as low as 17,000 to as high as 120,000.

Southern Africa

In Southern Africa, Botswana, Lesotho and Swaziland continued in their roles as satellites and supplied manpower for the mines in South Africa. Although the numbers of migrants had declined in recent years, the International Labour Organisation (ILO) estimated that some 21,000 nationals of Botswana and 10,000 Swazis were employed in South Africa as of 1978. Lesotho, the poorest and most vulnerable of the countries dependent on the South African economy, had over 97,000 workers—50 per cent of its male and 10 per cent of its female labour force—employed in South Africa as of 1978. Government projections estimated an increase in the "absent population" to some 180,000 workers by 1985.

As its economy continued to expand, South Africa not only required a continuing inflow of unskilled workers but desired increased immigration of skilled personnel. In early 1980, the Government announced a new policy designed to compensate for the shortage of artisans in all sectors of the economy. According to the new policy, which involved the easing of restrictions on oversea recruiting and assistance to employers who were seeking workers abroad, artisans would be allowed to enter South Africa without firm job offers, a decision that was a reversal of previous policy. In addition, it was planned to streamline immigration procedures, to begin an advertising campaign and, as of April 1980, to increase the Government's allowance towards the costs of passage of approved immigrants.[11]

With respect to the refugee situation, thousands of refugees had fled from Namibia in recent years in reaction to security measures imposed by South African forces that operated in the territory. (For example, as many as 50,000 Namibians had been ordered removed from "prohibited areas" along the 1,000-mile border with Angola.) On the other hand, due largely to its political neutrality and central location, Botswana had served as a place of asylum for refugees and political exiles from Angola, South Africa and Zimbabwe. Since Botswana does not have sufficient agricultural land to allow large numbers of refugees to settle, it serves primarily as a country of transit. In addition to many hundreds of registered refugees, Lesotho and Swaziland had large numbers of unregistered refugee students from South Africa, although the latter country was not currently a major source of refugees.[12]

Western Africa

Although data for Western Africa are extremely imprecise, it would appear that international migration flows in 1980 corresponded roughly to those of the previous few years. The Ivory Coast continued to be the principal labour-importing country. According to the 1975 census, there had been 1.4 million foreign nationals in the country, of whom 719,000 had been economically active and who had made up about 26 per cent of the total economically active popula-

[9] "Algerian aide, after Paris talks, asks help for displaced workers", *The New York Times*, 22 January 1980.

[10] "Assistance to refugees in the Sudan: Report of the Secretary-General" (A/35/410).

[11] *Africa Research Bulletin* (Exeter, England), 15 January-14 February 1980.

[12] "Assistance to student refugees from Namibia, Zimbabwe and South Africa: Report of the Secretary-General" (A/35/149).

tion. Although the government policy of "ivorization"—that is, the filling of managerial positions with nationals of the Ivory Coast—was still in effect, there had not been a significant reduction in the number of skilled personnel from overseas.

Several other countries in the region continued to serve as lesser poles of attraction for foreign workers. For example, as of 1975, total immigrant labour in Ghana was estimated at 224,000; they had come primarily from Nigeria, Togo and the Upper Volta. The most recent estimate (circa 1976) of foreign nationals in Senegal was 355,000, of whom 157,000 were economically active. Of that total, 51,000 had come from outside Africa, with the remainder from within the region—namely, the Gambia, Guinea, Guinea-Bissau and the Upper Volta.

In recent years, nationals of Benin had migrated in large numbers to Gabon, attracted by its expanding economy. That situation possibly was changing, however, because Gabon had expelled some 10,000 Beninese workers in 1978, following a dispute between the two countries. Similarly, the Upper Volta had suspended its labour agreement with Gabon in 1977, although its nationals continued to migrate in large numbers to the Ivory Coast.

Western Africa had been less affected by refugee movements than the other regions of Africa. At various regional meetings, Governments had emphasized the need for "burden-sharing", which involved countries from the less affected areas. A formal mechanism, however, had not been set up. At the Pan African Conference on the Situation of Refugees in Africa, held at Arusha in 1979, the representative of Ghana reported that his Government had invited refugees from other regions but that the response to the offer had not been encouraging.[13]

Lastly, although the Government of Guinea desired to increase its population growth, estimates of the number of Guinean exiles who were living abroad—chiefly in France, the Ivory Coast and Senegal—had been as high as 1 million, or nearly one quarter of the Guinean population. In mid-1977, the President had announced a general amnesty for all Guineans who were living abroad, as well as a number of incentive measures for the repatriation of students, intellectuals and entrepreneurs. It was estimated that from 20,000 to 30,000 exiles had returned to Guinea since the amnesty, although several hundred thousand still remained abroad.[14]

B. Area of responsibility of Economic Commission for Europe

Eastern Europe

In accordance with the manpower co-operation agreement of the Council for Mutual Economic Assistance (CMEA) in 1971, the "mutual contractual exchange of manpower"—i.e., the mutual transfer of labour in specified economic fields for turning out production for the common benefit—continued to occur.

Although there are no official statistics concerning labour migration in the Eastern European countries, it is known that in 1980 a majority of foreign workers—chiefly from Bulgaria, Czechoslovakia, Poland and Romania—were employed in the German Democratic Republic, a country that also received daily commuters from across the Polish border. Czechoslovakia received the second largest number of foreign workers, mainly from Poland and Yugoslavia.

All of the Eastern European countries continued to send and to receive small contingents of specialized workers. Bulgaria had sent a small number of specialists to other CMEA countries and had brought in Yugoslav construction workers on fixed-term contracts. Since 1972, with contracts extended up to 1975 and again up to 1980, Hungary had been sending some 3,000 technicians and engineers per annum to work on contracts of from two to three years in various industrial establishments in the German Democratic Republic; in turn, Hungary had been receiving smaller numbers of specialized workers from that country and Romania. Poland had been sending large numbers of workers to Czechoslovakia and the German Democratic Republic, as well as to the Union of Soviet Socialist Republics, under different CMEA joint-project obligations, in addition to the thousands of its nationals who commuted daily across the border to the German Democratic Republic. Romania, which had in recent years sent specialists to Bulgaria, Hungary and the USSR to work on various joint CMEA projects, had received workers from Czechoslovakia, the German Democratic Republic and the Soviet Union. Apart from the mutual transfer of specialized labour, the Governments of the Eastern European countries had adopted a considerable range of policies that affected emigration. On the one hand, Hungary had adopted rather flexible emigration and travel regulations. It was estimated that some 90 per cent of all applications were granted permission to emigrate. Most cases involved family reunification; and despite the laws that restricted emigration to persons over age 55, there was a high degree of tolerance in practice. At the other extreme, the German Democratic Republic had made a thorough and methodical effort to limit emigration—as shown by a wide variety of travel restrictions, as well as by its efforts to build a strong sense of national identity. Emigration for the purpose of family reunification did occur, however, and involved the average annual emigration of some 10,000 nationals of the German Democratic Republic to the Federal Republic of Germany.

The emigration policies of the other Eastern European countries fell somewhere in between those of Hungary and the German Democratic Republic. Although the Government of Bulgaria generally discouraged emigration, it gave some recognition to the right of family reunification, as provided for under the Helsinki Accords (1975). In recent years, Bulgarian refugees, who were mostly young people and members of the Turkish Muslim minority, had sought asylum in the Federal Republic of Germany, Turkey and the United States of America. Czechoslovak refugees included a continuing flow of ethnic Germans to the Federal Republic of Germany, as well as persons who left under the family reunification provisions of the Helsinki Accords. In Poland,

[13] "Report of the Conference on the Situation of Refugees in Africa", Arusha, United Republic of Tanzania, 7-17 May 1979 (REF/AR/CONF/Rpt.1).

[14] United States of America, Library of Congress, Congressional Research Service, *World Refugee Crisis: The International Community's Response* (Washington, D.C., 1979), p. 65.

the laws restricted emigration, which had declined since the mid-1960s and which remained lower than it had been before the signing of the Helsinki Accords. The Government denied many applications for exit visas, even for the purpose of family reunification, although a significant flow of ethnic Germans continued to depart for the Federal Republic of Germany, according to provisions of the Helsinki Accords. Lastly, many of the Jewish nationals of Romania had left that country in recent years, while its ethnic German minority had been emigrating to the Federal Republic of Germany at a rate of about 10,000 persons per annum.

Northern Europe

Except for the United Kingdom, which considered immigration to be too high, there had been little change in the perceptions and policies of the Northern European countries. Denmark had had continuing net emigration in recent years, in part as a result of its policy of allowing immigration for the purpose of family reunification. Outward movement from Finland decreased by some 3,000 persons during 1978, while inward movement remained virtually stable. Although Sweden remained the first destination for Finnish migrants, there had been concern among both the Finnish and Swedish authorities because of the increasing proportion of spontaneous migration—i.e., migration not channelled through the employment services of the two countries, as envisaged in the original Nordic Common Labour Market Agreement. In Norway, the restrictions on immigration were still in effect, except for inhabitants of the other Nordic countries. In recent years, Norway had experienced a slight annual net influx; however, while the net immigration from other European countries had increased, flows from various Asian countries had decreased considerably.

Although no major policy changes had taken place in Sweden, a number of measures had been taken to enforce immigration control, to improve co-operation with sending countries, and to promote the integration of foreign workers. Although the policy required that all non-Nordic entrants must be in possession of residence and, if appropriate, work permits before arrival in Sweden, only about 20 per cent had complied with that provision; the remainder had been "exceptionally" admitted. The Parliamentary Committee on Aliens Legislation had recently proposed that those regulations should henceforth be firmly applied. Since the policy of Sweden was designed to promote the use of all groups within the potential domestic labour force—including resident foreigners—as a means of requiring as little new immigration as possible, the Government had been concerned about the increasing proportion of immigration from Finland that was not channelled through the employment services of the two countries.[15]

Although the United Kingdom had been a net exporter of population in recent years, the Government's current policy was intended to curb future immigration from Commonwealth countries. Legislation proposed in late 1979 would restrict most future immigration to the wives and children of male heads of families who were legally settled in Great Britain. The objectives of that legislation were to achieve a reduction of some 1,500-2,000 in annual immigration into Great Britain—out of a total immigration of some 70,000.[16] Immigration had already been sharply curtailed over the past few years and the country was experiencing a net outflow of 5,500 emigrants per annum, as well as a zero rate of natural increase.

On the issue of refugee resettlement, Denmark, Finland, Norway and Sweden had been among the highest contributors to UNHCR on a per capita basis. All of the countries had resettled small numbers of Indo-Chinese refugees, and Sweden had accepted those who were physically handicapped. Although the United Kingdom had a stock of some 153,000 refugees, it announced at the Meeting on Refugees and Displaced Persons in South-East Asia, held at Geneva from 19 to 21 July 1979, that it would take 10,000 additional Indo-Chinese refugees. In general, however, the authorities considered that they should give priority to current and future refugees from traditional Commonwealth areas.

Southern Europe

As countries that were among the major suppliers of temporary "guest workers" to Western Europe, the countries in Southern Europe had received a continuing flow of return migrants and had a positive net migration balance. Although most Governments in the region had encouraged return migration, Malta continued to discourage returnees, since an influx of predominantly working-age population would cause further problems for its already strained labour market. At the same time, however, the Government had made various efforts—such as the employment of some 8,000 persons in its Emergency Labour Corps—to prevent high unemployment from being translated into higher emigration.

In recent years, Greece had had a positive net migration balance, as a result of the return movement of former labour migrants and of its policy of allowing the repatriation of ethnic Greeks. The trend in Italy had been largely similar. Since 1974, Italy had experienced a net migration gain, which reflected an excess of return migrants over emigrants, although the positive net migration balance concealed a considerable flow of migrant workers that appeared to have increased in recent years. Italy was sending a significant volume of emigrants to new destinations in Africa, Latin America and Asia, as a result of growing activity of Italian firms in those areas. At the same time, Italy received significant numbers of illegal migrants, from various countries of Northern Africa and Asia, who served essentially as replacement migrants.

In the case of Portugal, official emigration figures showed a rise of nearly 10 per cent in 1978 in total departures, largely as a result of movement to new destinations in Africa, Western South Asia and other regions of Asia. There had been a marked increase in the numbers of Portuguese workers on fixed-term contracts sent to such petroleum-exporting countries as Algeria, Iraq and the Libyan Arab Jamahiriya. Emigration to certain traditional des-

[15] Organisation for Economic Co-operation and Development, Directorate for Social Affairs, Manpower and Education, *SOPEMI: Continuous Reporting System on Migration, 1979 Report* (Paris, 1979), p. 43.

[16] "Disarranging marriages", *The Economist*, 8 December 1979, p. 12.

tinations, such as France and the Federal Republic of Germany, had shown a high proportion of females in recent years, indicating the importance of family reunification in movement towards those countries.

Although Spain had received a continuing flow of return migrants, large numbers of its nationals remained abroad. Approximately 959,000 Spaniards resided in other European countries as of 1978, of which 477,700 were in the active population. In addition, some 1.7 million Spaniards were resident in non-European countries, primarily in the Americas. The Government continued to promote oversea employment. Assisted emigration to various oversea countries increased by nearly 14 per cent during 1978, of which 35.2 per cent went to Venezuela. Employment offers from abroad totalled nearly 150,000 in 1978, of which a majority had come from Europe, with some 117,000 from France alone. (Most of the offers from France were for seasonal workers, however, and mainly for nominated candidates known to the employer). The 50,000 returns from European countries in 1978 represented a drop of some 20 per cent over the previous year.[17]

Yugoslavia had been affected by a similar return migration flow, although the net drop of 10,000 workers (32,000 outward and 42,000 inward) in the migration balance during 1978 was probably compensated by a similar increase in the numbers of family members who emigrated. That would leave the total number of Yugoslav citizens in European countries at nearly 1.1 million, of which 695,000 were employed. In addition, there were an estimated 348,000 Yugoslav migrants in various non-European countries, as well as some 13,000 workers employed abroad by various Yugoslav enterprises, mainly in building, contracting and dock work. Although discussion of the subject continued in national, regional and local political circles, few concrete programmes existed for the employment of returned Yugoslav migrants. In particular, the federal law on the acquisition and utilization of foreign funds for the expansion of such employment remained inoperative throughout 1978.[18]

In the period 1978-1980, the countries in Southern Europe had been relatively less affected by refugee flows than those in Northern and Western Europe. Italy continued to be a country of transit for Eastern European refugees. Spain had accepted some 100,000 Latin American political refugees over the years, including many Cubans; and it had agreed to accept several hundred more Cubans during 1980. Portugal had set up a programme for the repatriation of former Angolan residents in 1978, although it was not yet certain at what rate those return migrants would be absorbed. It had accepted small numbers of refugees from East Timor but had been unable to accept all those who claimed Portuguese citizenship, due to the continuing presence of large numbers of refugees from its former colonies in Africa.

Western Europe

The situation of former "guest workers" in Western Europe had changed little since 1978. The existing stock of foreign workers had not been greatly reduced, while immigration that permitted the reunification of families of foreign workers continued in a number of countries. A major issue that required resolution was that of the integration of foreign workers and their families. Towards that end, Belgium and the Federal Republic of Germany had passed legislation in 1979 that would facilitate the integration of foreign workers, while Switzerland had revised its nationality laws. The Netherlands also had adopted new legislation during 1979, in an attempt to regulate more closely, and to some extent restrict, the employment of foreign workers. Although a number of measures previously introduced by the French Government to reduce the foreign labour force had been declared unconstitutional, the Government had continued to press in that direction and had approved a new series of restrictive measures during 1979.

To summarize the situation in the major receiving countries, the population of Austria had declined slowly in recent years, as a result of a deficit of births and a reduction in the stock of foreign workers. There had been no legal changes in Austrian international migration policy since 1976. Entry policy continued to be based largely on labour market considerations: foreign workers were recruited on an annual basis for specified employment. The number of work permits issued in 1978 was, however, the lowest in a decade.[19]

Although the volume of immigration in Belgium had declined in recent years, there continued to be a slight excess of entries over departures. The Government had not limited immigration for the purpose of family reunion nor had it attempted to induce workers, including the unemployed, to return to their countries of origin. In recent years, however, the Government had applied more rigorous legal measures to reduce clandestine immigration.

Belgium was one of several Western European countries that had adopted new legislation since 1978 to improve the situation of its foreign workers. In March 1979, the Government of Portugal had ratified an agreement previously concluded with Belgium that included a number of entirely new provisions: family reunification after one month; employment rights for members of the worker's family; the setting-up of associations for Portuguese immigrants; and co-operation on vocational training activities that would take into account an eventual return to Portugal.[20]

The Federal Republic of Germany had adopted similar legislation. Although it had kept an almost total ban on the entry of new foreign workers, other than those from countries in the European Economic Community (EEC), the Government's policy permitted the entry of family members and facilitated their subsequent access to the labour market. Whereas the spouse and unmarried children continued to be allowed to join a foreign worker after one year's residence of the latter, their eventual admission to work had been modified in 1979, which had eased the situation of spouses and children of non-EEC foreign workers. Children would be eligible to obtain a work permit two years after entry—or earlier if they had attended a vocational training course of at

[17] Organisation for Economic Co-operation and Development, *SOPEMI . . . 1979 Report*, p. 52.

[18] *Ibid.*, p. 54.

[19] *Ibid.*, p. 40.

[20] Social and Labour Bulletin, February 1979, p. 206.

least six months' duration. Spouses would, as a rule, have to wait four years before they could obtain a work permit in sectors of the economy that suffered from a labour shortage. As an exception, in districts where shortages were particularly acute, a work permit could be issued after three years.[21]

The integration of foreign children and young people was another major aim of the Government's policy and the object of extensive action by both the *lander* and the federal authorities. Plans had been formulated for the improvement of the transition from school to work and the reorganization of advisory and information services for migrants in general. Lastly, within the framework of aid to return and development in the emigration countries, negotiations on training and investment assessment had been begun with the Government of Greece and initial discussions held with the Government of Yugoslavia.

As a means of facilitating the integration of its foreign-born population, Switzerland had recently modified its nationality laws. The over-all policy remained governed by the Ordinance of the Federal Council and stated that the number of foreigners who held established or annual residence permits and engaged in gainful activity should be gradually lowered so as to maintain a reasonable balance between the Swiss and foreign population. The principal change in the policy of Switzerland concerned the attribution of Swiss nationality. As of 1 January 1978, the child of a native-born Swiss woman and her foreign husband had acquired Swiss nationality, provided only that the parents were domiciled in Switzerland at the time of the birth.

In the case of the Netherlands, legislation adopted during 1979 was directed towards the regulation, and to a certain degree the restriction, of the use of foreign manpower. The Netherlands had a slight migration surplus, as a result of a policy that permitted reunification of the families of foreign workers. Under the New Act on the employment of foreign workers, effective at the beginning of 1979, no employer could hire a foreign worker without a work permit issued by the Ministry of Social Affairs. (No work permit was required from foreigners with a residence permit, from citizens of EEC countries or from migrant workers who had been legitimately employed in the Netherlands for more than three years and who possessed a permanent work permit.) Applications for a work permit were to be submitted jointly by the employer and the worker, but the permit would be issued in the name of the employer—who would be penalized in cases of infringement, under the Economic Offences Act. To restrict to some extent the future entry of foreign workers, the Act introduced the concept of "permit quotas"—i.e., the maximum number of work permits that might be issued simultaneously in any enterprise.[22]

In spite of the fact that a number of measures introduced by the French Government during 1977[23]—as a means of reducing the foreign labour force—had been repealed as unconstitutional in 1978 by the Council of State, the Government had approved a new series of immigration measures in 1979 (due to be discussed in the National Assembly in October). Those measures were geared to reduction of the foreign population in France by about 150,000 perons per annum, chiefly by means of not automatically renewing existing permits—something the Government had done almost universally since 1974.

Under the proposed measures, the number of permits would be reduced to two types. An immigrant who had lived in France continuously for 20 years could qualify as a "privileged resident" and would be issued a 10-year permit, as well as be given a guarantee of automatic renewal. The second type of permit, the three-year permit, was reserved for refugees. Although the Government envisaged that large numbers of foreign workers would return to their countries of origin during 1980, that did not in fact occur. Due, for example, to a protest from the Government of Algeria, France agreed to prolong all Algerian permits for a one-year period.

According to the provisions of another bill, on the subject of illegal immigration, presented by the Interior Ministry in 1979, the deportation of illegal immigrants would be made easier, since their expulsion could be decreed by Interior Ministry officials and could circumvent the courts.

All countries in the region continued to be actively involved in refugee resettlement.[24] Summarizing recent developments in the major refugee-receiving countries:

(*a*) Austria, a country with a tradition of granting asylum to refugees from Eastern Europe, continued to serve as a staging facility for émigrés from the Soviet Union;

(*b*) Belgium had accepted more than 1,500 Indo-Chinese refugees;

(*c*) Although the Netherlands had absorbed thousands of Surinamese in recent years, it had agreed to accept some 1,000 Indo-Chinese refugees during 1979;

(*d*) In spite of its small size and density, Switzerland had accepted large numbers of Indo-Chinese refugees. As in the case of Sweden, its policy had been to accept hard-to-place refugees, such as those who were physically or mentally handicapped;

(*e*) France had a large refugee resettlement programme that admitted from 14,000 to 16,000 refugees per annum, although there were reports that those numbers might be reduced. Because of ties that derived from its former role as a colonial Power in Eastern South Asia, the majority of the 1,000-1,200 refugees per month were from Democratic Kampuchea, the Lao People's Democratic Republic or Viet Nam. Refugee flows into France were of demographic significance, because refugees constituted more than 20 per cent of all immigrants in 1980;[25]

(*f*) The Federal Republic of Germany continued to give top resettlement priority to ethnic Germans from the Soviet

[21] *Ibid.*, pp. 205-206.

[22] *Social and Labour Bulletin*, March 1979, p. 313.

[23] Those measures included imposition of a three-year ban on immigration, termination of the issuance of work permits, extension of return assistance to all workers who had resided in France for a five-year period, suspension of family immigration and an offer of a cash bonus to those foreign workers who agreed to return to their countries of origin.

[24] Office of the United States Coordinator for Refugee Affairs, *op. cit.*

[25] Organisation for Economic Co-operation and Development, Directorate for Social Affairs, Manpower and Education, *SOPEMI: Continuous Reporting System on Migration, 1980 Report* (Paris, 1980), p. 14.

Union and Eastern Europe, of whom it had accepted some 58,000 in 1978, although it had recently accepted smaller groups of non-German refugees, including some 3,000 Indo Chinese during 1978. At the meeting at Geneva in 1979, it had raised its offer of resettlement places to 20,000, although there were subsequent reports that it might decide to reduce its pledge.

Cyprus, Israel and Turkey

The three non-Arab countries in western South Asia—Cyprus, Israel and Turkey—had very different international migration trends. Cyprus, as a result of its rapid economic recovery, had a continuing decline in emigration, accompanied by the gradual repatriation of many of its nationals who had been uprooted in 1974. Unemployment, which had been estimated at 35 per cent of the labour force in 1974, was down to 1.8 per cent; and the country was experiencing labour shortages.[26]

Although Israel remained one of the few countries at world level that desired increased immigration, the trend had run counter to the Government's policies. According to a report of the Knesset Immigration Committee, 2,000 Israelis were emigrating each month, mostly to the United States of America. Some 25,000 Israelis were expected to emigrate in 1980, 10,000 more than the number who had emigrated in 1979. If the current trend were to continue, more Jews would be emigrating from Israel than would be arriving from other countries, a phenomenon that was of serious concern to most Israelis. In addition to a rise in the emigration of Israeli nationals, there had been a decline in the number of Jews who immigrated to Israel under the provisions of the Law of Return, by which any person of the Jewish faith might freely immigrate to Israel. Although Israel had received significant numbers of Jews from the Soviet Union in recent years, more than 65 per cent of that group chose to settle in other countries.[27]

Although Turkey had received a steady flow of return migrants since around 1974, some 759,000 Turkish workers, of which about 80 per cent were male, were living outside the country at the end of 1978, approximately 44,000 more than had been living abroad in the previous year. Although the proportion of Turks who resided in The Federal Republic of Germany was still about 70 per cent, there were as many as 40,000 in Saudi Arabia and 22,000 in the Libyan Arab Jamahiriya, as well as smaller numbers in other non-traditional receiving countries. As a result of high unemployment and underemployment and generally unfavourable economic conditions, pressure to emigrate was expected to persist.[28]

On the issue of refugee resettlement, although the situation had improved considerably, there were still some 8,000 Cypriots in refugee camps. In addition to allowing the unrestricted immigration of refugees of the Jewish faith, Israel also accepted small numbers of non-Jewish refugees. At the meeting on refugees held at Geneva in 1979, for example, it had pledged to admit some 200 Indo-Chinese refugees. The Government of Turkey continued to operate a refugee programme for ethnic Turks from such countries as Bulgaria.

Northern America

The major innovation of the 1978 Immigration Act had been that the Government of Canada would determine annual immigration quotas. As the Government reported in the Fourth Inquiry, "the flow may be increased, maintained or decreased each year, depending on economic conditions". The Immigration Act was notable in that it gave landed immigrants the same basic rights as Canadian citizens, except for the right to vote. Moreover, an immigrant was to be allowed to apply to bring in his relatives as soon as he arrived in Canada.

The cumulative intake of refugees had made Canada one of the largest contributors to Indo-Chinese resettlement. Its unique system, which involved the Government's sponsoring one refugee for each one privately sponsored and which enabled a group of five persons to sponsor a refugee family, had surpassed expectations and had provided 25,000 offers of sponsorship by December 1979, against the target figure of 21,000 which had been set for the period ending 31 December 1980.

Family reunification, rather than labour force needs, was the corner-stone of immigration policy in the United States of America. Of the seven preferences that defined, limited and ranked those eligible for the 290,000 numerically limited visas available, four preferences—which constituted 74 per cent of the total visas—were reserved for close relatives of United States citizens and permanent residents. The major arguments for maintenance of a heavy emphasis on family reunification were humanitarian concerns and the fact that familial ties provided a good foundation for the integration of new immigrants into society.

Because of the numerical ceiling (290,000), as well as limits per country (20,000) and preference limitations that strongly favoured family reunification, over 790,000 persons had been on lists at various visa-issuing ports throughout the world in 1978, waiting to immigrate to the United States. As a result, vast numbers of aliens were frustrated by the United States immigration laws and attempted to violate those laws each year. The major portion of aliens attempted to circumvent the inspection process altogether by crossing the land border between posts of entry.[29]

Concerned that illegal migration could no longer be controlled by existing law and practice, as it had in the past, the Government of the United States had begun in 1971 to explore policy alternatives for regulation of the flow of illegal migrants. Since attempts by the federal Government to formulate a policy on the illegal migration phenomenon had so far failed, state governments had increasingly attempted to control the situation within their own borders. The most recent initiative by the Congress was the creation of a Select Commission on Immigration and Refugee Policy,

[26] "Uprooted Greek Cypriots rebuilding lives", *The New York Times*, 24 April 1980.

[27] Office of the United States Coordinator for Refugee Affairs, *op. cit.*, p. 59.

[28] Organisation for Economic Co-operation and Development, *SOPEMI: . . . 1979 Report*, p. 53.

[29] United States of America, Departments of Justice, Labor and State, *Interagency Task Force on Immigration Policy: Staff Report* (Washington, D.C., March 1979).

which was mandated to study and evaluate existing laws and procedures governing the admission of immigrants and refugees, and to make recommendations to the President and the Congress not later than 30 September 1980.

Although the over-all evaluation of United States immigration policy was still in progress, the Congress passed a new Refugee Assistance Act in 1980, to establish a "permanent and systematic procedure" for admission and settlement of refugees in the United States.[30] The Act broadened the definition of "refugee status" to incorporate the United Nations definition and to include persons who feared persecution within their own country, and it established two basic categories: refugees; and those seeking asylum. Whereas preceding legislation had limited non-emergency admissions to about 17,400 per annum, the 1980 Act was expected to allow approximately 50,000 non-emergency refugee admissions for the years 1980-1982.

Subsequently, however, when the United States Government decided to treat the more than 100,000 Cubans, as well as large numbers of Haitians, who arrived in the country during the spring of 1980 as applicants for asylum, the Government in effect created a separate category with no numerical limit.

Union of Soviet Socialist Republics

Since 1978, as a participant in various CMEA joint projects, the Soviet Union had employed mainly Bulgarians—in more than 20 large industrial projects—as well as thousands of Polish workers and technicians, and smaller numbers of specialists from various CMEA countries. It had, in turn, sent between 500 and 1,000 workers and specialists annually to most of the Eastern European countries.

The Government still strictly controlled entrance into and exit from the USSR; family reunification was the only justification for emigration and the Government retained the prerogative of identifying appropriate family members.

Currently, the Government permitted only three ethnic or religious groups to emigrate in any large numbers: Jews, Germans and Armenians, each of which has a homeland outside of the Soviet Union. The emigration of Jews had reached a record level of 50,461 in 1979; and they continued to emigrate in the first few months of 1980 at about the same rate as they had in late 1979, although the flow subsequently began to taper off. As a matter of government procedure, emigration visas usually listed Israel as the country of destination, although the proportion of those who were actually going to Israel had been declining—to 40-50 per cent or less—as more emigrants preferred to go to the United States of America.[31]

C. Area of responsibility of Economic Commission for Latin America

Caribbean

Although the major migration flows in the Caribbean region had been outward, there had been some intraregional movement of seasonal and temporary workers, accompanied by sizeable illegal flows to countries in the region that had higher per capita incomes, such as the Bahamas and Barbados.

The latter situation appeared to be changing. Although large numbers of Haitians had entered the Bahamas illegally since the early 1960s, many as a first step in stage migration to the United States, the Bahamas had launched an intensive campaign in 1978 to rid the islands of illegal migrants. At first, it had expelled some 20,000 illegal Haitians and then had begun an intensive campaign to expel an additional 30,000-40,000. It had set a voluntary deadline of mid-1979, after which arrest and deportation were to be carried out. The Governments of Barbados and of Trinidad and Tobago had become similarly strict.

With the closing of many former avenues for permanent emigration from the Caribbean, there had been some attempts to set up temporary labour schemes, although those efforts had been generally unsuccessful. Jamaica, for example, had entered into an agreement with Venezuela in 1979 for the exportation of temporary workers, but the experiment ended in failure when both countries argued that the other had violated the terms of the agreement.

In addition to the continued exodus of skilled personnel—over which most Governments in the Caribbean region had shown growing concern, but against which they had experienced little success—there was the largely illegal movement of unskilled workers towards such destinations as the United States of America, Puerto Rico and Venezuela. A number of Governments had openly sanctioned that flow. The Dominican Republic, for example, had acknowledged the impact of emigration in bringing about a desired reduction in population growth, as well as the positive effects of remittances on its balance of payments.[32] Likewise, in a number of official statements, the Government of Haiti had reported that remittances were an important source of revenue; and it had made no attempt to curtail the continuing flow of "boat people" to the United States.[33]

The latter position raises an interesting point—namely, the problem of determining which persons are *bona fide* refugees and which are economic migrants. In the case of Haiti, while there had been a continuing movement of highly skilled Haitians to the United States, the latter country had been reluctant to accept the unskilled, particularly if they entered the country illegally; and its over-all position had been that the Haitian "boat people" were economic rather than political refugees and should not be entitled to political asylum. However, in the wake of the acceptance of large numbers of Cubans in the spring of 1980, the treatment of the Haitians by the United States was severely criticized; and it decided to accept both groups as applicants for political asylum. As of the summer of 1980, an average of 500 Haitians were arriving daily in the United States.

As stated above, Cuba sanctioned the departure of over

[30] United States of America, Refugee Act of 1980, Public Law 96-212, 17 March 1980.

[31] Office of the United States Coordinator for Refugee Affairs, *op. cit.*, pp. 12-43.

[32] *Population Policy Compendium: Dominican Republic*, situation as assessed in September 1979, joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities (New York, 1979).

[33] *Population Policy Compendium: Haiti*, situation as assessed in August 1980 (New York, 1980).

100,000 persons—or approximately 1 per cent of its population—during the spring of 1980. The flow of refugees is unlikely to resume in the near future, since the Government of Cuba unilaterally terminated the departures.

Middle America

There had been a number of policy changes in Middle America, chiefly as a result of the displacement of hundreds of thousands of Nicaraguan refugees during the period 1978-1979. Costa Rica, a country that desired a continuing reduction in its population growth, had changed its position on immigration and currently considered it to be too high, largely as a result of the influx of Nicaraguan refugees. At the Meeting on Refugees at Geneva in 1979, Costa Rica had withdrawn its offer to accept several hundred Indo-Chinese refugees; it had reported that its refugee population, made up largely of Nicaraguans, constituted some 2.5 per cent of its total population. The Government had stated that it would be unable to accept additional refugees until a substantial number of Nicaraguans were repatriated. In the spring of 1980, however, Costa Rica agreed to serve as a staging area for the first flows of Cuban refugees and offered to accept some 300 Cubans for permanent resettlement.

Honduras was the second country in the region that had changed its position on immigration and regarded it as too high, largely as a result of the arrival of an estimated 100,000 refugees from Nicaragua. The Government's international migration policy, which had been in effect since 1971, sought to maintain a balance at the regional level between the native and immigrant populations, to establish strong national population clusters along the frontiers and to attract skilled immigrants. However, in spite of the Government's desire for selective immigration, the major flows had been largely unplanned and had consisted of illegal migrants from neighbouring countries in Middle America, followed by the more recent influx of Nicaraguan refugees.

Mexico continued to be a major emigration country, and illegal emigration remained a sensitive political issue for the Government. The current Administration had acknowledged that the emigration of large numbers of undocumented workers to the United States was an important matter to be negotiated with that country. It had emphasized that the problem of emigration was closely related to that of unemployment and that Mexico did not currently have the capacity fully to resolve its unemployment problems, although increased assistance from the United States (through trade measures, for example) was acknowledged to be a possible means of reducing the pressure on Mexican nationals to emigrate. Although hundreds of thousands of Mexican nationals left the country each year, legally as well as illegally, few formal attempts had been made to secure their return.[34] In recent years, the Government had been primarily concerned with the human rights aspects of emigration and had urged the adoption of bilateral accords to protect undocumented workers. Mexico had been relatively unaffected by refugee movements. It had no formal refugee programme and handled requests for asylum on a case-by-case basis. At the 1979 Meeting on Refugees, the Government had reported that it was not in a position to offer places for resettlement, due to its high rate of population growth and the emigration of its own nationals as a result of unemployment pressures.

In contrast to emigration in Mexico, which consisted largely of clandestine flows, El Salvador was one of the few countries at world level that had an explicit policy to promote the emigration of its nationals. Its Programme for the Settlement of Salvadorian Nationals in Bolivia involved the proposed transfer of unemployed urban workers and their families to agricultural colonization areas in Bolivia. Another programme involved the hiring of Salvadorian workers on fixed-term contracts for urban construction works in Saudi Arabia. (The Government had signed an agreement with a private consortium to send some 5,000 semi-skilled Salvadorian construction workers, although as of late 1978 only 35 workers had actually been sent). Although its emigration policy was largely in the planning stages, the Government had organized an *ad hoc* commission at a high administrative level to develop an expanded emigration programme.[35]

Temperate South America

In Temperate South America, although Argentina continued to be one of the major destinations for Latin American migrants, the Government desired increased immigration, since it recognized that, in spite of a policy of profertility incentives, Argentina would not be able to achieve a rate of natural increase comparable to that of other countries of Latin America. Although the current Administration had somewhat scaled down its expectations from the 5 million immigrants that had been desired at the time of the World Population Conference in 1974, it retained its goal of attracting immigrants from Western European countries, although it had received only an insignificant flow of Europeans in recent years. The major immigration that it continued to receive was the largely illegal flow of some 40,000 persons per annum from Bolivia, Chile, Paraguay and, to a lesser extent, Brazil and Uruguay. The Government had been generally tolerant of that movement and had granted an amnesty to some 150,000 illegal migrants during the 1970s.[36]

While Uruguay desired an increased rate of population growth, the Government did not consider that immigration would be an important component of demographic change. The country had lost about 10 per cent of its population through emigration between the censuses of 1963 and 1975, and economic difficulties had resulted in continuing outmigration to Argentina, a flow that would not easily be reversed.

Although Chile had adopted a new national population policy in November 1978 and desired to increase population growth, it planned to do so through modification of fertility and mortality, rather than through an increase in immigration. The Government was reported to have refused offers

[34] *Population Policy Compendium: Mexico*, situation as assessed in January 1979, (New York, 1979).

[35] *Population Policy Compendium: El Salvador*, situation as assessed in September 1979 (New York, 1979).

[36] *Population Policy Compendium: Argentina*, situation as assessed in January 1979, (New York, 1979).

by the Government of Japan and by the former Government of Southern Rhodesia (now the independent State of Zimbabwe) to engage in planned immigration schemes, largely as a result of political opposition from local groups.[37] Furthermore, for a number of years Chile had had a net outward migration of both skilled and unskilled workers, including large numbers of political refugees.

There had been a number of policy changes in the region which affected refugees, notably in Argentina. Whereas the thousands of political refugees from Chile, Uruguay and Paraguay who had arrived in Argentina during the early 1970s had been prohibited from seeking work, those who had arrived since 1976 had been regarded as immigrants. Moreover, in 1979, Argentina had agreed to admit some 1,000 Indo-Chinese refugee families, although it had requested financial assistance for their resettlement. In recent years, Argentina had, in turn, generated thousands of refugees, who had sought asylum throughout Latin America, as well as in Western Europe and in the United States of America. At the 1979 Meeting on Refugees, Chile had stated that although it had a tradition of granting asylum to refugees, it could not offer resettlement places to refugees from Eastern South Asia, chiefly for economic and geographical reasons. Similarly, Uruguay had not participated in international refugee relief efforts.

Tropical South America

The major immigration flows in Tropical South America had responded more to market forces than to governmental policies and had been directed both to countries with higher levels of development and to areas of high economic growth within countries with low over-all levels of development. Venezuela remained the major pole of attraction in the region. Although the Government desired to decrease immigration, the country had received the largest flows of any country in the region. While Venezuela had long been the preferred destination for Colombian migrants, its labour market had expanded greatly in recent years to attract migrants of all skill levels—from Argentina, Colombia, the Dominican Republic, Peru and Uruguay. Despite official concern over the continuing influx, the creation of an agency for the recruitment of foreign workers, the signing of a labour importation agreement with the Governments of Portugal and Spain, and the membership of Venezuela in the Andean Pact assured that selective immigration would continue. The largely illegal nature of the flow made it difficult to control, however, and there had been a growing movement within Venezuela to safeguard the national identity. In addition, the alleged maltreatment of illegal workers had aggravated tensions between Venezuela and the major sending countries.

The immigration of large numbers of Brazilians into Paraguay, in the same decade that hundreds of thousands of Paraguayans were living abroad, was an illustration of the complex forces that had determined international migration in the region. Paraguay had long been a net exporter of migrants, particularly to neighbouring Argentina. Although it had a high rate of natural increase, the Government considered its rate of population growth to be too low, since around 15 per cent of its total population had been living outside the country as of the early 1970s. In the past several years, the direction of the flow had been reversed; and many Paraguayans were returning to their country of origin, due to the fact that construction of the Itaipú and Yactera dams on the border between Argentina and Paraguay and the economic activity generated by groups of foreign colonists had increased the attraction of Paraguay as a migration destination.

Two countries in the region—Brazil and Peru—had recently adopted stricter policies with respect to immigration, although neither was a major receiving country. In Brazil, weak immigration from neighbouring countries, in spite of the fact that it was one of the most economically developed countries in the region, may be explained by its underdeveloped transportation infrastructure and by rather poor communications with other countries in the region. It had been the composition, rather than the size, of recent flows that appeared to have led to a change in the Government's policy. Because of its concern over political activities which involved foreign nationals, the illegal entry of refugees from Eastern South Asia and the activities of foreign missionaries, the Government had drafted a new immigration law that, unless drastically amended, would subject foreigners to various new controls. A proposed national immigration council would monitor foreigners' activities, regulate the treatment of foreign technicians temporarily in the country and rigidly circumscribe the activities in which foreigners might engage.[38]

Although Peru had received comparatively little immigration, in February 1979 the Government had issued a new decree on the hiring of alien workers. Under the decree, nationals must account for the total staff employed in an enterprise during its first three years of operation and for 90 per cent thereafter. Employers who hired foreign workers must prepare and implement systematic plans for the training of nationals to replace foreign experts. The new decree also established a Permanent Board for Migrant Workers within the Ministry of Labour, which would review all applications for a labour contract with an alien, as well as applications for exceptions to the aliens' quota.[39]

A trend observable in several countries in the region was that of encouraging selective immigration. Since the publication of the preliminary results of its 1976 census, Bolivia had attempted to attract immigrants as a means of achieving a larger population size. It had established a National Immigration Council in 1976 and had formulated an "open-door policy", under which several categories of immigrants (spontaneous, directed and selective) were granted benefits that ranged from free grants of land to duty-free importation of machinery and tools to promote their settlement in Bolivia. The Government's policy was, however, essentially selective, since it would like to attract skilled migrants and those qualified in land settlement. In the late 1970s, it had expressed a desire for some 150,000 immigrants of Euro-

[37] *Population Policy Compendium: Chile*, situation as assessed in March 1981 (New York, 1981).

[38] "Brazil draws up harsh legislation to control aliens", *Business Latin America* (New York), 13 August 1980, pp. 257-258.

[39] *Social and Labour Bulletin*, March 1979, pp. 315-316.

pean stock from countries in Southern Africa.[40] That scheme had not materialized, however, and the only accord that it had signed to date was with the Government of El Salvador in 1978. The international migration policy of Ecuador also favoured selective immigration, as well as the repatriation of qualified Ecuadorian nationals. The Government recruited qualified migrants through its oversea consular offices and recently concluded an agreement with the Intergovernmental Committee on European Migration (ICEM) to recruit technicians and other qualified personnel.

Before concluding this brief discussion, it is important to cite the example of Colombia, a country with a rather unique international migration policy. The Government of Colombia treated international migration as an extension of migration within the country and had been one of the first labour-sending countries to regard its international migration policies as part of a broader scheme of socio-economic development. The Government's labour migration policies were designed to retain migrants in their place of origin, but to assist those who made the decision to migrate in finding satisfactory employment both within and outside Colombia. Towards that end, the National Employment Service of the Ministry of Labour (SENALDE) continuously evaluated employment conditions in various regions of the country and channelled workers to regions where there was labour demand. In addition, five Border Offices for Employment and Labour Migration had been established along the borders with Brazil, Ecuador, Peru and Venezuela, in order to assist returning migrants in finding employment.[41]

Most countries in the region had participated to only a limited extent in international refugee relief efforts. Although Venezuela continued to accept some political refugees from other countries of Latin America, the Government maintained that it was not in a position to receive refugees from outside the region. Bolivia had not participated to any extent in refugee relief efforts, while Colombia accepted only small numbers of refugees on a case-by-case basis. Ecuador had accepted a considerable number of political refugees from other countries of Latin America, but had not recently been involved in refugee relief efforts, while the recent economic difficulties of Peru limited its ability to contribute.

Several countries in the region had recently changed their position on refugees. In late 1978, Brazil had withdrawn from ICEM; it had cited its lack of need for immigrants and the ICEM shift in focus from European migrants to refugees from Eastern South Asia. At the Meeting on Refugees at Geneva in 1979, Brazil had stated that its high rate of inflation and continuing unemployment, as well as the difficulties it had encountered in assimilating previous Asian immigrants, were further reasons for its rejection of resettlement proposals that involved Indo-Chinese refugees. In addition, the new immigration law would affect hundreds of thousands of refugees from other countries of Latin America who resided in Brazil, since the law stipulated that foreigners in a clandestine or irregular situation might not legalize their stay. The Government of Brazil maintained that those persons should apply for assistance from UNHCR, although few were likely to meet UNHCR criteria. Lastly, Paraguay, which had traditionally accepted large numbers of refugees, had modified its position, as a result of difficulties encountered in a recent experiment with the resettlement of immigrants from the Republic of Korea and refugees from Eastern South Asia.

Guyana, a country with vast undeveloped tropical areas, was the only country in the region that was willing to accept large numbers of refugees from Eastern South Asia. In 1979, a consortium of private religious groups had attempted to arrange for several thousand (eventually 30,000) Lao refugees to be relocated in a remote area of Guyana. As of December 1979, the Prime Minister of Guyana had responded positively to a proposed plan for the resettlement of some 750 Lao refugees, but the refugees themselves subsequently declined the offer.[42]

D. Area of responsibility of Economic Commission for Western Asia

Western South Asia[43]

The large flow of foreign workers into the oil-producing countries of Western South Asia had continued in recent years, although possibly at a slower rate than during the early 1970s. The greatest inflow had occurred in the United Arab Emirates. As was the case in several other countries in the region, the Government had recently decided to tighten its labour laws. Foreign workers—which included some 400,000 persons from Bangladesh, India and Pakistan—were given until June 1980 to regularize their papers and to comply with labour laws that stipulated that foreign workers must be sponsored by a national of the United Arab Emirates or by a recognized firm. All persons who were working for employers other than their original sponsors, or those who had been sold sponsorship papers and then found work themselves, would face deportation, while those without passports might be jailed prior to their expulsion.[44]

Saudi Arabia remained a major country of employment in 1980, although it too had tightened its regulations with regard to the employment of foreign workers. In contrast with the position of the other major countries of employment in the region, Arabs had constituted 91 per cent of the total migrant labour force of Saudi Arabia as of 1975. That difference had arisen in part from the Government's policy of giving priority to Arab applicants for work permits, as well as its proximity to, and common borders with, the major suppliers of Arab labour—Democratic Yemen, Jordan, Oman and Yemen.

The Government of Saudi Arabia had attempted to legalize and formalize all employment in the country, including that of the growing number of foreign workers. Every migrant worker in the country was required by law to have a

[40] *Population Policy Compendium: Bolivia*, as assessed in January 1979, joint publication of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat and the United Nations Fund for Population Activities (New York, 1979).

[41] *Population Policy Compendium: Colombia*, as assessed in January 1981 (New York, 1981).

[42] *Latin American Index* (Washington, D.C.), 31 May 1980.

[43] Excluding Cyprus, Israel and Turkey.

[44] "The U.A.E. labor quake", *Monday Morning*, 6 March 1980.

sponsor. To facilitate that sponsorship provision, an amnesty had been declared in early 1978, during which migrants without sponsors or work permits were to be allowed to register without penalty. In spite of those efforts, clandestine movements had continued. In 1979, the Government had deported large numbers of illegal migrants, and it was reported to be considering the setting-up of a computer system to carry out checks of possible illegal migrants, since uncontrolled immigration was perceived to be a threat to the Islamic basis of the Saudi régime.[45]

Kuwait, the country with the largest population and greatest oil reserves among the Gulf States, had adopted a similar position. Although its development had been expedited by the employment of large numbers of Jordanians and Palestinians, as well as Iraqis, Lebanese and Syrians, the Government had become increasingly concerned over the high proportion of foreigners in the labour force. As a reflection of that concern, a decree had been issued in March 1979 by the Kuwait Social Affairs and Labour Ministry, which regulated work permits for foreigners employed in the private sector. Under the terms of the decree, an employer who wished to recruit a foreign worker must apply to the Ministry for a work permit. Unless otherwise stipulated, the employer would be responsible for the repatriation of the worker at the end of the contract or if the contract was terminated by mutual agreement.[46]

Although it had one of the more diversified economies in the Arabian peninsula, Bahrain had not been able to afford foreign manpower on as large a scale as some of the other Arab countries. Although as of 1975 it had employed some 30,000 expatriate workers (40 per cent of the labour force), it had been less dependent on foreign labour than the more resource-rich countries. Because it had been less able to compete for Arab labour, it was employing growing numbers of Asian workers, whose share in the total immigrant population had risen from 32 to 64 per cent during the period 1971-1977.[47]

In Qatar, a resource-rich State with a total population of only 67,900 as of 1975, foreign workers had made up over four fifths of the labour force both in 1970 and in 1975. Whereas migrants in the public sector were virtually all Arabs, largely from Egypt, the private sector was dominated by non-Arabs, although the demand for their labour fluctuated from year to year.

Examining the situation in the major sending countries, Jordan, like Egypt, had a tradition of supplying expatriate labour within the Arab world. Although there were fewer Jordanians abroad than Egyptians as a result of the smaller population size, they made a more significant contribution to the Jordanian economy, which was based largely on remittances. There was an important and growing trend among Jordanian migrants, particularly the more highly qualified, towards taking up permanent residence in countries of employment, a trend that was largely a result of the Government's liberal attitude towards emigration. The Government maintained its policy of placing no restraints on the out-flow of labour or skills, even though the economy had begun to suffer acute labour shortages in recent years.[48]

Oman continued to be both a sending and a receiving country for migrant workers. Rural Omanis migrated abroad for employment in Saudi Arabia or the United Arab Emirates, although their numbers, and thus their remittances, had declined in recent years. The outward movement of Omani nationals had had a serious disruptive effect on the rural economy. The growing employment of Asian labourers in the rural areas of Oman had not alleviated the problem, since the Asians were usually employed in the service sector, and not as agricultural workers.[49]

Another important sending country was the Syrian Arab Republic, a country with a history of permanent emigration of families, followed by the more recent phenomenon of the temporary departure of males. Syrians had been drawn to Jordan in large numbers to serve as replacements in the labour force for Jordanians who had left, a movement that had been aided by the fact that Syrians did not need visas to work in Jordan. Since that movement had led to domestic labour shortages, the Government had a policy intended to discourage emigration. Although the departure of government employees had been effectively curtailed, skilled and semi-skilled manual workers, as well as the unskilled, continued to emigrate, because they were less amenable to government control.[50]

Yemen continued to be a major supplier of labour to Saudi Arabia and the other Gulf States. Although remittances had been of great importance to its economy in recent years, there was some dispute both in the theoretical literature and within Yemen itself on the economic costs versus the benefits of migration. The Government had generally held the view that migration was depleting the work force of its more able members, was bringing about a decline in agricultural productivity, and was causing domestic inflation by sudden large cash inflows to the economy. It had attempted to place some controls on the flow of migrant labour, although those controls had generally been ineffective.[51]

Data on the labour force of Democratic Yemen are difficult to acquire. It is known that substantial numbers of its nationals had returned from Saudi Arabia in recent years, although the rate of return was possibly declining by 1980.

E. Area of responsibility of Economic and Social Commission for Asia and the Pacific

China

The major immigration to China in recent years had been arrival of some 265,000 Indochinese refugees between March 1978 and January 1980. Of that number, some 263,000 refugees had fled across the border from Viet Nam in 1978, while the remainder had come from first-asylum countries in response to the offer by China to accept 10,000 refugees from Eastern South Asia.

[45] *Middle East International* (London), 16 March 1979, pp. 9-10.

[46] *Social and Labour Bulletin*, April 1979, p. 445.

[47] J. S. Birks and C. S. Sinclair, *op. cit.*, p. 74.

[48] *Ibid.*, p. 50.

[49] *Ibid.*, p. 60.

[50] *Ibid.*, pp. 55-56.

[51] *Ibid.*, p. 58.

China was the only country in East Asia—and one of the few centrally planned economies at world level—to accept such large numbers of refugees for permanent resettlement. The Government's humane policy had been motivated in part by the fact that the refugees were regarded as returned oversea Chinese. The policy was not to confine the refugees to camps but to integrate them into state farms, fishing villages, co-operatives and other existing work units, as it had done for other oversea Chinese who had returned voluntarily. Most of the refugees had been settled in the south of China, with the largest concentration in Guangdong, Yunnan and Fujian Provinces and the Guanxi Zhuang Autonomous Region.[52]

In February 1979, the China Construction Engineering Corporation (CCEC), a state enterprise established in 1957, had decided to undertake complete technical co-operation projects which would include surveying, design, and construction, as well as to enter into joint contracts with foreign countries. It had also decided to provide manpower for some of those projects, although, of 72 contracts signed as of September 1980, only 8 involved the provision of teams of Chinese workers.

A majority of the approximately 40 contracts signed during 1979 were for highway and hospital construction projects in Iraq and Yemen. Most of the oversea commercial contracts were arranged through Japanese firms, although CCEC had signed a letter of intent with a firm in the United States of America and with several firms in France and Italy for possible future projects in Western South Asia.

The Government of China repeatedly denied that its workers were being sent abroad in order to ease unemployment "since the CCEC has only sent a few thousand abroad each year, and this would not have any impact on employment in a country with a population of nearly one billion inhabitants".[53]

Another change in the international migration policy of China was the imposition of strict controls on illegal emigration to Hong Kong. In 1979, the Government of the United Kingdom had exercised diplomatic pressure on China to curb illegal flows, and the Government of China complied and instituted strict penalties.

In addition to the more than 200,000 emigrants who had entered Hong Kong illegally during 1979, some 70,000 Chinese nationals had entered legally, with exit permits, valid for periods of from 3 to 12 months, issued by the Government of China.[54] Up to October, 1980, when the Government of Hong Kong changed its policy, nearly all Chinese nationals with exit permits were allowed to stay permanently in the Colony, where they were known as "overstayers".[55]

Japan

Although Japan had been neither a labour importer nor exporter of any significance during the period 1978-1980, a number of Japanese firms had offered teams of Chinese workers to third countries for use on oversea construction projects, such as a number of highway and hospital construction projects planned for Iraq.

Because it is an island country with a homogeneous population that does not easily assimilate foreigners, Japan had been little affected by illegal population movements. Although it had provided first asylum to small numbers of "boat people", it had been criticized by various refugee-receiving countries because it did not accept larger numbers of Indo-Chinese refugees for permanent settlement. (Even the small number of refugees that Japan had admitted on a permanent basis must apply for new visas every year for at least 10 years and were unlikely ever to be eligible for Japanese citizenship). At the Meeting on Refugees at Geneva in 1979, the Government had defended its position on the grounds that, as a result of linguistic and other assimilation problems, a majority of refugees who had been admitted had left voluntarily for third countries. Although it had pledged in the spring of 1979 to underwrite 50 per cent of the UNHCR 1980 budget for refugees from Eastern South Asia and to accept 500 Indo-Chinese refugees, it was not able to fill its quota, due to the strict criteria for admission which remained in force.[56]

Other East Asia

Although the Republic of Korea had had a downturn in fertility, the Government desired a reduction in the rate of population growth, in part as a result of continuing unemployment. In recent years, it had developed a highly organized "project package" approach to labor migration, which involved supplying total projects from design through execution to markets in Western South Asia. Although such projects provided manpower—including management and personnel, from skilled to unskilled—along with machinery and supplies, the Government was not interested in manpower export *per se*. In fact, it had moved to prohibit recruitment of its construction workers by foreign firms.[57]

A peninsula country that shares a tightly controlled border with the Democratic People's Republic of Korea, the Republic of Korea is a racially homogeneous society with no minorities. It had offered asylum to those Indo-Chinese refugees who were rescued at sea and brought to its port. However, as the Government had stated at the Meeting on Refugees in 1979, the majority of these refugees subsequently chose third countries for resettlement, due to such factors as the language barrier and the limited employment opportunities in the Republic of Korea.

The Government of Mongolia, as a result of severe manpower shortages in almost all sectors of the economy, had permitted the temporary immigration of labourers from the USSR and other CMEA countries, under special contracts with respective Governments. Apart from the temporary residence of Mongolian students in various CMEA countries, however, there was no sizeable emigration from the country.

[52] "For Indochina refugees, home and work", *China Reconstructs*, vol. 29, No. 1 (August 1980), pp. 18-20.

[53] "Does China export labour?", *Beijing Review*, No. 43, 27 October 1980, pp. 21-22.

[54] "Hong Kong: another tide of illegals", *Asiaweek*, 18 November 1979.

[55] "Hong Kong: thousands in a legal limbo", *Far Eastern Economic Review*, 28 November 1980.

[56] *The Economist*, 1 March 1980.

[57] Charles B. Keely, "Asian worker migration to the Middle East", Center for Policy Studies Working Paper No. 52, New York, The Population Council, January 1980, p. 2.

Eastern South Asia

In Eastern South Asia, the major intraregional flow of labour migrants since 1978 had been that of Malaysian workers to Singapore, a country to which they were drawn by higher wages. The future of that flow is uncertain, however, due to incipient changes in the manpower recruitment policies. In recent years, as a result of its successful industrialization programme, the densely populated country had experienced labour shortages in the manufacturing sector. Manufacturing firms had taken on large numbers of Malaysians and somewhat smaller numbers of Thai workers, although the recruitment of foreign labour had been considered a temporary measure, since Government planners felt that the encouragement of more technologically advanced industries and an increase in the participation of women offered a better long-term solution. Recently, a number of manufacturing firms in Singapore had raised their starting salaries by 10-20 per cent as a means of attracting native workers, following the Government's imposition of stricter controls on the employment of foreign unskilled labour and its rejection of a number of applications to import workers from Indonesia, Sri Lanka and Thailand.[58] The Government of Singapore was also reported to be considering somewhat of a revision of its anti-natalist policies.

A majority of the labour-exporting countries in the region sent workers outside the region, principally to markets in Western South Asia. In recent years, the Philippines had developed a highly organized system of labour recruitment similar to the model of the Republic of Korea, although it differed to the extent that the Philippines supplied workers for foreign firms, as well as professionals and a large group of merchant seamen.[59] The Philippines Overseas Development Board, one of several institutions that was chartered to deal with the country's "temporary excess of manpower", had recruited growing numbers of Filipino workers. (A labour pact signed by the Philippines and the Libyan Arab Jamahiriya, for example, in the fourth quarter of 1979 represented nearly a 40 per cent increase over the numbers recruited in the previous year.) In addition to that organized flow, illegal Filipino migrants—primarily domestic workers—were reported in Italy and in several other European countries.

Thailand was another country in Eastern South Asia in which the recruitment of labour migrants had increased significantly in recent years. Whereas the Labour Department had recorded fewer than 1,000 Thais working abroad in 1975, their numbers were estimated at as many as 50,000.[60] Once confined largely to the construction field but currently moving into various service industries, Thai workers were employed in Bahrain, Dubai, Iraq, Kuwait, the Libyan Arab Jamahiriya, Qatar and the United Arab Emirates, as well as in Singapore in Eastern South Asia. Lastly, Indonesia also sent manpower to markets in Western South Asia, although its manpower exportation had been of a smaller magnitude and generally less organized than that in some neighbouring countries.

Of course, the major international migration flows in the region since 1978 had been those which involved refugees. However, one major refugee upheaval in the region had virtually been resolved. During 1978, an estimated 200,000 Burmese Muslims had fled across the border to neighbouring Bangladesh, a movement that was precipitated by a census in the Arakan border region of the Muslim minority, who were citizens of Burma, but who had sometimes been apprehended as illegal migrants. In July 1978, Burma and Bangladesh had reached an agreement to return those refugees who could produce evidence of their prior legal residence in Burma and to co-operate to prevent future illegal border-crossing between the countries. The outlook as of late 1979 was for the eventual repatriation of a large proportion, but not all, of the refugees.[61] Those refugees who could not or would not return to Burma were primarily ethnic Bengalis whose ultimate status was to be decided by the Government of Bangladesh.

The situation that involved massive flows of Indo-Chinese refugees to various countries within Eastern South Asia remained far from resolved. Briefly summarizing the position of the major receiving countries:

(*a*) Prior to 1979, Indonesia had received few Indochinese refugees. When the Government of Malaysia hardened its policy, however, during 1979 and refused to admit the growing influx, many of the refugees who were rejected by Malaysia were believed to have made their way to Indonesia, whose refugee population grew by about the number that Malaysia pushed back out to sea;

(*b*) The Philippines had both generated and received refugees during the period 1978-1980. Some 90,000 Filipino Muslims resided on the Malaysian island of Sabah, where they made up a major part of its population. The Philippines had provided first asylum to some 11,000 boat refugees. Although that flow had been smaller than those received by other countries in the region, the Philippines had joined with Indonesia, Malaysia, Singapore and Thailand in June 1979 in announcing that it would not accept additional refugees. At the Meeting on Refugees, however, in July 1979, the Philippines had offered UNHCR an island to serve as a refugee processing centre;

(*c*) Although Singapore had co-operated in arrangements for the transit of refugees from Indonesia and Malaysia *en route* to resettlement in other countries, it did not accept refugees for permanent resettlement because of its high population density;

(*d*) Malaysia, which once had considered immigration to be satisfactory, considered it to be too high in 1980, based upon its refugee influx. The country had given temporary asylum to some 118,000 Vietnamese refugees since 1975, making Malaysia a major country of first asylum. Although it had at first considered the boat refugees to be illegal immigrants and had confined them to camps, the

[58] "Labour shortage threatens investment growth in Singapore", *Asia Research Bulletin*, 31 December 1978, p. 512.

[59] "Exported . . . then exploited", *Far Eastern Economic Review*, 26 September 1980.

[60] "In Bangkok, a free-for-all", *Asiaweek*, 18 January 1980, p. 44.

[61] Office of the United States Coordinator For Refugee Affairs, *op.cit.*, p. 55.

Government's refugee policy was essentially humane. The heavy exodus in 1979 had put that policy under strain, however; and Malaysia came to the forefront of world attention as a result of its decision to refuse to accept additional refugees and to force refugee boats into international waters, a policy that it adopted to reduce the flow of refugees at the source and to heighten pressure on Western countries to relieve Malaysia of its refugee burden. Although there had been a net decrease in the number of refugees in Malaysian camps during the third quarter of 1979, the Government indicated that it would remain firm if a new influx were to occur, since it feared that the refugees, who were largely ethnic Chinese from Viet Nam, would remain in Malaysia, upsetting the balance between the predominant Malay community, and the Indians and Chinese who made up half of the population;

(*e*) Lastly, Thailand had borne a heavy burden, as the principal country of asylum for land refugees from Democratic Kampuchea, the Lao People's Democratic Republic and Viet Nam. In view of the fear of invasion across the border with Democratic Kampuchea and differences with the Lao People's Democratic Republic along the Mekong River, refugees that had originally been treated as illegal immigrants upon their arrival in Thailand. Border authorities had frequently tried to dissuade refugees from entering the country; and, on several occasions, they had been forcibly repatriated on the grounds that they were economic refugees or illegal entrants. That had been the case in June 1979, when the Government of Thailand had forcibly expelled more than 50,000 refugees from Democratic Kampuchea. Subsequently, at the urging of Western countries, Thailand decided to open its borders to a huge flow of refugees from the some 560,000 Kampucheans who camped along the frontier.[62] Thailand would not consider permanent resettlement of its refugees until their numbers have been substantially reduced. Like the Government of Malaysia, the Government of Thailand had been concerned by the net increase in the camp populations, for, unlike the boat refugees, whose stay in the camps had usually been a matter of months, large numbers of land refugees had remained in various Thai camps for as long as four years.

Conversely, summarizing the situation in the major sending countries:

(*a*) As of June 1980, there were some 800,000 refugees from Democratic Kampuchea in Thai camps and along the frontier areas, many of whom had been awaiting resettlement since 1975. Unlike their Vietnamese and Lao counterparts, who had been granted refugee status in Thailand, the Kampucheans had at first been considered to be illegal aliens by the Thai authorities and had been expelled from Thailand.[63] Allowed to return and confined in camps, the Kampucheans had been generally ineligible for resettlement in a country such as the United States, since they did not meet certain criteria for the admission of Indo-Chinese refugees (those criteria included having immediate family members in the United States, having had close association with the Government of the United States, etc.). In mid-June 1980, a repatriation programme was begun by the Government of Thailand and United Nations refugee officials, in response to what they said were requests from many of the refugees to be allowed to return to Democratic Kampuchea. Although nearly 7,000 refugees were repatriated before border hostilities brought a halt to the programme, a majority chose not to be repatriated.

(*b*) Approximately 150,000 refugees from the Lao People's Democratic Republic—including lowland Lao as well as refugees from the Hmong hill tribes—were currently living in UNHCR-financed camps in Thailand. Many of the refugees, who had continued to seek asylum in Thailand at a rate of about 6,000 per month during 1979, were ethnic Chinese from urban areas who were identified with the merchant class, or who had associations with the former régime;

(*c*) Lastly, in the case of Viet Nam, there had been a sharp increase in the number of refugees leaving that country, beginning in the spring of 1978, largely as a result of various policies (such as regulations that abolished private business) designed to impose the political, social and economic patterns of the northern part of the country on the south. The business and professional middle class, which included most of the Chinese community, as well as others considered surplus to the cities, were left with no other options than to emigrate or settle in the remote New Economic Zones.[64] The departure of large numbers of ethnic Chinese during 1978 and 1979 was followed by that of numbers of ethnic Vietnamese. During 1979, regional and international resentment had grown over what was seen as expulsion by Viet Nam of an unwanted population, with profits to the Government greater than any foreign exchange source. After the Meeting on Refugees at Geneva in July 1979, Viet Nam had adopted a self-imposed moratorium on the exodus of refugees. Although the volume of departures declined considerably, it resumed significance in the following year. A number of countries, including Canada and the United States, permitted legal immigration of Vietnamese refugees, primarily on a family reunification basis. In May 1979, UNHCR had signed an agreement with the Government of Viet Nam, following its announcement that it would permit legal emigration. As of 1979, details were being worked out as to the type of offices that would be set up in Viet Nam to select and process those permitted to depart.[65]

Middle South Asia

While no country in Middle South Asia desired significant immigration in 1980, several encouraged emigration. The Government of Pakistan, which had long desired to increase emigration, was taking a more active role in regulating the outflow of migrant workers, who were departing for many new destinations in the Gulf States. Under its Emigration Ordinance of 1979, the Government introduced measures for regulating the recruitment of Pakistanis who desired to leave the country to work abroad. The new

[62] "Thais will open border this week to huge new flow of Cambodians", *The New York Times*, 19 November 1979.

[63] "Fleeing Cambodians: a delicate problem for the Thai regime", *The New York Times*, 24 April 1979.

[64] Milton Osborne, "Indochina's refugees", *International Affairs*, January 1980.

[65] "Hanoi to cooperate on emigration plan", *The New York Times*, 7 March 1979.

regulations, which provided for the establishment of a Bureau of Emigration and Oversea Employment, stipulated that all oversea recruiting agents must apply for a license. Given the Government's longstanding concern with the emigration of qualified personnel, permission to recruit individuals for oversea posts would be denied if the Bureau considered such emigration to be a brain or skill drain. Unlawful emigration was subject to five years' imprisonment and/or a fine (seven years for a second offence), while unlawful recruitment was liable for to up to 14 years' imprisonment or a fine, or both.[66]

Along with the other labour-supplying countries in the region, Bangladesh had stepped up the exportation of manpower for oversea construction projects. Unlike those countries which sold whole project packages, Bangladesh provided manpower alone to employers in Western South Asia or to third-country contractors in that region. The Government apparently expected that flow to continue, for it included minimum quinquennial targets for oversea workers to Western South Asia in its 20-year plan for 1980-2000.

Sri Lanka also was sending temporary workers to an increasing number of destinations. More than 50,000 Sri Lankans had been working in Western South Asia during the late 1970s, with a majority in Kuwait, Oman, Saudi Arabia and the United Arab Emirates. Sri Lankans were also employed in the Federal Republic of Germany. Although the Government condoned the emigration of unskilled labour, it was concerned by the departure of qualified personnel and required a compulsory period of government service for certain professional categories. India had been developing project exportation to some degree. Although the Indian Airport Authority and other private and public concerns were becoming active in oversea project work, the Government did not emphasize project and manpower exportation to the same extent as some other Asian countries, in part because India is a continental economy and traditionally inward-looking.

Bhutan, the only country in the region that desired to attain higher rates of population growth, had been little affected by international migration, except for the estimated 4,000 Tibetan refugees who had remained in the country since they fled from their homeland in 1959. In 1979, the National Assembly of Bhutan had decided that the Tibetans had either to accept Bhutanese citizenship or be repatriated to China at the end of 1980. Bhutan subsequently changed its position, however, and gave the refugees the option of resettling in India.[67]

Bangladesh had been affected by refugee movements of considerable scale. Some 200,000 Burmese Muslims from the Arakanese border had begun crossing into Bangladesh in the spring of 1978. In that same year, the two Governments had agreed to a repatriation scheme that was generally successful, for fewer than 10,000 refugees remained in Bangladesh as of 1979.[68] A refugee situation of longer standing was that of the Bihari refugees, non-Bengali speaking residents of Bangladesh who claimed to be citizens of Pakistan. Many of those refugees had remained in camps since the 1960s, although their numbers had been somewhat reduced by assimilation.

India was seriously affected by communal violence during 1980, much of it involving Bengali immigrants. Some 243,000 refugees were driven into camps in Tripura State when discord between tribal people and the mostly Hindu Bengali immigrants from what is now Bangladesh erupted in a fierce conflict in June 1980. A similar campaign against Bengali immigrants was conducted in Assam State. Some Indian nationals would like to ease tensions by deporting those immigrants who had arrived after 1971, as opposed to those who had arrived in the wake of partition.

The most serious refugee situation in Middle South Asia, and one of the most serious in the world, involved the massive influx of refugees into Pakistan, a country that had long attempted to stimulate emigration to relieve its own population pressures. By mid-1980, Pakistan had received nearly 1 million refugees from neighbouring Afghanistan—about 7 per cent of that country's total population. Although the numbers remained uncertain, since many of the refugees were tribal people from ethnic groups that inhabited both sides of the porous border between Afghanistan and Pakistan, it was certain that the refugee situation had put an enormous financial and administrative burden on Pakistan, which was the major receiving country, followed by Iran, which had received at least 100,000. Although the earlier flows had consisted largely of rural Afghans, there was a new and growing exodus by Kabulis and other urbanized groups.

Australia-New Zealand

In 1978, the Government of Australia had announced a new immigration policy which was expected to attract some 210,000 immigrants during the following three years. Taking note of the desirability of maintaining a steady rate of immigration, and to provide a reliable basis for planning in the public and private sectors, the Government had reported that it would implement a triennial rolling immigration programme, commencing with the period 1978/79-1980/81, a system that would allow for flexibility on an annual basis.[69]

The implementation of the new immigration policy had met some opposition in government circles. The announcement of a higher immigrant intake of 87,000 in the third quarter of 1979, for example, had led to charges that the policy would lead to worsening unemployment.

During the period from 1975 to 1979, Australia had accepted some 21,500 Indo-Chinese refugees, including more than 2,000 direct arrivals; and it expected to admit a total of some 32,000 by June 1980. That group would result in a higher ratio of refugees to population (1:290) than in any other major country of resettlement.

The policy of New Zealand, to maintain its moderate level of immigration, which had been in effect since early 1976, had a goal of an annual net immigration of only about 5,000 persons. In its reply to the Fourth United Nations

[66] "Pakistan: Legislation protects overseas job seekers", *Social and Labour Bulletin*, No. 3, 1979, p. 314.

[67] "A crisis for 4,000 Tibetans", *Asiaweek*, 28 September 1979, p. 23.

[68] Office of the United States Coordinator for Refugee Affairs, *op. cit.*, p. 55.

[69] M. J. R. Mackellar, *Australia's Immigration Policy* (Canberra, Government Publishing Service, 1978).

Population Inquiry, the Government reported that "migration is currently limited to specific occupation groups whose skills are in demand and to humanitarian cases such as refugees and family reunification. This is a reflection of the current economic situation in New Zealand and the consequent level of unemployment of citizens and permanent residents."

Since 1978, more persons had been emigrating from New Zealand than had been arriving. In 1978, for example there had been a net loss of some 27,000 persons—in a country which had registered a gain of 26,000 as late as 1973. The free transfer of emigrants' assets to their new countries of residence was creating an additional burden on the country's balance of payments; thus, the emigration problem had become a source of serious concern. Observing that the rise in departures since 1967 had been both exponential and steady, a government publication reported that some minor changes had been made in the immigration policy in 1979: the Government would consider the application of persons who did not have a specific skill in demand, but who had sufficient capital and expertise in the entrepreneurial field to qualify for permanent residence.[70].

New Zealand had been among the first five countries in refugees settled per capita. It had permanently resettled over 1,100 Indo-Chinese and planned to admit about the same number during 1980. At the Meeting on Refugees at Geneva in July 1979, it had agreed to accept another 1,800 refugees by June 1981, by which date one in every 1,000 New Zealanders would be an Indo-Chinese refugee.

Conclusion

The following brief conclusion summarizes some of the major problems with respect to international migration, with highlights from several of the major world regions.

With regard to Western Europe, where migration had basically stopped, the migrant problem in 1980 was one of stocks rather than of flows. Although the size of the foreign population in and outside the labour force was continuing to increase in most host countries, that had been a result of families being reunited and the birth of children. There seemed to be little possibility of a return to the mass migration of the 1960s, since most Governments appeared to have made a firm decision that future economic growth would depend upon more advanced technology rather than upon an abundance of labour. (That strategy was apparent in France, for example, where the Seventh National Plan, in contrast to preceding plans, called for the substitution of capital for labour and the reintegration of indigenous workers into jobs once held by migrants.)

In Western Europe, the former host countries were undergoing profound transformations, largely as a result of their past *laissez-faire* policies towards the movement of millions of persons. Western European guest-worker policies had been designed to control the inflow of foreigners, rather than their stock or return flow; and the numbers present or returning had been expected to be regulated by the interplay of market forces and the return orientation attributed to migrants. Of course, one of the major problems had been the *de facto* permanence of millions of "temporary" guest workers. The presence of highly visible immigrant groups, who were less advantaged, socially and economically, than the national populations, posed serious problems for policy-makers in many of the Western European countries. Moreover, the presence of an entire generation of youth who were growing up with hyphenated identities in countries that did not even have those concepts as part of their cultural framework was a further example of the changes taking place.

Currently, the policies that governed the lives of foreign workers in most Western European countries were a patchwork of confusion and contradiction. Some Governments admitted them to citizenship in due course and allowed them some of the rights attached to citizenship in the interim. Others treated them as temporary workers, ineligible for many social welfare benefits, and for economic and political rights. Although some progress had been made since 1978—the Federal Republic of Germany, for example, had recently passed legislation that would allow the spouses of foreign workers to seek employment; Belgium and Portugal had ratified an agreement that would allow family reunification within a period of months; and Switzerland had changed its nationality law—there was a great gap in a majority of countries between pronouncements of concern for the integration of workers and actual policies in 1980.

In spite of the problems that affected many of the Western European countries in 1980, receiving countries had derived many benefits from migrant labour, which had contributed to their domestic product and made their manufacturing industries more competitive. Moreover, at world level, countries that imported labour were in a better position to control migration flows to suit their needs than were countries that exported labour, which were buffeted by fluctuations in the demand for labour and in remittances.

On the subject of remittances, many of the labour-exporting countries had shown resourcefulness in designing policies to attract remittances from their expatriate workers, but they had given much less attention to the utilization of those remittances, a crucial factor in determining their impact on a country's development. The Compensatory Financing Facility of the International Monetary Fund was recently extended to cover fluctuations in remittances as well as ordinary export earnings, which was an important step in the right direction, although there was a need for more bilateral co-operation to meet the adjustment problem.

With respect to the reintegration of returning workers in their countries of origin, it is obvious that economic development cannot take place as a result of the return of a disorganized mass of unskilled labour. A number of labour-importing countries in Western Europe had assisted in setting up training programmes for returning migrants, although those programmes had not generally been successful. Even if returning migrants were trained, most of the labour-exporting countries were unable to absorb more than small numbers of skilled technicians and managers, since the basic problem remained the lack of employment-creating investments. It is clearly necessary for countries to

[70] "Recent developments in New Zealand's immgration policy", paper submitted to the New Zealand Demographic Society, Proceedings of the Fifth Annual Conference, Wellington, 28-29 June 1979.

implement an integrated policy package covering the entire "migratory chain", that is, the process of migration, its over-all socio-economic effects and the optimal allocation of remittances in employment-generating projects.

Examining the situation in another major world region, the resource-rich countries of Western South Asia had been growing in importance as labour-importing countries, and were beginning to recruit workers from many of the countries that had formerly supplied Western European markets, as well as from an increasing number of Asian countries. The swing to Asian labour was the result of the concurrence of a variety of social and economic policy aims of the Governments of the oil-producing countries. Concern was growing in many of those countries over the wider social implications of hosting large migrant populations. Apart from fears of numerical domination, there was concern over the cultural impact that the large expatriate communities might have on the host societies. A policy that was increasingly being adopted was to develop "enclave" industrial areas, where workers were channelled to new industrial areas that were apart from urban areas, thus minimizing the cultural impact of the foreign workers. Unlike the situation in Western Europe, where market forces had been the major determinants of return migration, a majority of workers in the resource-rich countries were employed on fixed-term contracts and returned to other countries of origin upon expiration of those contracts.

While Governments of the labour-sending countries had become increasingly involved on the recruitment end, either through the regulation or sometimes the provisions of recruitment sevices, they had been less involved with other aspects of the migratory chain. Little emphasis had been placed on the problem of the reintegration of returning workers, although that might be related to the fact that the migrant streams were not very mature. There was little hard data on the uses made of remittances from workers in Western South Asia, although there was impressionistic evidence that it had led to an increase in land prices and to wasteful consumerism. Moreover, although it is well known that the absence of male workers can have important effects on community structures and family life, there were almost no countries, except the Republic of Korea, that had any type of policy for the maintenance of family and cultural ties.

A serious problem was that of dealing with possible fluctuations in future labour demand. Although the more "package export"-oriented countries had given more attention to the current and future impact of manpower recruitment on domestic needs, those countries which emphasized manpower exportation had chiefly focused on immediate recruitment needs, with less attention to future demands. While some of the "package export" countries were exploring avenues for future immigration, on the assumption that the markets in Western South Asia would not grow indefinitely, others seemed to count on over-expanding markets. (Bangladesh, for example, had included ambitious targets up to the year 2000 for manpower exportation to Western South Asia).

A caveat is in order at this point. There are major differences in the demographic context of manpower migration to Western Europe and of that to Western South Asia. During the 1960s, the Western European countries had required immigration to compensate for a shortage of low skilled labour, resulting from such factors as declining fertility and rising levels of education. Even currently, immigration for the purpose of family reunification was generally tolerated in the aging societies of Western Europe, since bringing in immigrants helped to maintain a certain demographic dynamism. In contrast, many of the labour-importing countries in Western South Asia had rapid population growth although a small population size. Some of those countries, which were in the labour-intensive construction phase of their development, would only temporarily need manpower until they were able to meet their own manpower needs. Clearly, there will be much uncertainty in the future.

A frequent slogan in the debate on international migration in recent years has been that "it is clear that capital should go to meet the men rather than the contrary". With few exceptions, however, the growing awareness among policy-makers of the comparative advantages of relocating industry rather than people has not yet resulted in practical action. In general, there is a pressing need for bilateral and multilateral agreements to regulate international migration—as recommended by the World Population Plan of Action—in order to even out fluctuations, make remittances more predictable and assist return migration when it occurs. Steps in this direction have been taken within the Organisation for Economic Co-operation and Development in Europe, but similar measures are needed elsewhere.

The discussion to date has focused on organized migration flows. It is well known that a considerable and probably growing proportion of labour migration is of an illegal nature. Indeed, in some regions of the world, particularly in Africa and Latin America, illegal migration is the dominant type. Even in some economically advanced countries, illegal migration serves the purpose of a *de facto* guest-worker system. Receiving Governments can choose to ignore the presence of illegal workers in times of economic expansion and then suddenly tighten up during an economic downturn. Although the major burden falls on the workers themselves, who suffer violations of their civil and human rights, the receiving countries are faced with growing problems. Even those countries with accurate data-gathering systems have little idea of the actual number of illegal workers, to what extent they use basic services, whether they displace native workers or depress wages etc.

Even in the absence of hard data on illegal flows, there was a tendency in 1980 for a large number of Governments to be moving in the direction of stricter controls over illegal migration. For the most part, those actions were being taken unilaterally by receiving countries. There had been some attempts by groups of receiving countries to work in concert, but there was less evidence of effective formal co-operation on that issue between sending and receiving countries.

A final word must be said on the problem of refugees. It is important to take note that a number of the countries that had changed their perception of international migration during the period 1978-1980, did so largely as a result of an influx of refugees. In those countries which accepted immi-

grants for permanent settlement according to a quota system, refugees were in a sense competing with more traditional migrants for a limited number of places (and vice versa). In spite of their humanitarian sentiments, a number of Western countries had often treated refugees as immigrants, admitting groups on a highly selective basis. (The United States of America, for example, did not accept refugees from the former Republic of South Viet-Nam, while refugees from Democratic Kampuchea accounted for only 5 per cent of the total number of Indo-Chinese refugees that it had accepted.)

A major problem is that while labour migration is usually determined by market forces, with flows being directed to higher income countries and to those which require labour, refugees have often fled to some of the world's poorest countries. Difficulties of assuring asylum and arranging for resettlement of refugees are greatly increased when receiving countries already feel overpopulated, or when they have achieved a desired reduction in population growth. Malaysia and Thailand, for example, countries that had experienced significant fertility declines, were greatly concerned by the recent influx of Indo-Chinese refugees. In other instances, the burden had fallen on countries that were the least able to absorb them. For example, the refugee population in Somalia—currently estimated at 1.3 million—had increased its total population size by about one third. Pakistan, a country that encouraged the emigration of its own nationals to relieve unemployment pressures, had received nearly 1 million refugees from Afghanistan by the middle of 1980.

The refugee problem is made more difficult by such factors as their age/sex composition. In many of those countries with the largest numbers of refugees, the camp populations were comprised almost exclusively of women, children and the elderly. A further problem is that resettlement of rural refugees is difficult in countries where land is scarce and rural underemployment is extensive, while resettlement of urban refugees is constrained by unemployment. The demographic prospects for the coming decades suggest that it will only become more difficult to resolve such situations until the principle of international burden-sharing is accepted globally.

In conclusion, measured against the recommendations of the World Population Plan of Action—that Governments should facilitate international freedom of movement, provide proper treatment and services for migrant workers in receiving countries, improve local conditions in sending countries, diminish the impact of the "brain drain" from developing countries, and find durable solutions for refugees—international migration policies at world level remain to be improved.

Annex

STATISTICAL DATA

TABLE 38. GOVERNMENTS' PERCEPTIONS OF THE EFFECT OF NATURAL INCREASE ON DEVELOPMENT AND THE DESIRABILITY OF INTERVENTION TO CHANGE RATES, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Governments' perceptions of the effect of natural increase as a positive contribution to development	Governments' perceptions of the effect of natural increase as a constraint on development, and the desirability of intervention							
	Rates too low		Rates neither too low nor too high			Rates too high		
	Effect of constraints				Effect of constraints			
	Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
	Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Full intervention appropriate (1)	Some support appropriate[a] (2)	No intervention appropriate (3)	(4)	(5)	Some support appropriate[a] (6)	Full intervention appropriate (7)	Total
A. Area of responsibility of Economic Commission for Africa								
Eastern Africa								
Predominant (A)	—	—	—	Somalia	Madagascar Malawi	—	—	3
Significant (B)	—	—	Mozambique	Zambia	Burundi Djibouti Ethiopia United Republic of Tanzania	Rwanda	Mauritius Seychelles Uganda	10
Minor (C)	—	—	—	—	—	Comoros Zimbabwe	Kenya	3
Middle Africa								
Predominant (A)	—	—	—	—	Sao Tome and Principe	—	—	1
Significant (B)	—	—	Angola Congo	—	Chad Zaire	—	—	4
Minor (C)	Central African Republic Equatorial Guinea Gabon	—	—	—	—	United Republic of Cameroon	—	4
Northern Africa								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	Libyan Arab Jamahiriya	—	—	—	Sudan	Algeria	Morocco	4
Minor (C)	—	—	—	—	—	—	Egypt Tunisia	2
Southern Africa								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	—	—	—	—	—	Botswana South Africa Swaziland	3
Minor (C)	—	—	—	—	—	—	Lesotho	1
Western Africa								
Predominant (A)	—	—	Benin Mali	—	Gambia	—	—	3
Significant (B)	Guinea Ivory Coast	—	Guinea-Bissau	Nigeria	Cape Verde Mauritania Niger Sierra Leone Togo Upper Volta	Liberia Senegal	—	12
Minor (C)	—	—	—	—	—	—	Ghana	1
TOTAL	6	—	6	3	17	7	12	51
B. Area of responsibility of Economic Commission for Europe								
Eastern Europe								
Predominant (A)	—	—	Czechoslovakia Hungary Romania	Poland	—	—	—	4

TABLE 38 (*continued*)

Governments' perceptions of the effect of natural increase as a positive contribution to development	Governments' perceptions of the effect of natural increase as a constraint on development, and the desirability of intervention							
	Rates too low		Rates neither too low nor too high			Rates too high		
	Effect of constraints				Effect of constraints			
	Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
	Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Full intervention appropriate (1)	Some support appropriate[a] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[a] (6)	Full intervention appropriate (7)	Total

B. *Area of responsibility of Economic Commission for Europe* (continued)

Eastern Europe (continued)

Significant (B)	Bulgaria German Democratic Republic	—	—	—	—	—	—	2
Minor (C)	—	—	—	—	—	—	—	—

Northern Europe

Predominant (A)	—	—	Sweden	Denmark Iceland United Kingdom	—	—	—	4
Significant (B)	—	—	Finland Ireland	Norway	—	—	—	3
Minor (C)	—	—	—	—	—	—	—	—

Southern Europe

Predominant (A)	—	—	Albania Greece	Portugal Spain Yugoslavia	Italy San Marino	—	—	7
Significant (B)	—	Holy See	—	—	Malta	—	—	2
Minor (C)	—	—	—	—	—	—	—	—

Western Europe

Predominant (A)	—	—	Austria	—	—	—	—	1
Significant (B)	—	Germany, Federal Republic of	Belgium Switzerland	—	Netherlands	—	—	4
Minor (C)	France Liechtenstein Luxembourg Monaco	—	—	—	—	—	—	4

Western South Asia (part)

Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	Cyprus	—	—	—	—	Turkey	2
Minor (C)	Israel	—	—	—	—	—	—	1

Northern America

Predominant (A)	—	—	—	United States of America	—	—	—	1
Significant (B)	—	—	—	—	Canada	—	—	1
Minor (C)	—	—	—	—	—	—	—	—

Union of Soviet Socialist Republics

Predominant (A)	—	Byelorussian SSR Ukrainian SSR USSR	—	—	—	—	—	3
Significant (B)	—	—	—	—	—	—	—	—
Minor (C)	—	—	—	—	—	—	—	—
TOTAL	7	6	11	9	5	—	1	39

TABLE 38 (continued)

Governments' perceptions of the effect of natural increase as a positive contribution to development	Governments' perceptions of the effect of natural increase as a constraint on development, and the desirability of intervention							
	Rates too low		Rates neither too low nor too high			Rates too high		
	Effect of constraints					Effect of constraints		
	Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
	Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Full intervention appropriate (1)	Some support appropriate[a] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[a] (6)	Full intervention appropriate (7)	Total
C. *Area of responsibility of Economic Commission for Latin America*								
Caribbean								
Predominant (A)	—	—	—	—	Cuba	—	—	1
Significant (B)	—	—	—	—	—	—	Barbados Grenada Trinidad and Tobago	3
Minor (C)	—	—	—	—	—	Bahamas Dominica Saint Lucia Saint Vincent and the Grenadines	Dominican Republic Haiti Jamaica	7
Middle America								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	—	—	—	Honduras Panama	Guatemala Nicaragua	Costa Rica Mexico	6
Minor (C)	—	—	—	—	—	—	El Salvador	1
Temperate South America								
Predominant (A)	—	Chile	—	—	—	—	—	1
Significant (B)	—	—	—	—	—	—	—	—
Minor (C)	Argentina Uruguay	—	—	—	—	—	—	2
Tropical South America								
Predominant (A)	—	—	—	Brazil	—	—	—	1
Significant (B)	—	Paraguay	Ecuador	Guyana	Colombia Venezuela	Peru	—	6
Minor (C)	Bolivia	—	—	—	Suriname	—	—	2
TOTAL	3	2	1	2	6	7	9	30
D. *Area of responsibility of Economic Commission for Western Asia*								
Western South Asia[b]								
Predominant (A)	—	Kuwait	Iraq	Bahrain	—	—	—	3
Significant (B)	Oman Qatar Saudi Arabia United Arab Emirates	—	—	—	Democratic Yemen Jordan Lebanon Syrian Arab Republic Yemen	—	—	9
Minor (C)	—	—	—	—	—	—	—	—
TOTAL	4	1	1	1	5	—	—	12
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*								
China								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	—	—	—	—	—	China	1
Minor (C)	—	—	—	—	—	—	—	—
Japan								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	—	—	—	Japan	—	—	1
Minor (C)	—	—	—	—	—	—	—	—

TABLE 38 *(continued)*

Governments' perceptions of the effect of natural increase as a positive contribution to development	Governments' perceptions of the effect of natural increase as a constraint on development, and the desirability of intervention							
	Rates too low		Rates neither too low nor too high			Rates too high		
	Effect of constraints				Effect of constraints			
	Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
	Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Full intervention appropriate (1)	Some support appropriate[a] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[a] (6)	Full intervention appropriate (7)	Total
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)								
Other East Asia								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	Democratic People's Republic of Korea Mongolia	—	—	—	—	—	Republic of Korea	3
Minor (C)	—	—	—	—	—	—	—	—
Eastern South Asia								
Predominant (A)	—	—	Singapore	Burma	—	—	—	2
Significant (B)	Democratic Kampuchea Lao People's Democratic Republic	—	—	—	Malaysia	—	Indonesia Philippines Viet Nam	6
Minor (C)	—	—	—	—	—	—	Thailand	1
Middle South Asia								
Predominant (A)	—	—	—	Maldives	—	—	—	1
Significant (B)	—	Bhutan	—	—	Afghanistan	—	Iran	3
Minor (C)	—	—	—	—	—	—	Bangladesh India Nepal Pakistan Sri Lanka	5
Australia-New Zealand								
Predominant (A)	—	—	Australia	—	—	—	—	1
Significant (B)	—	—	—	—	New Zealand	—	—	1
Minor (C)	—	—	—	—	—	—	—	—
Melanesia								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	—	—	—	—	—	Solomon Islands	Papua New Guinea	2
Minor (C)	—	—	—	—	—	—	—	—
Micronesia-Polynesia								
Predominant (A)	—	—	—	—	—	—	—	—
Significant (B)	Nauru	—	—	—	—	Kiribati Tuvalu	Fiji Tonga	5
Minor (C)	—	—	—	—	—	—	Samoa	1
TOTAL	5	1	2	2	4	3	16	33
Developed countries	6	5	12	9	7	—	—	39
Developing countries	19	5	9	8	30	17	38	126
TOTAL	25	10	21	17	37	17	38	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level that could be considered too low or too high.

[b] Excluding Cyprus, Israel and Turkey.

TABLE 39. COMBINATIONS OF POLICY OPTIONS SELECTED BY GOVERNMENTS TO SOLVE PROBLEMS ASSOCIATED WITH NATURAL INCREASE, BY PERCEPTION OF THE EFFECT OF NATURAL INCREASE ON DEVELOPMENT, ITS ACCEPTABILITY AND THE DESIRABILITY OF INTERVENTION TO CHANGE IT, AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND GEOGRAPHICAL REGIONS, JULY 1980

Geographical region and country	Policy options[a]					Governments' perceptions of the effect of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low		Rates neither too low nor too high			Rates too high		
						Effect of constraints				Effect of constraints			
						Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
						Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	Full intervention appropriate (1)	Some support appropriate[b] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[b] (6)	Full intervention appropriate (7)	
A. *Area of responsibility of Economic Commission for Africa*													
Eastern Africa													
Burundi	•	•	x	•	x	—	—	—	—	x	—	—	
Comoros	•	•	•	x	x	—	—	—	—	—	x	—	
Djibouti	—	•	x	x	x	—	—	—	—	x	—	—	
Ethiopia	•	•	x	•	x	—	—	—	—	x	—	—	
Kenya	•	—	x	•	x	—	—	—	—	—	—	x	
Madagascar	•	•	x	•	x	—	—	—	—	x	—	—	
Malawi	•	•	x	x	x	—	—	—	—	x	—	—	
Mauritius	•	—	x	x	x	—	—	—	—	—	—	x	
Mozambique	—	—	x	x	x	—	—	x	—	—	—	—	
Rwanda	•	•	x	•	x	—	—	—	—	—	x	—	
Seychelles	•	—	x	x	x	—	—	—	—	—	—	x	
Somalia	•	•	x	x	•	—	—	—	x	—	—	—	
Uganda	•	—	x	x	x	—	—	—	—	—	—	x	
United Republic of Tanzania	•	•	x	•	x	—	—	—	—	x	—	—	
Zambia	•	•	x	•	x	—	—	—	x	—	—	—	
Zimbabwe[c]	•	•	x	x	[c]	—	—	—	—	—	x	—	
Middle Africa													
Angola	—	•	x	x	x	—	—	x	—	—	—	—	
Central African Republic	—	•	x	•	x	x	—	—	—	—	—	—	
Chad	•	•	•	x	x	—	—	—	—	x	—	—	
Congo	•	•	x	•	x	—	—	x	—	—	—	—	
Equatorial Guinea	—	•	x	x	x	x	—	—	—	—	—	—	
Gabon	—	+	x	x	x	x	—	—	—	—	—	—	
Sao Tome and Principe	•	•	x	x	x	—	—	—	—	x	—	—	
United Republic of Cameroon	—	•	x	•	x	—	—	—	—	—	x	—	
Zaire	—	•	x	x	x	—	—	—	—	x	—	—	
Northern Africa													
Algeria	•	•	x	x	•	—	—	—	—	—	x	—	
Egypt	•	—	x	x	x	—	—	—	—	—	—	x	
Libyan Arab Jamahiriya	—	+	x	x	x	x	—	—	—	—	—	—	
Morocco	•	—	x	x	x	—	—	—	—	—	—	x	
Sudan	—	•	x	x	x	—	—	—	—	x	—	—	
Tunisia	•	—	x	x	x	—	—	—	—	—	—	x	
Southern Africa													
Botswana	•	—	x	x	x	—	—	—	—	—	—	x	
Lesotho	•	—	•	x	x	—	—	—	—	—	—	x	
South Africa	•	—	x	x	x	—	—	—	—	—	—	x	
Swaziland	•	—	x	x	x	—	—	—	—	—	—	x	

Western Africa													
Benin	•	=	x	x	•	—	—	x	—	—	—	—	
Cape Verde	•	•	•	•	x	—	—	—	—	x	—	—	
Gambia	•	•	x	•	x	—	—	—	—	x	—	—	
Ghana	•	–	x	x	x	—	—	—	—	—	—	x	
Guinea	–	+	x	x	x	x	—	—	—	—	—	—	
Guinea-Bissau	–	•	x	•	x	—	—	x	—	—	—	—	
Ivory Coast	–	=	x	x	x	x	—	—	—	—	—	—	
Liberia	•	•	x	x	x	—	—	—	—	—	x	—	
Mali	•	=	x	x	•	—	—	x	—	—	—	—	
Mauritania	•	=	x	x	x	—	—	—	—	x	—	—	
Niger	•	=	•	•	x	—	—	—	—	x	—	—	
Nigeria	•	•	x	•	x	—	—	—	x	—	—	—	
Senegal	•	•	x	x	x	—	—	—	—	—	x	—	
Sierra Leone	•	•	•	x	x	—	—	—	—	x	—	—	
Togo	•	=	x	•	x	—	—	—	—	x	—	—	
Upper Volta	•	=	x	x	x	—	—	—	—	x	—	—	
					TOTAL	6	—	6	3	17	7	12	51

B. *Area of responsibility of Economic Commission for Europe*

Eastern Europe													
Bulgaria	•	+	x	•	x	x	—	—	—	—	—	—	
Czechoslovakia	•	=	x	•	•	—	—	x	—	—	—	—	
German Democratic Republic	•	=	x	•	x	x	—	—	—	—	—	—	
Hungary	•	=	x	•	•	—	—	x	—	—	—	—	
Poland	•	•	x	•	•	—	—	—	x	—	—	—	
Romania	•	=	x	•	•	—	—	x	—	—	—	—	
Northern Europe													
Denmark	•	•	•	•	•	—	—	—	x	—	—	—	
Finland	–	=	x	x	x	—	—	x	—	—	—	—	
Iceland	•	•	x	•	•	—	—	—	x	—	—	—	
Ireland	•	=	x	x	x	—	—	x	—	—	—	—	
Norway	•	•	x	•	•	—	—	—	x	—	—	—	
Sweden	•	•	x	•	•	—	—	x	—	—	—	—	
United Kingdom	•	•	x	•	•	—	—	—	x	—	—	—	
Southern Europe													
Albania	–	=	x	•	x	—	—	x	—	—	—	—	
Greece	•	+	x	x	x	—	—	x	—	—	—	—	
Holy See	•	•	•	•	x	—	x	—	—	—	—	—	
Italy	•	•	x	x	x	—	—	—	—	x	—	—	
Malta	•	•	•	x	x	—	—	—	—	x	—	—	
Portugal	•	•	x	x	•	—	—	—	x	—	—	—	
San Marino	•	•	•	•	•	—	—	—	—	x	—	—	
Spain	•	•	x	x	•	—	—	—	x	—	—	—	
Yugoslavia	•	•	x	x	•	—	—	—	x	—	—	—	
Western Europe													
Austria	•	•	x	x	•	—	—	x	—	—	—	—	
Belgium	•	=	•	•	•	—	—	x	—	—	—	—	
France	–	+	x	x	x	x	—	—	—	—	—	—	
Germany, Federal Republic of	•	•	x	x	x	—	x	—	—	—	—	—	
Liechtenstein	•	+	•	x	x	x	—	—	—	—	—	—	
Luxembourg	•	+	•	x	x	x	—	—	—	—	—	—	
Monaco	•	+	•	x	x	x	—	—	—	—	—	—	
Netherlands	•	•	x	x	x	—	—	—	—	x	—	—	
Switzerland	•	•	x	x	x	—	—	x	—	—	—	—	

TABLE 39 *(continued)*

Geographical region and country	Policy options[a]					Governments' perceptions of the effect of natural increase as a constraint on development and desirability of intervention							Total
						Rates too low		Rates neither too low nor too high			Rates too high		
						Effect of constraints				Effect of constraints			
						Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
						Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	Full intervention appropriate (1)	Some support appropriate[b] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[b] (6)	Full intervention appropriate (7)	
B. *Area of responsibility of Economic Commission for Europe* (continued)													
Western South Asia *(part)*													
Cyprus	•	•	x	x	x	—	x	—	—	—	—	—	
Israel	•	+	x	x	x	x	—	—	—	—	—	—	
Turkey	•	−	x	x	x	—	—	—	—	—	—	x	
Northern America													
Canada	•	•	•	x	x					x			
United States of America	•	•	•	x	•				x				
Union of Soviet Socialist Republics													
Byelorussian SSR	•	=	x	•	x		x						
Ukrainian SSR	−	=	x	•	x		x						
USSR	−	=	x	•	x		x						
					TOTAL	7	6	11	9	5	—	1	39
C. *Area of responsibility of Economic Commission for Latin America*													
Caribbean													
Bahamas	•	•	x	x	x	—	—	—	—	—	x	—	
Barbados	•	−	•	x	x	—	—	—	—	—	—	x	
Cuba	•	•	x	x	•	—	—	—	—	x	—	—	
Dominica[c]	•	−	•	•	[c]	—	—	—	—	—	x	—	
Dominican Republic	•	•	•	x	x	—	—	—	—	—	—	x	
Grenada	•	−	x	x	x	—	—	—	—	—	—	x	
Haiti	•	−	x	x	x	—	—	—	—	—	—	x	
Jamaica	•	−	x	x	x	—	—	—	—	—	—	x	
Saint Lucia[c]	•	•	•	•	[c]	—	—	—	—	—	x	—	
Saint Vincent and the Grenadines[c]	•	•	•	•	[c]	—	—	—	—	—	x	—	
Trinidad and Tobago	•	−	x	x	x	—	—	—	—	—	—	x	
Middle America													
Costa Rica	•	−	x	x	x	—	—	—	—	—	—	x	
El Salvador	•	−	x	x	x	—	—	—	—	—	—	x	
Guatemala	•	•	x	•	x	—	—	—	—	—	x	—	
Honduras	•	•	•	x	x	—	—	—	—	x	—	—	
Mexico	•	−	x	x	x	—	—	—	—	—	—	x	
Nicaragua	•	•	x	x	x	—	—	—	—	—	x	—	
Panama	•	=	x	•	x	—	—	—	—	x	—	—	
Temperate South America													
Argentina	−	+	x	x	x	x	—	—	—	—	—	—	
Chile	•	•	x	•	•	—	x	—	—	—	—	—	
Uruguay	•	+	x	x	x	x	—	—	—	—	—	—	
Tropical South America													
Bolivia	−	+	x	x	x	x	—	—	—	—	—	—	

Brazil	•	•	x	•	•	—	—	—	x	—	—	—	
Colombia	•	=	x	x	x	—	—	—	—	x	—	—	
Ecuador	•	•	x	x	x	—	—	x	—	—	—	—	
Guyana	•	•	x	x	•	—	—	—	x	—	—	—	
Paraguay	—	•	x	x	x	—	x	—	—	—	—	—	
Peru	•	•	x	•	x	—	—	—	—	—	x	—	
Suriname	•	•	x	x	x	—	—	—	—	x	—	—	
Venezuela	•	•	x	x	x	—	—	—	—	x	—	—	
					TOTAL	3	2	1	2	6	7	9	30

D. *Area of responsibility of Economic Commission for Western Asia*

Western South Asia[d]													
Bahrain	•	•	•	x	•	—	—	—	x	—	—	—	
Democratic Yemen	•	•	x	x	x	—	—	—	—	x	—	—	
Iraq	•	+	x	•	x	—	—	x	—	—	—	—	
Jordan	•	—	x	x	x	—	—	—	—	x	—	—	
Kuwait	•	=	•	x	x	—	x	—	—	—	—	—	
Lebanon	•	•	x	x	x	—	—	—	—	x	—	—	
Oman	—	=	x	x	x	x	—	—	—	—	—	—	
Qatar	•	=	•	x	x	x	—	—	—	—	—	—	
Saudi Arabia	—	=	x	x	x	x	—	—	—	—	—	—	
Syrian Arab Republic	•	•	x	•	x		—	—	—	x	—	—	
United Arab Emirates	—	=	x	x	x	x	—	—	—	—	—	—	
Yemen	•	•	•	x	x	—	—	—	—	x	—	—	
					TOTAL	4	1	1	1	5	—	—	12

E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*

China	•	—	x	•	x	—	—	—	—	—	—	x	
Japan	•	•	x	•	•	—	—	—	—	x	—	—	
Other East Asia													
Democratic People's Republic of Korea	—	=	x	•	x	x	—	—	—	—	—	—	
Mongolia	—	=	x	•	x	x	—	—	—	—	—	—	
Republic of Korea	•	—	x	x	x	—	—	—	—	—	—	x	
Eastern South Asia													
Burma	•	•	x	•	•	—	—	—	x	—	—	—	
Democratic Kampuchea	—	+	x	x	x	x	—	—	—	—	—	—	
Indonesia	•	—	x	•	x	—	—	—	—	—	—	x	
Lao People's Democratic Republic	—	+	x	•	x	x	—	—	—	—	—	—	
Malaysia	•	=	x	x	x	—	—	—	—	x	—	—	
Philippines	•	—	x	•	x	—	—	—	—	—	—	x	
Singapore	•	=	•	•	•	—	—	x	—	—	—	—	
Thailand	•	—	x	x	x	—	—	—	—	—	—	x	
Viet Nam	•	—	x	x	x	—	—	—	—	—	—	x	
Middle South Asia													
Afghanistan	•	•	x	x	x	—	—	—	—	x	—	—	
Bangladesh	•	—	x	•	x	—	—	—	—	—	—	x	
Bhutan	—	•	x	x	x	—	x	—	—	—	—	—	
India	•	—	x	•	x	—	—	—	—	—	—	x	
Iran	•	—	x	x	x	—	—	—	—	—	—	x	
Maldives	•	•	x	•	•	—	—	—	x	—	—	—	
Nepal	•	—	x	x	x	—	—	—	—	—	—	x	
Pakistan	•	—	x	x	x	—	—	—	—	—	—	x	
Sri Lanka	•	—	x	x	x	—	—	—	—	—	—	x	

TABLE 39 *(continued)*

Geographical region and country	Policy options[a]					Governments' perceptions of the effect of natural increase as a constraint on development and desirability of intervention							
						Rates too low		Rates neither too low nor too high			Rates too high		
						Effect of constraints				Effect of constraints			
						Predominant (A)	Significant (B)	Minor (C)	No constraints	Minor (C)	Significant (B)	Predominant (A)	
						Higher rates desirable		Neither higher nor lower rates desirable			Lower rates desirable		
	Mortality	Fertility	Spatial distribution	International migration	Technology and organization	Full intervention appropriate (1)	Some support appropriate[b] (2)	(3)	No intervention appropriate (4)	(5)	Some support appropriate[b] (6)	Full intervention appropriate (7)	Total
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)													
Australia and New Zealand													
Australia	•	•	x	x	x	—	—	x	—	—	—	—	
New Zealand	•	•	•	x	x	—	—	—	—	x	—	—	
Melanesia													
Papua New Guinea	•	−	•	•	x	—	—	—	—	—	—	x	
Solomon Islands[c]	•	•	•	•	[c]	—	—	—	—	—	x	—	
Micronesia-Polynesia													
Fiji	•	−	x	x	x	—	—	—	—	—	—	x	
Kiribati[c]	•	=	x	•	x	—	—	—	—	—	x	—	
Nauru	•	=	•	x	•	x	—	—	—	—	—	—	
Samoa	•	−	•	x	x	—	—	—	—	—	—	x	
Tonga	•	−	x	x	x							x	
Tuvalu[c]	•	•	x	•	[c]	—	—	—	—	—	x	—	
					TOTAL	5	1	2	2	4	3	16	33

[a] *Key:*

Policy options for mortality and fertility

+ Increase (e.g., a "+" in the fertility column indicates that the Government has a policy of increasing fertility)
− Decrease
= Maintain at current levels in the face of probable decrease if no intervention occurred
• No intervention

Policy options for spatial distribution, international migration and technology and organization

x Intervention
• No intervention

[b] Although Governments perceived the rates as neither too low nor too high and did not define any coherent policy of intervention, they may have implemented some measures to prevent the rates from evolving in the future to a level that could be considered too low or too high.

[c] Country became independent during the period 1973-1980 and has not yet officially stated all aspects of its population policies.

[d] Excluding Cyprus, Israel and Turkey.

TABLE 40. AVERAGE LIFE EXPECTANCY AT BIRTH, 1975-1979, AND GOVERNMENTS' PERCEPTIONS OF ITS ACCEPTABILITY IN PREVAILING ECONOMIC AND SOCIAL CIRCUMSTANCES, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Under 50 years		*50-61 years*		*62[a]-69 years*		*70 years and over*		*All ages*		
Acceptable	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Total*
				A. *Area of responsibility of Economic Commission for Africa*						
				Eastern Africa						
Rwanda	Burundi Comoros Djibouti Ethiopia Madagascar Malawi Mozambique Somalia Zambia	—	Kenya Uganda United Republic of Tanzania Zimbabwe	Seychelles	Mauritius	—	—	2	14	16
				Middle Africa						
—	Angola Central African Republic Chad Congo Equatorial Guinea Gabon Sao Tome and Principe United Republic of Cameroon Zaire	—	—	—	—	—	—	—	9	9
				Northern Africa						
—	Sudan	—	Algeria Egypt Libyan Arab Jamahiriya Morocco Tunisia	—	—	—	—	—	6	6
				Southern Africa						
—	Botswana Swaziland	—	Lesotho South Africa	—	—	—	—	—	4	4
				Western Africa						
—	Benin Gambia Ghana Guinea Guinea-Bissau Ivory Coast Liberia Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo Upper Volta	—	Cape Verde	—	—	—	—	—	16	16
TOTAL										
1	36	—	12	1	1	—	—	2	49	51

TABLE 40 *(continued)*

Under 50 years		*50-61 years*		*62[a]-69 years*		*70 years and over*		*All ages*		
Acceptable	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Total*
B. *Area of responsibility of Economic Commission for Europe*										
					Eastern Europe					
—	—	—	—	Hungary	—	Bulgaria Czechoslovakia German Democratic Republic Poland Romania	—	6	—	6
					Northern Europe					
—	—	—	—	—	—	Denmark Iceland Ireland Norway Sweden	Finland United Kingdom	5	2	7
					Southern Europe					
—	—	—	—	Portugal	Albania Yugoslavia	Greece Holy See Malta San Marino Spain	Italy	6	3	9
					Western Europe					
—	—	—	—	—	—	Austria Belgium Germany, Federal Republic of Liechtenstein Luxembourg Monaco Netherlands Switzerland	France[b]	8	1	9
					Western South Asia (part)					
—	—	—	Turkey	—	—	Cyprus Israel	—	2	1	3
					Northern America					
—	—	—	—	—	—	Canada United States of America	—	2	—	2
					Union of Soviet Socialist Republics					
—	—	—	—	—	—	—	Byelorussian SSR Ukrainian SSR USSR	—	3	3
TOTAL										
—	—	—	1	2	2	27	7	29	10	39

TABLE 40 (*continued*)

Under 50 years		*50–61 years*		*62[a]–69 years*		*70 years and over*		*All ages*		
Acceptable	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Acceptable*	*Not acceptable*	*Total*
C. *Area of responsibility of Economic Commission for Latin America*										
				Caribbean						
—	—	Dominican Republic	Haiti	Trinidad and Tobago	Bahamas Dominica Grenada Saint Lucia Saint Vincent and the Grenadines	Barbados Cuba Jamaica	—	5	6	11
				Middle America						
—	—	—	Guatemala Honduras Nicaragua	Costa Rica Panama	El Salvador Mexico	—	—	2	5	7
				Temperate South America						
—	—	—	—	Chile Uruguay	Argentina	—	—	2	1	3
				Tropical South America						
—	—	Ecuador	Bolivia Peru	Guyana	Brazil Colombia Paraguay Suriname Venezuela	—	—	2	7	9
TOTAL										
—	—	2	6	6	13	3	—	11	19	30
D. *Area of responsibility of Economic Commission for Western Asia*										
				Western South Asia[c]						
—	Democratic Yemen Oman Saudi Arabia Yemen	Iraq Jordan Qatar Syrian Arab Republic	—	Kuwait United Arab Emirates	Bahrain Lebanon	—	—	6	6	12
TOTAL										
—	4	4	—	2	2	—	—	6	6	12
E. *Area of responsibility of Economic Commission for Asia and the Pacific*										
				China						
—	—	—	—	—	China	—	—	—	1	1
				Japan						
—	—	—	—	—	—	Japan	—	1	—	1
				Other East Asia						
—	—	—	—	Republic of Korea	Democratic People's Republic of Korea Mongolia	—	—	1	2	3
				Eastern South Asia						
—	Democratic Kampuchea	Malaysia Philippines	Burma Indonesia Thailand	Singapore	—	—	—	3	6	9

TABLE 40 *(continued)*

	Under 50 years		50–61 years		62[a]–69 years		70 years and over		All ages		
	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Acceptable	Not acceptable	Total
E. *Area of responsibility of Economic Commissions for Asia and the Pacific* (continued)											
***Eastern South Asia* (continued)**											
		Lao People's Democratic Republic Viet Nam									
Middle South Asia											
	—	Afghanistan Bangladesh Bhutan Maldives Nepal	—	India Iran Pakistan	Sri Lanka	—	—	—	1	8	9
Australia-New Zealand											
	—	—	—	—	—	—	Australia New Zealand	—	2	—	2
Melanesia											
	—	Papua New Guinea	—	Solomon Islands	—	—	—	—	—	2	2
Micronesia-Polynesia											
	—	—	—	—	—	Kiribati Tonga Samoa Tuvalu	Fiji Nauru	—	2	4	6
TOTAL	—	9	2	7	3	7	5	—	10	23	33
Developed countries											
	—	—	—	—	2	2	28	7	30	9	39
Developing countries											
	1	49	8	26	12	23	7	—	28	98	126
TOTAL	1	49	8	26	14	25	35	7	58	107	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] A life expectancy at birth of 62 years corresponds to the average world life expectancy by 1985 referred to in paragraph 22 of the World Population Plan of Action. The other categories in this table were chosen in reference to this figure.

[b] In its reply to the Third United Nations Population Inquiry, the Government of France noted that, whereas it considered that levels of average life expectancy for females were acceptable in prevailing economic and social circumstances, those for males were not considered acceptable.

[c] Excluding Cyprus, Israel and Turkey.

TABLE 41. GOVERNMENTS' PERCEPTIONS AND POLICIES WITH RESPECT TO THE CURRENT FERTILITY LEVEL AND ACCESS TO EFFECTIVE FERTILITY REGULATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980[a]

Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
Intervention to raise rates appropriate, and incentives and disincentives implemented to raise rates I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented to lower rates* VI	*Total*
		A. *Area of responsibility of Economic Commission for Africa*				
			Eastern Africa			
—	—	Mozambique (4)	Burundi (2) Ethiopia (3) Malawi (1) Somalia (2) United Republic of Tanzania (4) Zambia (4)	Comoros (2) Djibouti (3) Madagascar (3) Rwanda (4) Zimbabwe (4)	Kenya (4) Mauritius (4) Seychelles (4) Uganda (4)	16
			Middle Africa			
Gabon (1)	Central African Republic (2) Equatorial Guinea (1)	—	Angola (3) Chad (1)[b] Congo (4) Sao Tome and Principe (2) Zaire (4)	United Republic of Cameroon (3)	—	9
			Northern Africa			
Libyan Arab Jamahiriya (1)	—	—	Sudan (4)	Algeria (4)	Egypt (4) Morocco (4) Tunisia (4)	6
			Southern Africa			
—	—	—	—	—	Botswana (4) Lesotho (4) South Africa (4) Swaziland (4)	4
			Western Africa			
Guinea (2)	—	Benin (2) Ivory Coast (2) Mali (4) Mauritania (2) Niger (2) Togo (3) Upper Volta (2)	Cape Verde (4) Gambia (3) Guinea-Bissau (3) Nigeria (3)	Liberia (4) Senegal (4) Sierra Leone (3)	Ghana (4)	16
TOTAL 3	2	8	16	10	12	51
		B. *Area of responsibility of Economic Commission for Europe*				
			Eastern Europe			
Bulgaria (4) German Democratic Republic (4)	—	Hungary (4) Romania (4)	Poland (4) Czechoslovakia (4)	—	—	6
			Northern Europe			
—	—	Finland (4) Ireland (2)	Denmark (4) Iceland (4) Norway (4) Sweden (4) United Kingdom (4)	—	—	7
			Southern Europe			
Greece (2)	—	Albania (4) Yugoslavia (4)	Holy See (1) Italy (3) Malta (1) Portugal (4) San Marino (2) Spain (3)	—	—	9

TABLE 41 *(continued)*

Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
Intervention to raise rates appropriate, and incentives and disincentives implemented to raise rates I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented to lower rates* VI	*Total*
B. *Area of responsibility of Economic Commission for Europe* (continued)						
Western Europe						
France (4) Liechtenstein (2) Luxembourg (3) Monaco (4)	Germany, Federal Republic of (3)	Belgium (3)	Austria (4) Netherlands (3) Switzerland (3)	—	—	9
Western South Asia (part)						
Israel (4)	Cyprus (2)	—	—	—	Turkey (4)	3
Northern America						
—	—	—	Canada (4) United States of America (4)	—	—	2
Union of Soviet Socialist Republics						
—	—	Byelorussian SSR (4) Ukrainian SSR (4) USSR (4)	—	—	—	3
TOTAL 8	2	10	18	—	1	39
C. *Area of responsibility of Economic Commission for Latin America*						
Caribbean						
—	—	—	Cuba (4)	Bahamas (3) Dominican Republic (4) Saint Lucia (4) Saint Vincent and the Grenadines (4)	Barbados (4) Dominica (4) Grenada (4) Haiti (4) Jamaica (4) Trinidad and Tobago (4)	11
Middle America						
—	—	Panama (4)	Honduras (4)	Guatemala (4) Nicaragua (4)[b]	Costa Rica (4) El Salvador (4) Mexico (4)	7
Temperate South America						
Argentina (2) Uruguay (1)	Chile (4)	—	—	—	—	3
Tropical South America						
Bolivia (2)	—	Colombia (4)	Brazil (4) Ecuador (4) Guyana (2) Paraguay (4) Peru (4)[c] Suriname (2) Venezuela (4)	—	—	9
TOTAL 3	1	2	9	6	9	30

TABLE 41 *(continued)*

Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
Intervention to raise rates appropriate, and incentives and disincentives implemented to raise rates I	*Intervention not appropriate; neither incentives nor disincentives implemented II*	*But incentives and disincentives implemented to maintain rates III*	*Intervention not appropriate; neither incentives nor disincentives implemented IV*	*Intervention not appropriate; neither incentives nor disincentives implemented V*	*Intervention to lower rates appropriate, and incentives and disincentives implemented to lower rates VI*	*Total*
D. *Area of responsibility of Economic Commission for Western Asia*						
			Western South Asia[d]			
Iraq (2)	—	Kuwait (2) Oman (2) Qatar (2) Saudi Arabia (1) United Arab Emirates (2)	Democratic Yemen (4) Lebanon (3) Syrian Arab Republic (4) Yemen (4)	Bahrain (3) Jordan (4)	—	12
TOTAL 1	—	5	4	2	—	12
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*						
			China			
—	—	—	—	—	China (4)	1
			Japan			
—	—	—	Japan (4)	—	—	1
			Other East Asia			
—	—	Democratic People's Republic of Korea (4) Mongolia (4)	—	—	Republic of Korea (4)	3
			Eastern South Asia			
Democratic Kampuchea (1)[b] Lao People's Democratic Republic (1)	—	Malaysia (4) Singapore (4)	Burma (2)	—	Indonesia (4) Philippines (4) Thailand (4) Viet Nam (4)	9
			Middle South Asia			
—	—	—	Bhutan (4) Maldives (2)	Afghanistan (4)[b]	Bangladesh (4) India (4) Iran (4)[b] Nepal (4) Pakistan (4) Sri Lanka (4)	9
			Australia-New Zealand			
—	—	—	Australia (3) New Zealand (4)	—	—	2
			Melanesia			
—	—	—	—	Solomon Islands (4)	Papua New Guinea (4)	2
			Micronesia-Polynesia			
—	—	Nauru (4) Kiribati (4)	—	Tuvalu (4)	Fiji (4) Samoa (4) Tonga (4)	6
TOTAL 2	—	6	6	3	16	33

TABLE 41 *(continued)*

Governments' perceptions of the acceptability of the current fertility level and the desirability of intervention to change it						
Rates not satisfactory: too low; higher rates desirable		*Rates satisfactory*		*Rates not satisfactory: too high; lower rates desirable*		
Intervention to raise rates appropriate, and incentives and disincentives implemented to raise rates I	*Intervention not appropriate; neither incentives nor disincentives implemented* II	*But incentives and disincentives implemented to maintain rates* III	*Intervention not appropriate; neither incentives nor disincentives implemented* IV	*Intervention not appropriate; neither incentives nor disincentives implemented* V	*Intervention to lower rates appropriate, and incentives and disincentives implemented to lower rates* VI	*Total*
E. Area of responsibility of Economic and Social Commission for Asia and the Pacific (continued)						
			Developed countries			
7	1	10	21	—	—	39
			Developing countries			
10	4	21	32	21	38	126
TOTAL 17	5	31	53	21	38	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Figures in parentheses refer to Governments' policies concerning provision of support for effective individual fertility regulation:
(1) Access limited;
(2) Access not limited, but no support provided;
(3) Access not limited and indirect support provided;
(4) Access not limited and direct support provided.

[b] Perception and policy are those prevailing as of the last monitoring.

[c] Recently changed its policies with respect to support for effective individual fertility regulation and is now in category (3).

[d] Excluding Cyprus, Israel and Turkey.

TABLE 42. GOVERNMENTS' POLICIES CONCERNING EFFECTIVE USE OF MODERN METHODS OF FERTILITY REGULATION IN RELATION TO GOVERNMENTS' PERCEPTIONS AND POLICIES WITH RESPECT TO THE CURRENT FERTILITY LEVEL, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Governments' perceptions and policies with respect to the current fertility level	*Governments' policies concerning effective use of modern methods of fertility regulation*				
		Access not limited			
	Access limited (1)	*No support provided* (2)	*Indirect support provided* (3)	*Direct support provided* (4)	*Total*
A. *Area of responsibility of Economic Commission for Africa*					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented	Gabon Libyan Arab Jamahiriya	Guinea	—	—	3
Intervention not appropriate; neither incentives nor disincentives implemented	Equatorial Guinea	Central African Republic	—	—	2
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	—	Benin Ivory Coast Mauritania Niger Upper Volta	Togo	Mali Mozambique	8
Intervention not appropriate; neither incentives nor disincentives implemented	Chad[a] Malawi	Burundi Sao Tome and Principe Somalia	Angola Ethiopia Gambia Guinea-Bissau Nigeria	Cape Verde Congo Sudan United Republic of Tanzania Zaire Zambia	16
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	Botswana Egypt Ghana Kenya Lesotho Mauritania Morocco Seychelles South Africa Swaziland Tunisia Uganda	12
Intervention not appropriate; neither incentives nor disincentives implemented	—	Comoros	Djibouti Madagascar Sierra Leone United Republic of Cameroon	Algeria Liberia Rwanda (2)[b] Senegal Zimbabwe	10
TOTAL	5	11	10	25	51
B. *Area of responsibility of Economic Commission for Europe*					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented	—	Greece (1)[b] Liechtenstein	Luxembourg	Bulgaria France German Democratic Republic Israel Monaco	8
Intervention not appropriate; neither incentives nor disincentives implemented	—	Cyprus	Germany, Federal Republic of	—	2
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	—	Ireland	Belgium	Albania Byelorussian SSR	10

TABLE 42 *(continued)*

Governments' perceptions and policies with respect to the current fertility level	*Governments' policies concerning effective use of modern methods of fertility regulation*				
		Access not limited			
	Access limited (1)	*No support provided (2)*	*Indirect support provided (3)*	*Direct support provided (4)*	*Total*
B. *Area of responsibility of Economic Commission for Europe* (continued)					
				Czechoslovakia Finland Hungary Romania Ukrainian SSR USSR	
Intervention not appropriate; neither incentives nor disincentives implemented..	Holy See Malta	San Marino	Italy Netherlands Spain (2)[b] Switzerland	Austria Canada Denmark Iceland Norway Poland Portugal Sweden United Kingdom United States of America Yugoslavia	18
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	Turkey	1
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	—	—
TOTAL	2	5	7	25	39
C. *Area of responsibility of Economic Commission for Latin America*					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented	Uruguay	Argentina Bolivia	—	—	3
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	Chile	1
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	—	—	—	Colombia Panama	2
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	Guyana Suriname	Peru (4)[b]	Brazil Cuba Ecuador Honduras Paraguay Venezuela	9
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	Barbados Costa Rica Dominica El Salvador Grenada Haiti Jamaica Mexico Trinidad and Tobago	9
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	Bahamas	Dominican Republic Guatemala	6

TABLE 42 *(continued)*

Governments' perceptions and policies with respect to the current fertility level	*Governments' policies concerning effective use of modern methods of fertility regulation*				
		Access not limited			
	Access limited (1)	*No support provided* (2)	*Indirect support provided* (3)	*Direct support provided* (4)	*Total*
C. *Area of responsibility of Economic Commission for Latin America* (continued)					
				Nicaragua[a] Saint Lucia Saint Vincent and the Grenadines	6
TOTAL	1	4	2	23	30
D. *Area of responsibility of Economic Commission for Western Asia*[c]					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented	—	Iraq	—	—	1
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	—	—
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	Saudi Arabia	Kuwait Oman Qatar United Arab Emirates	—	—	5
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	Lebanon	Democratic Yemen Syrian Arab Republic Yemen	4
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	—	—
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	Bahrain	Jordan	2
TOTAL	1	5	2	4	12
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented	Democratic Kampuchea[a] Lao People's Democratic Republic	—	—	—	2
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	—	—
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	—	—	—	Democratic People's Republic of Korea Kiribati Malaysia Mongolia Nauru Singapore	6
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	Burma Maldives	Australia	Bhutan Japan New Zealand	6
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	Bangladesh China Fiji	16

TABLE 42 *(continued)*

Governments' perceptions and policies with respect to the current fertility level	*Governments' policies concerning effective use of modern methods of fertility regulation*				
		Access not limited			
	Access limited (1)	*No support provided (2)*	*Indirect support provided (3)*	*Direct support provided (4)*	*Total*
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)					
				India Indonesia Iran[a,d] Nepal Pakistan Papua New Guinea Philippines Republic of Korea Samoa Sri Lanka Thailand Tonga Viet Nam	
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	Afghanistan[a] Solomon Islands Tuvalu	3
TOTAL	2	2	1	28	33
Developed countries					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented....	—	2	1	4	7
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	1	—	1
Rates satisfactory					
But incentives and disincentives implemented to maintain rates.....	—	1	1	8	10
Intervention not appropriate; neither incentives nor disincentives implemented.....	2	1	5	13	21
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented....	—	—	—	—	—
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	—	—	—	—
TOTAL	2	4	8	25	39
Developing countries					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented....	5	4	—	1	10
Intervention not appropriate; neither incentives nor disincentives implemented.....	1	2	—	1	4
Rates satisfactory					
But incentives and disincentives implemented to maintain rates.....	1	9	1	10	21
Incentives not appropriate; neither incentives nor disincentives implemented.....	2	7	7	16	32
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented....	—	—	—	38	38
Intervention not appropriate; neither incentives nor disincentives implemented.....	—	1	6	14	21
TOTAL	9	23	14	80	126
World					
Rates not satisfactory: too low; higher rates desirable					
Intervention to raise rates appropriate, and incentives and disincentives implemented....	5	6	1	5	17
Intervention not appropriate; neither incentives nor disincentives implemented.....	1	2	1	1	5

TABLE 42 *(continued)*

Governments' perceptions and policies with respect to the current fertility level	*Governments' policies concerning effective use of modern methods of fertility regulation*				
		Access not limited			
	Access limited (1)	*No support provided* (2)	*Indirect support provided* (3)	*Direct support provided* (4)	*Total*
		World (continued)			
Rates satisfactory					
But incentives and disincentives implemented to maintain rates	1	10	2	18	31
Intervention not appropriate; neither incentives nor disincentives implemented	4	8	12	29	53
Rates not satisfactory: too high; lower rates desirable					
Intervention to lower rates appropriate, and incentives and disincentives implemented	—	—	—	38	38
Intervention not appropriate; neither incentives nor disincentives implemented	—	1	6	14	21
TOTAL	11	27	22	105	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Perception and policy are those prevailing as of the last monitoring.

[b] Country whose Government changed its policy concerning access to modern methods of contraception between 1 July 1978 and 1 July 1980. Figure in parentheses refers to situation as of 1 July 1978.

[c] Excluding Cyprus, Israel and Turkey.

[d] According to the most recent information, access to effective use of modern methods of fertility regulation is still permitted, but all voluntary organizations have been transferred to the various government departments.

TABLE 43. LEGAL STATUS AND GROUNDS FOR GRANTING ABORTION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND GEOGRAPHICAL REGIONS, JULY 1980

Geographical region and country	Date of law[a]	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for:			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
A. Area of responsibility of the Economic Commission for Africa															
Eastern Africa															
Burundi	...	b	b	Life (in practice)	b	b	b	b	b	b	b	I, 2-10 years	I, 2-5 years	b	—
Comoros	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Djibouti	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Ethiopia	1957	b	b	Life Health	b	Rape and incest operate only as extenuating factors in sentencing	b	b	Woman's consent required If unable for health reasons, her next of kin or her legal representative may consent on her behalf	Performing physician and another physician, specialist in the disease endangering health, life of the mother, must give authorization	b	I, up to 5 years	I, 3 months-5 years	b	—
Kenya	1972	b	b	Life	b	b	b	b	b	b	b	I, up to 14 years	I, up to 7 years	I, up to 3 years	—
Madagascar	1962	b	b	Life	b	b	b	b	b	b	b	I, 1-5 years; and fine	I, 6 months-2 years and fine	b	—
Malawi	1968	b	b	Life	b	b	b	b	b	b	b	I, up to 14 years	I, up to 7 years	I, up to 3 years	—
Mauritius	1945	b	b	Life	b	b	b	b	b	b	b	I, up to 10 years Harsher penalties for medical personnel	I, up to 10 years	I, up to 10 years	—
Mozambique	...	b	b	Life	b	b	b	b	b	b	b	I, 2-8 years	I, 2-8 years Less severe penalty if offence committed in order to conceal her dishonour	b	Law in force up to independence. No information on current legal situation
Rwanda	1970	b	b	Life (in practice)	b	b	b	b	b	b	b	Penal servitude, 2-10 years	Penal servitude, 2-5 years	b	—
Seychelles	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
Somalia	1962	b	b	Life	b	b	b	b	b	b	b	I, 1-5 years Harsher penalties for medical personnel	I, 1-5 years	I, 6 months-2 years	—

Uganda	1964	b	b	Life Physical health Mental health	b	b	b	b	b	Approval of two medical practitioners required in practice	b	I, 14 years	I, 7 years	b	–
United Republic of Tanzania	...	b	b	Life Health	b	Mother suffering from some severe psychiatric illness	b	b	b	Approval of two attending physicians required	b	I, 14 years	I, 7 years	I, 3 years	–
Zambia	1972	b	Risk of injury to the physical or mental health of any existing children	Life Physical health Mental health	Serious risk of physical or mental abnormalities	b	The pregnant woman's actual or reasonably foreseeable environment and age taken in account in determining any abortion	b	b	Approval of medical practitioner performing abortion and of two others required, unless emergency	In government or approved hospitals unless emergency	I, 14 years	b	I, 7 years	–
Zimbabwe	1978	b	b	Physical health	Danger of serious physical or mental imparirment of the foetus	Unlawful intercourse	b	b	b	b	b	b	b	b	–
Middle Africa															
Angola	...	b	b	Life	b	b	b	b	b	b	b	I, 2-8 years	I, 2-8 years Less severe penalty if offence committed in order to conceal her dishonour	b	Law in force up to independence. No information on current legal situation
Central African Republic	1961	b	b	Life (in practice)	b	b	b	b	b	b	b	I, 1-5 years; and/or fine	I, 6 months-2 years; and/or fine	b	–
Chad	1967	b	b	Life	b	b	b	b	b	Performing physician needs attested written approval of two other physicians, one of whom must be an expert on the list of the Civil Court	b	I, 1-5 years; and fine If foregoing is habitual, I, 5-10 years Harsher penalties for medical personnel, same as above and in addition, suspension from professional practice from 5 years to life	I, 2 months-2 years; and fine	b	–

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Middle Africa *(continued)*															
Congo	1810	b	In practice, permissible in cases where the birth of a child would result in socio-economic hardship on the mother or family	Life Health	b	b	b	b	b	For health reasons, a committee of physicians has to examine each case individually For socio-economic reasons, recommendation of a social worker needed	b	b	b	b	Abortion performed frequently New law pertaining to the subject currently drawn
Equatorial Guinea	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
Gabon	1963	b	b	Life	b	b	b	b	b	b	b	I, 1-5 years, and fine Harsher penalties for medical personnel	I, 6 months-2 years; and fine	b	–
Sao Tome and Principe	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
United Republic of Cameroon	1967	b	b	Health	b	Rape	b	b	b	Performer must be a qualified medical person and approval of two consultant physicians required Abortion on juridical ground requires verification by the public prosecutor's office	b	I, 1-5 years; and fine Harsher penalties for physicians	I, 15 days-1 year; and/or fine	b	–
Zaire	1930	b	b	Life	b	b	b	b	b	b	b	I, 2-10 years	I, 2-5 years	b	–

Northern Africa															
Algeria	1966–1976	b	b	Life Health	b	b	b	b	b	Abortion has to be carried out by a physician or a surgeon, after consultation with another physician and after notification of the State Director of Health and Administrative authorities	b	I, 1–5 years; and fine Harsher penalties for medical personnel	I, 6 months–2 years	b	–
Egypt	1937	b	b	Health Life	Danger of deformed or congenitally abnormal child	b	b	b	Husband's consent required for abortion performed to save the life or preserve the health of the mother	Certification of a team of medical doctors required	b	I Harsher penalties for physicians and pharmacists	I	b	–
Libyan Arab Jamahiriya	1953–1973 and 1975	b	b	Life	b	b	b	b	Consent of the pregnant woman, or if she is minor, that of her guardian required	Agreement of two gynaecologists, one on whom is performing the operation, required	b	I, at least 6 months	I, at least 6 months	b	–
Morocco	1962–1967	b	b	Health	b	b	b	b	Spousal consent required Where pregnancy is interrupted without spousal consent, the chief medical officer must be informed	Abortion has to be openly performed by a physician	b	I, 1–5 years; and fine If habitual, double penalty	I, 6 months–2 years; and fine	b	–
Sudan	1925	b	b	Life	b	b	b	b	b	b	b	I, up to 3 years; and/or fine	b	b	–
Tunisia	1973	On request	b	Health Mental balance	Danger of serious infirmity	b	b	Within 3 months (on request)	Consent of the woman required	To be performed by a physician	In hospitals or authorized clinics	Punishable if performed in violation of the law			–

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/social security coverage*	*Performer*	*Woman*	*Supplier*	
Southern Africa															
Botswana	1964	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	b	I, up to 3 years	I, for several years (medication or instrument)	—
Lesotho	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
South Africa	1975	b	b	Life Physical health Mental health	Danger of a physical or mental defect	Rape Incest Pregnancy resulting from intercourse with women who are idiots or imbeciles	b	b	b	Certification of the woman's physician and of two other physicians required	Government hospitals Approved medical institutions	Punishable by imprisonment for up to 5 years, and/or by fine, if performed in violation of the law			—
Swaziland	...	b	b	Life Physical health Mental health	b	b	b	b	b	b	Government hospitals In practice, it is reported that those who cannot afford to pay are treated free of charge	b	b	b	Current status of abortion legislation not known; the basis of law is still the statutory law of South Africa in force before 1965
Western Africa															
Benin	1958 1973	b	b	Life	b	b	Abortion resulting from employment of any therapy is ~~executed~~ by legal system	b excused	b	Agreement of a committee of three physicians (including the performer) and an expert attached to the civil courts required	b	b	b	b	— —
Cape Verde	...														—
Gambia	1934	b	b	Life	b	b	b	b	b	b	b	I, 14 years	I, 7 years	I, 3 years	—
Ghana	1960 1962 1969	b	b	Health Medical or surgical treatment	b	b	b	b	b	b	Preferably government hospitals	I, up to 10 years; and/or fine	I, up to 10 years; and/or fine	b	—

Guinea	1966	[a]	[a]	Health	[a]	[a]	[a]	[a]	[a]	[a]	[a]	I, 1–2 years; and/or fine For medical personnel, same penalties and suspension from professional practice	I, 16 days–1 year; and/or fine	[a]	–
Guinea-Bissau	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Ivory Coast	1958	[b]	[b]	Life	[b]	[b]	[b]	[b]	[b]	To be performed by physician with written certification of two other physicians	[b]	[b]	[b]	[b]	–
Liberia	1979	[b]	[b]	Physical health Mental health	Danger of serious defects	Rape Other felonious intercourse	If the girl at the time of intercourse was below the age of 16	[b]	[b]	Certification of two physicians	[b]	[b]	[b]	[b]	Methods used to prevent implantation of a sterilized egg and a self-abortion by the pregnant woman do not constitute criminal offences
Mali	1961	[b]	[b]	Life	[b]	[b]	[b]	[b]	[b]	[b]	[b]	I, 1–5 years; and fine Harsher penalties for physicians and pharmacists	I, 1–5 years; and fine	[b]	–
Mauritania	1972	[b]	[b]	Life	[b]	[b]	[b]	[b]	[b]	[b]	[b]	I, 1–5 years; and fine	Fine	[b]	–
Niger	1961	[b]	[b]	Life	[b]	[b]	[b]	[b]	[b]	[b]	[b]	I, 1–5 years; and fine	I, 6 months–2 years; and fine	[b]	–
Nigeria	1958	[b]	[b]	*Life (in* northern provinces) Allowed in other provinces under authority of court decision	[b]	[b]	[b]	[b]	[b]	In practice, approval of two medical practitioners required	[b]	I, up to 14 years	I, 7–14 years	I, up to 3 years (except in the northern provinces, where the penalty is not specified)	–
Senegal	1965	[b]	[b]	Life	[b]	[b]	[b]	[b]	[b]	Performing physician must receive written certification from two other doctors	[b]	I, 1–5 years; and fine	I, 6 months–2 years; and fine	[b]	–

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Western Africa *(continued)*															
Sierra Leone	1939	b	b	Life Health	b	b	b	b	b	b	b	Penalties are imposed			—
Togo	1810	b	b	Life Health	b	b	b	b	b	b	b	b	b	b	—
Upper Volta	1810	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
B. *Area of responsibility of the Economic Commission for Europe*															
Eastern Europe															
Bulgaria	1973 1974	On request for woman with more than one living child and provided there are no specially listed medical contraindications	Where the pregnant woman is unmarried, a widow, separated from her husband Where she has one living child and is over 40 years of age	Where not allowed on request if there exist medical indications officially listed In cases of disease not listed, permission may be granted by special board	Included in the list of diseases	Rape	Pregnant woman is an alien	On request within 10 weeks	b	Authorization by boards established at district hospitals for termination of pregnancy on medical indications of woman without a child or with one living child	Only in hospitals and by physicians specialized in obstetrics and gynaecology	For physician, I, up to 3 years For others, I, up to 5 years	Not criminally responsible	b	—
Czechoslovakia	1973	b	Difficult conditions for the life of the woman or her children, such as: Woman is over 40 years (social condition); Woman has three or more living children; Unmarried woman; Woman has lost her husband or he is in a poor state of health;	Medical indications officially listed	Included in the list of medical indications	Rape Other criminal offence	If intra-uterine contraception has failed If conception occurred before 15 or after 45 years (age as a medical indication)	For medical reasons during the first 12 weeks For eugenic reasons during the first 24 weeks	Minors do not need parental consent	Approval of a three-member district committee required	Hospitals (department of gynaecology) As an exception to free health care, a fee is charged (except in exceptional cases)	I, 1-5 years	Not criminally responsible	b	—

			Poor level of living (housing, financial situation) Family unit broken down											
German Democratic Republic	1972	On request	Covered by the indication "for other important reasons" in the law	Physical health Mental health	Covered by the indication "for other important reasons" in the law	Rape Certain other forms of sexual misconduct	[b]	On request: during the first trimester	[b]	Permission of a commission of medical experts needed for abortion to be performed after the first 12 weeks Abortion is normally not allowed if there has been an abortion in the previous 6 months	To be performed by a physician in a recognized clinic Abortion itself, its preparation and post-operative treatment considered illness for the purpose of employment and social insurance	Abortion after first 12 weeks is generally illegal under the criminal code	[b]	—
Hungary	1973	Subject to authorization by special committees; but women who are single, divorced, separated from their husbands (at least 6 months), widows, over 40 years or who have at least three children possess right to have authorization	Where woman or spouse: Has no available accommodation; Is serving prison sentence (at least six months); Has other social grounds of an imperative nature	Medical indication	Probable medical indication affecting the conceptus Abortion may be granted if woman has two living children and anticipates that the viability of the conceptus or its health development is threatened	Criminal act	If intrauterine contraception has failed If the woman has two children and has undergone, in addition, at least one "obstetrical event"	For medical reasons; no limit For other reasons; up to twelfth week of pregnancy and eighth week for a minor (if procedural delays, up to sixteenth week)	Consent of the woman and "hearing" of the husband before the committee For a minor, consent of the legal representative can be substituted by a decision of the committee	Authorization by special committees required in all cases	In patient health care establishment Fee regulated by law	[b]	[b]	[b]	—

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Eastern Europe *(continued)*															
Poland	1956 1969	b	Where the pregnant woman is (or would be after the child were born) in "difficult living conditions"	Health	Not expressly permitted but usually considered a reason of "difficult living conditions"	Rape Other criminal acts	b	b	Consent of parents or guardian required for minor	The physician has to decide if the reasons stated by the woman are sufficient If he refuses, patient can request decision of a medical board	Hospitals and clinics Offices of private physicians	Punishable	Not criminally responsible for terminating her own pregnancy or co-operating in such a termination	b	—
Romania	1957 1966	b	b	Life Physical Mental	Where one of the parents suffers from a serious disease of a heredity nature or from one liable to cause serious congenital malformation	Rape Incest	Woman is more than 45 years She has four children under her care	First three months For life's reasons up to the sixth month	b	Approval of a medical board required	Specialized health unit	Punishable	Punishable	b	—
Northern Europe															
Denmark	1973	On request	Where pregnancy, childbirth or care of child constitutes a serious burden; following will be taken in account: Interests of the woman; Management of the household; Care of the other children; Age of woman;	Life Physical health Mental health	Danger of serious physical or mental disorder	Rape Other criminal acts	On account of her youth or immaturity (if woman is incapable of giving proper care to the child)	On request, first 12 weeks; after that time, illegal except for medical reasons or with authorization of a special committee	For woman under 18 years or legally incompetent, consent of parents or guardian required, but committee can decide that consent is not necessary	Committee approval required after the first 12 weeks of pregnancy	State or communal hospitals Attached clinics (ambulatorium) Fees following law	I, up to 2 years or fine for physician I, up to 4 years for non-physician	b	b	—

			Effort involved in her occupation; Her personal circumstances or (those of her family), including housing, income and health													
Finland	1970 1978	b	Disease or mental disfunction that will affect the ability of either or both parents to take care of the child Delivery of a child and its care in infancy would place a serious strain upon the mother in relation to her general living conditions and those of her family	Life Health	Danger of serious disease or of serious physical or mental defect	Criminal offences	Where the woman was under 17 or over 40 at the time of conception Where she already has given birth to at least four children	For any reasons, up to twelfth week For medical reasons, up to twentieth week allowed	b	In most cases, recommendation of two physicians or authorization of the State Medical Board required	Approved hospitals or institutions, except in an emergency	Hard labour, up to 4 years	1, but taking into account circumstances, the court may refrain from punishing the woman	b	–
Iceland	1975	b	Where pregnancy and child will cause the woman and her close relatives excessive problems on account of unsurmountable social circumstances, the following will be considered:	Life Physical health Mental health	Danger of malformation or child will suffer from serious disease due to genetic factors or damage which occurred during the foetal phase	Rape Other criminal acts	b	b	For woman under 16 years or legally incompetent, joint request by the woman and her parents or legal representative For mentally handicapped woman, request by legal representative	Written report of two physicians required In case of non-agreement, matter shall be submitted for a decision to a three-member committee	Approved hospitals	1, 5–7 years	b	b	–

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Northern Europe *(continued)*															
Iceland *(continued)*			Woman has given birth to several children at frequent intervals and only a short time has elapsed since the previous birth Woman lives in difficult family circumstances due to the presence of young children or to serious ill health of other persons in the household Woman could not look after a child satisfactorily in view of her youth and lack of maturity Other circumstances Where physical or mental disease seriously reduces the capacity of the woman or her partner to care for or bring up a child						For married women, joint request by woman and her husband, unless inadvisable						
Ireland	1861	b	b	Life	b	b	b	b	b	b	b	I, from 2 years to life	I, from 2 years to life	I, from 2 years to life	—

Norway	1978	On request	Where pregnancy, childbirth or care of the child may place the woman in difficult circumstances Abortion on the ground of health, eugenic and socio-economic reasons will take in account the overall situation of the woman, including the extent to which she can provide the child with satisfactory care	Life Physical health Mental health	Major risk for the child of serious disease as a result of his or her genotype, of a disease or of harmful influence during pregnancy Where woman is suffering from severe mental illness or is mentally retarded to a considerable degree	Criminal act	[a]	On request, up to end of twelfth week On other grounds, from end of twelfth week up to eighteenth week For particularly important grounds, after eighteenth week	Consent of woman required For women under 16 years, opinion of parents or guardian considered	For abortion after twelfth week, authorization of a committee of two physicians required	Up to twelfth week, approved institutions After twelfth week, hospitals only	[a]	[a]	[a]	—
Sweden	1974	On request (for Swedish citizen or resident or with special authorization of the National Board of Health and Welfare)	May be considered "substantial grounds"	Life Health Special grounds	May be considered "substantial grounds"	May be considered "substantial grounds"	[b]	Any reasons may justify an authorization of pregnancy termination after the eighteenth week, insofar as they can be determined to be "substantial grounds"	On request up to the end of eighteenth week Other reasons after eighteenth week	After eighteenth week, authorization of the National Board of Health and Welfare required	General hospital or approved establishment, except in emergency Procedures free until eighteenth week	I, up to 1 year; or fine for non-physicians	[b]	[b]	—
United Kingdom	1967	[b]	Actual or reasonable foreseeable environment of the woman may be taken in account in determining the risk involved for medical and eugenic reasons	Life Physical health Mental health Physical and mental health of children	Danger of serious physical or mental abnormalities	[b]	[b]	[b]	[b]	Approval of two registered physicians, except in emergency	Hospital covered under the National Health Service Act or approved establishment Free under National Health Service	[b]	[b]	[b]	—
Southern Europe															
Albania	1977	[b]	[b]	Life Health	[b]	[b]	[b]	[b]	[b]	[b]	[b]	I, up to 8 years	[b]	[b]	—

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Southern Europe *(continued)*															
Greece	1950 1978	b	b	Life Physical health Mental health	Danger of birth of children with defects	Rape Incest	Seduction of a girl under 16 years of age	For mental health reasons up to twelfth week For eugenic reasons, up to twentieth week	b	For life and physical reasons, physician other than the performing physician must certify the need; and for mental health a psychiatrist working in a public health establishment	b	I, at least 6 months	I, up to 3 years	I, at least 6 months	–
Holy See	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
Italy	1977 1978	On request After advice at a consulting centre or a health or welfare agency Waiting period of 7 days before the operation	Economic and social circumstances listed as situation that can endanger the woman's health	Life Physical health Mental health	Danger of serious abnormalities or deformations	b	b	On request during the first 90 days For health or eugenic reasons after first trimester	Minor women (under 18) need parental consent or consent of guardian Decision of a magistrate can replace those of the parents, if not advisable to consult them or if they refuse	After first 90 days, for health or eugenic reasons, certification of a specialist in obstetrics and gynaecology of the hospital where the pregnancy will be interrupted, needed During first 90 days, after a 7-day waiting period and after advice at a consulting centre or health and welfare agency	General or specialized hospitals Authorized private establishments during first 90 days	Criminal provisions included in the 1977 law			–

Malta	1942	b	b	Life	b	b	b	b	b	b	b	I, 18 months–3 years Harsher penalties for physicians and pharmacists	I, 18 months–3 years	b	–
Portugal	1886 1956	b	b	Life	b	b	b	b	b	b	b	I, 2–8 years	I, 2–8 years Less severe if woman committed the offence in order to conceal her dishonour	b	–
San Marino	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
Spain	1963	b	b	Life	b	b	b	b	b	b	b	I, 6 months–6 years Harsher penalties for physicians and midwives	I, 6 months–6 years	b	–
Yugoslavia	1974 (Federal) 1977 (Slovania) 1978 (Croatia)	On request up to tenth week in Slovania and after tenth week, if there is a risk to the woman's life, health or future motherhood that is more than the risk to the woman or the child associated with continuation of the pregnancy	Life Health (Croatia)	Danger of serious congenital, physical or mental defect (Croatia)	b	b	On request up to tenth week Other reasons after tenth week (according to area)	In Croatia, women under 16 years need parental consent In Slovania, application for legally incompetent woman must be filed by parents or guardian For minor, the health care institution must normally inform parents unless the woman has been recognized as fully competent to earn her living	After tenth week, authorization of a First Level Committee needed Possibility of appeal to a Second Level Committee	Hospital with department of gynaecology or especially authorized establishments Costs of abortion are normally paid by the health insurance system After the operation, woman is entitled to adequate care and sick leave	b	b	b	–
Western Europe															
Austria	1974	On request	b	Life Physical health Mental health	Danger of grave physical or mental defect	b	Where woman became pregnant when under 14 years of age	On request, during first three months after nidation Other reasons, after first three months	Consent of the woman	To be performed by a physician after medical consultation	b	I, up to 1 year for a physician	I, up to 1 year	b	In practice, restricted in hospitals and expensive in private establishments

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Western Europe *(continued)*															
Belgium	1867	b	b	Life	b	b	b	b	b	Practitioner must consult two other established physicians and give notice to the Council of the Order of Physicians	b	I, 2-5 years; and fine For physicians and pharmacists, I, 10-15 years	I, 2-5 years; and fine	b	Repressive legislation not enforced
France	1979	On request, "woman in distress situation"	b	Life Health	Danger of serious disease or condition considered to be incurable	b	b	On request up to tenth week Other reasons, after tenth week	Parents' or guardian's approval for minor	On request: woman must consult a counseling institution and wait for a period of one week from her initial request	Public hospital or authorized private hospital Private hospital may refuse to perform For therapeutic abortion, covered by Insurance Plan For other cases, it is not free but help is given if needed	b	b	b	—
Germany, Federal Republic of	1974 1975 1976	b	Current and future living conditions of the woman taken into account, according to medical findings, as part of the evaluation of the health risks	Life Physical health Mental health	Presuming the child's health will be irremediably injured	Certain crimes	b	For eugenic reasons, up to twenty-second week after conception For juridical reasons, up to twelfth week after conception	b	Woman has to consult counsellor 3 days before interruption Performing physician needs written confirmation from another physician for health, juridical and socio-economic reasons of abortion	Hospitals or authorized establishments Health insurance laws were reviewed so as to afford medical treatment, supplies of medicines, drugs and dressing materials, as well as hospital care to persons	I, up to 1 year; and in particularly serious cases, up to 5 years; or fine	I, up to 1 year; or fine, but the court may refrain from punishing her	b	Procedures that take effect before nidation of the fertilized ovum in the uterus are not deemed to be abortion within the meaning of the law

Liechtenstein	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Luxembourg	1978	b	Where the living conditions that may result from the birth are likely to endanger the physical or mental health of the woman	Life Physical health Mental health	Danger of serious disease, serious malformation or considerable mental defects	Rape	b	Up to twelfth week	b	Woman has to consult a gynaecologist who has informed her of the medical risks involved Indications for abortion must be certified by a physician other than that who performs	Hospital or approved establishment	I, 2–5 years; and fine	Fine No offence if she acts under pressure of situation of distress	b	—
Monaco	1967	b	Life	b	b	b	b	b	b	b	b	I, 1–5 years; and fine Harsher penalties for medical personnel	I, 6 months–3 years; and fine	b	—
Netherlands	1881	b	b	Life Health	b	b	b	b	b	b	b	I, up to 4½ years Harsher penalties for physicians, pharmacists or midwives	I, up to 3 years	b	Repressive legislation not enforced Practice very liberal; and several non-profit clinics, specializing in pregnancy interruptions, operate in the country
Switzerland	Federal law, 1937 Implementing regulations were issued by the Cantons: Geneva, 1954 Vaud, 1968	b	b	Life Health	b	In practice, rape	b	b	Written consent of the woman	The performing licensed physician has to receive a second opinion from another licensed physician	b	Penal servitude, up to 5 years	I, 3 years or more	b	—

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Western South Asia (part)															
Cyprus	1959	b	Socio-economic grounds	Life Physical health Mental health	Danger of deformed or retarded child	Rape Such circumstances that, if the pregnancy were not terminated, the social status of the woman or her family could be seriously jeopardized	b	b	b	For juridical reasons, consent of police authority and medical practitioner For medical and eugenic reasons, approval of a second registered medical practitioner	b	I, 14 years	I, 7 years	I, 3 years	—
Israel	...	b	b	Life Physical health Mental health	Danger of physical or mental defect	Pregnancy resulting from: Sexual relations prohibited by criminal code Incestuous relations Extra-marital sexual relations	Where woman is under minimum age of marriage or over 40 years	b	Consent of minor does not require approval of her representative	Approval of a three-member committee (two physicians and a social worker) required after interview with the woman	Recognized medical institutions	b	b	b	—
Turkey	1965	b	b	Life	Abnormalities in foetal development or of a genetic nature Risk of a child having a hereditary defect	Rape Other crimes	b	b	Consent of the woman required; or that of her guardian in the case of a minor; or or of a Court in the case of delinquents and persons who have lost their legal rights	Therapeutic Abortion Committee must approve all pregnancy terminations, unless emergency	Establishments determined by the Ministry of Health and Social Welfare	I, 2-5 years	If she performs herself, I, 1-4 years If she consents only, I, 1-5 years	b	—

Northern America															
Canada	1955 1970	b	b	Life Physical health Mental health	b	b	b	b	b	Qualified medical practitioner may perform an abortion with written certification of a Therapeutic Abortion Committee of the hospital (three physicians)	Accredited or approved hospital Provincial Government Hospital and medical plans, where applicable	I, life	I, 2 years	I, 2 years	–
United States of America	Supreme Court, 1973 statute may vary in the individual states	On request	b	Life Health	b	b	b	On request in first and second trimester After viability of the foetus or in "the third trimester" only if it is necessary to save the life or to protect health from serious injury	b	Prior to end of the first trimester, decision of woman and her physician In second trimester, the state, in promoting its interests in the woman's health, may regulate the abortion procedure in ways that are reasonably related to maternal health For third trimester, i.e., stage subsequent to viability, the state, in promoting the potentiality of human life, may regulate and even prescribe abortion, except where necessary in appropriate medical	For first trimester, no regulations For second trimester, usually in medical establishments of a certain type For third trimester, public hospitals cannot refuse to perform an abortion; private hospitals may prohibit abortion or refuse to perform it Congress as well as many states limited payment for abortion from federal or state funds, except for abortion for medical reasons	Abortion performed by a non-physician remains an offence			–

TABLE 43 *(continued)*

Geographical region and country	Date of law[a]	Grounds for termination of pregnancy: On request	Socio-economic	Medical	Eugenic	Juridical	Other	Legal period allowed	Modalities: Consent	Committee approval	Place of termination and insurance/social security coverage	Penalties for: Performer	Woman	Supplier	Remarks
North America *(continued)*															
United States of America *(continued)*										judgement, for the preservation of the woman's life and health. Viability is usually placed at about 7 months (28 weeks) but may occur earlier, even at 26 weeks					
Union of Soviet Socialist Republics															
Byelorussian SSR	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Ukrainian SSR	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
USSR	1965 1960 1969	On request	b	Permitted for medical reasons	Permitted on genetic grounds, for hereditary diseases, etc.	b	b	During first 12 weeks Later for medical reasons	b	b	Only hospitals and approved establishments Therapeutic abortions are free; for other legal abortion, small fee is charged Free also for working women	Deprivation of freedom, up to 1 year; or correctional tasks if performed by physician Deprivation of freedom, up to 2 years; or correctional tasks if performed by non-physician	Not criminally responsible	b	Abortion permitted on request but dissuasion campaign for natalist reasons
C. *Area of responsibility of the Economic Commission for Latin America*															
Caribbean															
Bahamas	...	b	Where it may be interpreted as a risk to health	Life Physical health Mental health	Where it may be interpreted as a risk to health		b	In practice within 20 weeks Majority under 12 weeks	b	Registered medical practitioner	Hospital, not necessarily government	b	b	b	—
Barbados	1868 1944	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	I	I	I, 2-3 years	—

Cuba	1979	On request	b	b	b	b	b	First trimester	b	b	Free	b	b	b	–
Dominica	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	–
Dominican Republic	1948	b	b	Life	b	b	b	b	b	b	b	I, 2–5 years For medical personnel, 5–20 years of hard labour	I, 2–5 years	b	–
Grenada	1935	b	b	Life Health	b	b	b	b	b	b	b	I, up to 10 years	I, up to 10 years	b	–
Haiti	1835	b	b	Life	b	b	b	b	b	b	b	I, 3–9 years Harsher penalties for physicans and pharmacists	I, 3–9 years	b	–
Jamaica	1864 1975	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	I, life or I, not less than 3 years or I, less than 2 years with or without hard labour	b	I, for more than 3 years or I, less than 2 years with or without hard labour	–
Saint Lucia	...	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	b	b	b	–
Saint Vincent and the Grenadines	...	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	b	b	b	–
Trinidad and Tobago	1925 1950	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	b	I, 4 years	b	–
Middle America															
Costa Rica	1970	b	b	Life Health	b	b	b	b	Written consent of the woman and her husband required	Performing physician has to consult other physicians Authorized midwife can also perform an abortion	b	I, 1–3 years If foetus less than 6 months, I, 6 months–2 years	I, 1–3 years If foetus less than 6 months, I, 6 months–2 years	b	–
El Salvador	1977 1877	b	b	Life	Grave deformity of the foetus	Rape	b	b	Consent of the mother required	Consultation with another physician required (in the case of saving life)	b	I, 2–4 years	I, 1–3 years	b	–

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Middle America *(continued)*															
Guatemala	1973	b	b	Life	b	b	b	b	b	Performing physician must consult with another physician	b	I, 1-3 years Harsher penalties for medical personnel	I, 1-3 years	b	—
Honduras	1906 1964	b	b	Life Health (after other methods have been tried without success)	b	b	b	b	Written consent of the mother and her husband or the closest relative required	Authorization by medical commission required	b	I, 2-3 years	Less severe penalty	b	—
Mexico	1931	b	b	Life	b	Rape	b	b	Consent of woman required	Performing physician must consult with another physician (except in emergency cases)	b	I, 1-3 years	I, 6 months-5 years I, 6 months-3 years when the interruption of concealed pregnancy resulting from an illegitimate relationship was performed by a woman of good reputation	b	—
Nicaragua	1949	b	b	Life	b	b	b	b	b	b	b	I, 1-2 years	I, 4 years or 2 years	b	—
Panama	1922	b	b	Life	b	b	b	b	b	b	b	I, 20 months-3 years Harsher penalties for medical personnel and for the husband	I, 8-30 months	b	—
Temperate South America															
Argentina	1921 1967	b	b	Life Health	b	Rape (if criminal procedure initiated) Incest	b	b	b	Only licensed physicians can perform	b	I, 1-4 years I, up to 6 years if woman dies following operation	I, 1-4 years	b	—

Chile	1967 1976	b	b	Life	b	b	b	b	b	Beside the performing physician, written approval of two physicians required	b	I, 540 days–3 years Harsher penalties for physicians	I, 3–5 years	b	–
Uruguay	1933	b	Serious economic difficulty (punishment reduced by from one third to one half or may be waived)	Life	b	Rape (punishment may be waived)	b	Within the first 3 months	b	To be performed by a physician	b	I, 6–24 months	I, 3–9 months	b	–
Tropical South America															
Bolivia	1972	b	b	Life Health	b	Pregnancy resulting from certain sexual crime	b	b	b	Performing physician needs judicial approval	b	I, 1–3 years If performed habitually, I, 1–6 years Interruption of pregnancy commited through negligence is an offence	I, 1–3 years Unsuccessful attempt not punishable	b	–
Brazil	1940 1941	b	b	Life	b	Rape	b	b	b	For therapeutic abortion, the attending physician needs authorization of a committee of three physicians called into conference	b	I, for at least 4 years	I, for at least 4 years	b	–
Colombia	1936	b	b	Life	b	Reduction in sentence of from one half to two thirds, or even judicial pardon, may be prescribed for an abortion performed to protect the honour of one's mother, spouse, daughter, sister or adopted daughter	b	b	b	b	b	I, 1–4 years Harsher penalties for medical personnel	b	–	

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Tropical South America *(continued)*															
Ecuador	1938	b	b	Life	b	Rape Cohabitation with retarded or insane woman	b	b	For abortion on juridical ground, consent of legal representative of the woman required	b	b	I, 2-5 years Harsher penalties for medical personnel	I, 6 months-5 years	b	–
Guyana	1954	b	b	Life Health (presumably)	b	b	b	b	b	b	b	I, life	I, 10 years	I, 5 years	–
Paraguay	1909	b	b	Life	b	b	b	b	b	b	b	I Harsher penalties for medical personnel and husband	I	b	–
Peru	1924 1969	b	b	Life Health	b	b	b	b	b	Approval of two physicians required	b	I, up to 4 years Harsher penalties for medical personnel	I, up to 4 years	b	Since human life begins with conception, abortion based on any ground (moral, social, economic or as a means of birth control), except for saving life or health of the mother, is prohibited
Suriname	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
Venezuela	1964	b	b	Life	b	b	b	b	Consent of the woman and relatives to be obtained by the physician after adequate explanation of necessity of the abortion and of procedures	b	Suitable environment Using all possible scientific resources	I, 12-30 months Harsher penalties for medical practitioner and husband	I, 6 months-2 years	b	–

D. *Area of responsibility of the Economic Commission for Western Asia*

Western South Asia[c]															
Bahrain	1956	b	b	Life	b	b	b	b	b	b	b	I, 10 years	I, up to 5 years	I, 3 years; and/or fine	—
Democratic Yemen	1969	b	b	Life	b	b	b	b	b	b	b	I, 3 years; and/or fine	I, 3 years; and/or fine	b	The 1969 law is applied for Aden region. Elsewhere, the Islamic religious law and tribal law are in force
Iraq	1969	b	b	Life	b	b	b	b	b	Recommendation by two medical specialists required	b	I, 1 year; and/or fine Harsher penalties for physicians	I, 1 year; and/or fine	b	—
Jordan	1960 1971	b	b	Life Health	b	b	b	b	Written consent of the woman or if legally incompetent, her husband or legal guardian	Certification of two licensed physicians	Licensed hospital or nursing home	I, 1-3 years Harsher penalties for medical personnel	I, 6 months-3 years	b	—
Kuwait	1960	b	b	Life	b	b	b	b	b	To be performed by an obstetrician	b	I, up to 10 years; and/or fine Harsher penalties for medical personnel	I, up to 5 years; and fine	I, up to 3 years; and/or fine	—
Lebanon	1943 1969	b	b	Life	b	b	b	b	Consent of woman required except in case of emergency or incapacity	Certification by two physicians other than the performer required	b	I, 6 months-3 years	I, 6 months-3 years	b	—
Oman	Since 1966 Islamic religious law in force	b	b	b	b	b	b	b	b	b	b	b	b	b	—
Qatar	1971 Criminal Code but no information	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Saudi Arabia	Islamic religious law in force	b	b	Life	b	b	b	b	b	b	b	b	b	b	—

TABLE 43 *(continued)*

Geographical region and country	Date of law[a]	Grounds for termination of pregnancy: On request	Socio-economic	Medical	Eugenic	Juridical	Other	Legal period allowed	Modalities: Consent	Committee approval	Place of termination and insurance/social security coverage	Penalties for: Performer	Woman	Supplier	Remarks
Western South Asia *(continued)*															
Syrian Arab Republic	1949 1970	b	b	Life	b	b	b	b	Written record concerning the abortion signed by the woman and her husband (or a guardian) is required	Performer has to be a medical specialist and reach agreement with another medical specialist	b	I, 1-3 years Harsher penalties for physicians and pharmacists	I, 6 months-3 years	b	–
United Arab Emirates	...	b	b	b	b	b	b	b	b	b	b	b	b	b	–
Yemen	Seemingly, Islamic religious law in force, but criminal law in 1963														–
E. *Area of responsibility of the Economic and Social Commission for Asia and the Pacific*															
China															
China	1979	On request (incentives and disincentives)	b	b	b	b	b	Usually 3 months	b	b	In hospitals, clinics and dispensaries After pregnancy termination, a woman receives 14 days sick leave with pay, or 30 days if the pregnancy was terminated after 3 months	–	–	–	Criminal code of China currently the only code entirely decriminalizing abortion In addition to all contraceptive methods, widely practiced as a method of family planning
Japan															
Japan	1907 1948	b	When from an economic view point, continuation of pregnancy or delivery may seriously affect the health	Health (continuation of pregnancy or delivery)	Husband or relative within the fourth degree suffers from heredity diseases or defects	Rape Fornication without the legal consent of the woman	b	24 weeks	Authorization of husband required	b	Not free but cheap	I, up to 2 years Harsher penalties for physicians and pharmacists	I, up to 1 year.	b	–

Other East Asia															
Democratic People's Republic of Korea	1950	b	Interruption of pregnancy allowed "for important reasons"				b	b	b	b	Presumably free of charge	I, up to 3 years	Woman inducing her own abortion or allowing another to do so is not criminally responsible	b	—
Mongolia	1960	b	b	Life Health	b	b	b	b	b	b	b	If performed by physician, I, up to 2 years If performed by a person who does not have higher medical qualification or if performed under unsanitary conditions, I, up to 5 years	Presumably, woman inducing her own abortion or allowing another person to do so is not criminally responsible	b	—
Republic of Korea	1973	b	b	Life Health Mother suffering from certain infectious diseases	If the woman or her spouse suffers from hereditary mental physical disease Suspected or confirmed foetal abnormality	Rape Incest Other unlawful intercourse	b	Before end of twenty-eighth week	Consent of the woman and husband required If not possible to obtain the spouse's consent, that of the woman alone is sufficient	b	b	I, up to 1 year; or fine Harsher penalties for medical personnel	I, up to 1 year; or fine	b	—
Eastern South Asia															
Burma	...	b	b	Life	b	b	b	b	b	b	b	I, up to 3 years; and/or fine	I, up to 3 years; and/or fine	b	—
Democratic Kampuchea	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—
Indonesia	1915	b	b	Life	b	b	b	b	b	b	b	I, 5½ years Harsher penalties for medical personnel	I, up to 4 years	b	—
Lao People's Democratic Republic	1922 1965	b	b	Life	b	b	b	b	b	b	b	I, 5–10 years		b	—
Malaysia	1976	b	b	Life	Permitted	Permitted	b	b	Consent of woman required	b	Free if performed in government hospitals	Where woman is in the early stage of pregnancy, I, up to 3 years; and/or fine Where the foetus can be felt or in the late period of pregnancy, I, up to 7 years; and/or fine		b	—

TABLE 43 *(continued)*

Geographical region and country	Date of law[a]	Grounds for termination of pregnancy						Legal period allowed	Modalities			Penalties for:			Remarks
		On request	Socio-economic	Medical	Eugenic	Juridical	Other		Consent	Committee approval	Place of termination and insurance/social security coverage	Performer	Woman	Supplier	
Eastern South Asia *(continued)*															
Malaysia *(continued)*													If done without consent of woman, I, up to 20 years; and fine		
Philippines	1930	b	b	Life	b	b	b	b	b	b	b	I, 6 months–6 years Maximum penalty specified above for physicians and midwives	I, 6 months–6 years	b	–
Singapore	1974	On request (if woman is a national or resident of Singapore)	b	Life Physical health Mental health	b	b	b	Up to twenty-fourth week (except for life and health)	Written consent of the woman required	b	Government hospitals or approved institutions Cost of abortions carried out in a government hospital is low ($5)	I, up to 3 years; and/or fine	b	b	–
Thailand	1956	b	b	Life Health	b	Rape Certain other crimes	b	b	b	b	b	I, up to 5 years; or fine	I, up to 3 years; or fine	b	–
Viet Nam	...	...	...	...	...	...	...	...	...	...	...	...	...	...	–
Middle South Asia															
Afghanistan	1976	b	b	Life	b	b	b	b	b	b	b	I, 24 months–15 years, depending upon the circumstances of the case; or a fine		b	–
Bangladesh	1860	b	b	Life	b	b	b	b	b	Opinion of two approved medical practitioners required in practice	Operations at government hospitals or health centres are free, in practice	I, up to 7 years, with or without fine If performed without consent of the woman or if she dies, up to 10 years and fine Jail for life is an alternative punishment	I, up to 7 years, with or without fine Jail for life is an alternative punishment	b	–

Bhutan	...	...	...	...	...	...	...	b	...	...	...	...	...	b	—
India	1971/72 1975		Actual or foreseeable socio-economic environment may be taken into account when health of mother is considered	Life Physical health Mental health	Danger of serious physical or mental abnormalities	Rape	Failure of contraception on the part of the wife or husband		Consent of woman required For minor or mentally ill woman, written consent of guardian required	Length of pregnancy less than 12 weeks, medical practitioner can perform Length of pregnancy between 12 and 20 weeks, approval of two medical practitioners required, unless emergency	Hospitals established or maintained by the Government Place approved by specific legislation (except in emergencies)	I, 3 years; and/or fine If foetus seemingly alive, I, up to 7 years	I, 3 years; and/or fine		—
Iran	1974 1976	b	Social or medico-social reasons	Life Physical health Mental health	Incurable defect	12 weeks for social and medico-social grounds First trimester for other reasons		b	Written consent of the "parents required" (of the woman alone if she is unmarried) Abortion on the ground of mental illness of one of the parents, written consent of a guardian required Abortion on the ground of health, consent of the mother alone required	For medical reasons, performing physician needs "endorsed opinion" of two other physicians For social or medico-social reasons, a physician can perform	Hospitals and clinics	b	b	b	No information concerning the law in the new Government
Maldives	...	b	b	Life	b	b	b	b	b	b	b	I, up to 3 years; and/or fine If foetus seemingly alive, I, up to 7 years; and fine	I, up to 3 years; and/or fine If foetus seemingly alive, I, up to 7 years; and fine	b	—
Pakistan	...														—
Nepal	1976	b	b	On grounds of "benevolence"	b	b	b	b	b	b	b	With consent of the woman, I, 1 year, if pregnancy is less than 6 months; I, 1 1/2 years if pregnancy is more than 6 months Without consent of woman, I, 2 years, if pregnancy is less than 6 months; I, 3 years, if pregnancy			—

TABLE 43 *(continued)*

Geographical region and country	*Date of law*[a]	*Grounds for termination of pregnancy*						*Legal period allowed*	*Modalities*			*Penalties for:*			*Remarks*
		On request	*Socio-economic*	*Medical*	*Eugenic*	*Juridical*	*Other*		*Consent*	*Committee approval*	*Place of termination and insurance/ social security coverage*	*Performer*	*Woman*	*Supplier*	
Middle South Asia *(continued)*															
Nepal *(continued)*															
												is more than 6 months Abortion resulting from violence, I, 3 months if pregnancy is less than 6 months; I, 6 months if pregnancy is more than 6 months Abortion resulting from violence without knowledge that woman is pregnant, fine (amount depending upon length of pregnancy)			
Sri Lanka	1883 1956	b	b	Life	b	b	b	b	Consent of woman required	b	b	I, up to 3 years; and/or fine If foetus seemingly alive, up to 7 years	I, up to 3 years; and/or fine	b	–
Australia-New Zealand															
Australia	Criminal statutes differ from one state to another	On request, but on grounds of health (northern territory)	Actual or foreseeable socio-economic environment may be taken in account in determining risk to or health of the woman (South Australia)	Life Physical health Mental health	Substantial risk of severe defect (northern territory and South Australia)	In practice (South Australia)		b	b	b	b	I, 10–15 years	Special sentence terms		–

New Zealand	1961 1977/78	b	b	Life Physical health Mental health	Danger of physical or mental abnormality	Incest Rape in itself is not a ground for abortion, but it may be taken into account under the medical indication	Woman severely subnormal Woman's being near the beginning or the end of the usual child-bearing years, while not being a ground "in itself," can be taken into account under the medical indication	For serious danger to the physical or mental health of the woman, not more than 20 weeks After 20 weeks, only to save the life or to prevent serious permanent injury to physical or mental health	b	Approval of two physicians who are official "certifying consultants"	Licensed institutions If pregnancy exceeds 12 weeks, only institutions with "full license"	I, up to 14 years	Fine	b	—
Melanesia															
Papua New Guinea	1899 1902	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	Penalties	Penalties	b	—
Solomon Islands	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
Micronesia-Polynesia															
Fiji	1976	b	b	Life Physical health Mental health	b	b	Eugenic, juridical or socio-economic reasons are not a ground in and of themselves but may be taken into account when judging the repercussions of pregnancy on the life and health of the mother	b	b	b	b	I, 14 years	I, up to 7 years	I, 14 years	—
Kiribati	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
Nauru	1899	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
Samoa	1969	b	b	Life Physical health Mental health	b	b	b	b	b	b	b	b	b	b	—
Tonga	...	b	b	Life	b	b	b	b	b	b	b	b	b	b	—
Tuvalu	...	...	...	...	...	...	...	...	...	...	...	...	...	...	—

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat; United Nations Fund for Population Activities, *Survey of Laws on Fertility Control* (New York, 1979); and *International Digest of Health Legislation,* vol. 30, No. 3 (1979).

Note: I = imprisonment.

[a] Or of an amendment to the law.

[b] The law or amendment currently in force does not refer to this aspect.

[c] Excluding Cyprus, Israel and Turkey.

[d] The laws legalizing voluntary abortion on both medical and social grounds have now been repealed.

TABLE 44. LEGAL STATUS AND GROUNDS FOR GRANTING STERILIZATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS AND GEOGRAPHICAL REGIONS, JULY 1980

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
A. *Area of responsibility of the Economic Commission for Africa*								
Eastern Africa								
Burundi	1940	No specific provision, but appears to be applicable to law dealing with intentional infliction of a corporal injury	b	b	b	b	b	—
Comoros	...	...	...	...	...	...	...	—
Djibouti	...	...	...	...	...	...	...	—
Ethiopia	1957	No specific provision, but seemingly legal if requested by patient and neither forbidden by law nor offends public decency	On request, but at least five living children and difficult socio-economic condition of the mother (as well as health reasons)	Preferably persons over 35 years of age	In practice limited to women	Spousal consent requested	Hospitals	Practised on a small scale with the support of the Family Guidance Association
Kenya	1962	No specific provision, but law dealing with an intentional infliction of a corporal injury is not applicable to sterilizations	b	b	b	b	State hospitals and clinics	Some sterilizations were performed Since 1978 officially stated as a family planning method for the moment
Madagascar	1962	No specific provision, but law dealing with intentional infliction of a corporal injury seems to be applicable to all forms of sterilization	b	b	b	b	b	—
Malawi	1968	No specific provision, but law dealing with intentional infliction of a corporal injury in force except if done in good faith	b	b	b	b	b	—
Mauritius	1938	No specific provision, but law dealing with intentional infliction of a corporal injury not clearly defined as applic-	b	b	b	b	b	—

		able or not to voluntary sterilization performed for family planning purposes						
Mozambique	1956	Non-therapeutic sterilization prohibited (no clarification about the legal situation after independence)	b	b	b	b	b	—
Rwanda	1940	No specific provision, but appears to be applicable to law dealing with intentional infliction of a corporal injury	b	b	b	b	b	—
Seychelles	...	...	...	...	...	...	...	—
Somalia	1962	Illegal and punishable for both the surgeon performing the sterilization and the patient consenting to such an act	b	b	b	b	b	—
Uganda	1964	No specific provision, but law dealing with intentional infliction of a corporal injury may not be applicable to sterilization operation since it is done in good faith	After multiple caesarian operations After a woman had 9–10 children By mutual consent of the couple	In practice, performed on women who are over 40 years of age, on the advice of the Family Planning Association	In practice, only tubal ligations	b	In hospitals only	—
United Republic of Tanzania	1930	No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith. Unclear if applicable to sterilization for medical reasons only or to sterilization for exclusively contraceptive purpose	b	b	b	b	b	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Eastern Africa *(continued)*								
Zimbabwe	...	...	...	...	...	...	...	—
Zambia	1931	No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith	b	b	b	b	b	b
Middle Africa								
Angola	1956	Contraceptive sterilization prohibited	b	b	b	b	b	b
Central African Republic	1961	No specific provision, but law dealing with intentional infliction of a corporal injury in force and probably applicable to voluntary sterilization	b	b	b	b	b	b
Chad	1967	No specific provision, but law dealing with intentional infliction of a corporal injury in force and applicable to voluntary sterilization	b	b	b	b	b	b
Congo	1958	No specific provision, but law dealing with intentional infliction of a corporal injury in force and applicable to voluntary sterilization	b	b	b	b	b	b
Equatorial Guinea	...	...	...	...	...	...	...	—
Gabon	1963	No specific provision, but law dealing with intentional infliction of a corporal injury is	...	...	...	...	...	—

		in force and there is no information as to the possible interpretation of this law						
Sao Tome and Principe	...	...	...	...	...	...	...	—
United Republic of Cameroon	1965	No specific provision, but law dealing with intentional infliction of a corporal injury is in force but may be not applicable to sterilization of a patient on his or her request	[b]	[b]	[b]	[b]	[b]	—
Zaire	1930	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and there is no information as to the possible interpretation of this law	...	...	...	...	...	—
Northern Africa								
Algeria	1966	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and probably applicable to voluntary contraceptive sterilization	Therapeutic Eugenic	[b]	[b]	Both spouses	Governmental medical institutions	—
Egypt	1937	Law does not contain any text prohibiting sterilization operations undertaken with the consent of the patient but Islamic law permits it for health and eugenic reasons only	On request, if the woman is over 35 years old Has three or more children, at least one of them a boy Possible exception to these prerequisites Eugenic	Woman has to be over 35 years old	Tubal ligations (No information on vasectomies)	[b]	University hospitals State hospitals (Department of Obstetrics and Gynaecology) Private hospitals and clinics	At official level, a project is being implemented in three university hospitals to investigate comparative methods for surgical sterilization of women

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Northern Africa *(continued)*								
Libyan Arab Jamahiriya	...	...	...	...	...	...	...	—
Morocco	1962	No specific provisions, but law dealing with intentional infliction of a corporal injury is in force and there is no information as to the possible interpretation of this law	[b]	[b]	[b]	[b]	[b]	There is a government program in family planning and some evidence that sterilizations are being performed in public hospitals in the cities
Sudan	1925	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization	[b]	[b]	[b]	[b]	[b]	—
Tunisia	1913–1973	No specific provision, but law dealing with intentional infliction of a corporal injury may not now be interpreted as applicable to voluntary sterilization	On request, but must have four children	Very young women excluded by the requirement of at least four children	Tubal ligations (vasectomies considered to be less acceptable for cultural reasons)	Spousal consent required in practice	Performed by physicians in government hospitals and clinics	Medical sterilization proclaimed an acceptable method of family planning
Southern Africa								
Botswana	1964	No specific provision, but law dealing with intentional infliction of a corporal injury is to be construed in accordance with English Criminal Code. Thus, the lawfulness of a contraceptive sterilization performed on the request of an informed patient may be supposed	On request, even for family planning purposes	[b]	Mostly female sterilization	Spousal consent required in practice	Hospitals	—

Lesotho	...	No specific statutory provision on voluntary sterilization but legally, sterilization is considered to be a surgical operation like any other	Usually many children or medical grounds	Most sterilized women are in the 35–45 age group	Female sterilization only	[b]	Performed by a registered medical practitioner in a recognized hospital	Female sterilization freely practised
South Africa	1975	The Abortion and Sterilization Act regulates only some issues of sterilization (persons incapable of consenting . . .) but implies clearly that a competent person can consent to his or her own sterilization and that such consent makes the operation lawful	On request (persons competent to give consent)	Minors cannot be sterilized. Incompetent persons can be sterilized if there is existence of certain genetic dangers of mental incapability of parenthood, certified by two physicians and authorized by the legal representative and the minister	[b]	[b]	[b]	—
Swaziland	...	No specific provisions and no information concerning the lawfulness of voluntary sterilization since the country became independent						—
Western Africa								
Benin	1958	When the country became independent, the French law was in force and purely contraceptive sterilization was considered a crime of intentional infliction of corporal injury. The current legal situation is not clarified	[b]	[b]	[b]	[b]	[b]	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Western Africa *(continued)*								
Cape Verde	...	...	...	...	...	...	...	—
Gambia	1966	No specific provisions, but law dealing with an intentional infliction of a corporal injury is in force unless it is a reasonable surgical operation for the benefit of the patient. Whether the operation is to be considered reasonable depends upon the state of the patient and upon all the circumstances of the case	Matter to be decided between patient and physician	[b]	[b]	[b]	[b]	—
Ghana	1960-1961	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force but provides that it is not a crime if done in good faith, for the purpose of medical or surgical treatment	Mostly medical reasons	[b]	[b]	Authorization of legal representative for incompetent persons Spousal consent is not a requirement "in the delivery of family planning services"	Medical units throughout the country	—
Guinea	1965	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and there is no information as to the interpretation of this law	...	...	...	...	...	—
Guinea-Bissau	...	...	...	...	...	...	...	—
Ivory Coast	1958	When the country became independent, the French law was in force and purely con-	[b]	[b]	[b]	[b]	[b]	There seems to be no interest in sterilization as a means of family planning

		traceptive sterilization was considered a crime of intentional infliction of corporal injury. The current legal situation is not clarified, but the Government, as reported, does not prohibit birth control						
Liberia	1956	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force but no clear indication about the permissibility of purely contraceptive sterilization	b	b	b	b	b	—
Mali	1961	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force	Medical indications	b	Female sterilization only	Spousal consent required in practice	Hospital in capital city	—
Mauritania	1972	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force	b	b	b	b	b	—
Niger	1961	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force	b	b	b	b	b	—
Nigeria	1960	No specific provisions, but a surgeon can perform a voluntary sterilization operation upon any person for his benefit "... if performed in good faith, and with reasonable care ... and with the consent of the person"	b	b	b	b	b	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Western Africa *(continued)*								
Senegal	1965	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force. But the question of possible applicability of this law to sterilization operations on consenting patients has not yet been clarified	b	b	Virtually no vasectomies	b	b	Voluntary sterilization for family planning purposes is rare, being employed only rarely by women with large families
Sierra Leone	1960	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and its possible applicability to voluntary sterilization has not yet been clarified	b	b	b	b	b	—
Togo	...	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and its applicability to voluntary sterilization presumably does not arise	b	b	b	b	b	Not practiced in Togo
Upper Volta	1958	When the country became independent, the French law was in force and purely contraceptive sterilization was considered a crime of intentional infliction of a corporal	b	b	b	b	b	—

		injury. The current legal situation is not clarified						
B. *Area of responsibility of the Economic Commission for Europe*								
Eastern Europe								
Bulgaria	1968	No specific provision, but seemingly legal since law dealing with intentional infliction of a corporal injury is not applicable to voluntary sterilization, considered an act not socially dangerous	[b]	Consenting mature person	[b]	No spousal consent required	Institutions of state health care	—
Czechoslovakia	1966, 1971, 1972	Legal except if considered "more than slightly socially dangerous"	On request if the woman is over 35 years old and has at least three children or is younger than 35 but has four children Medical Genetic	35 years for women	Full equality guaranteed by broad possibility of vicarious male sterilization	[b]	State hospitals and clinics	Number of operations statistically insignificant
German Democratic Republic	1968	Legal for medical reasons; otherwise, law dealing with intentional infliction of a corporal injury is in force but whether a sterilization performed in violation of the law might be punishable as such an offence might depend upon the degree of "social danger" presented by the circumstances of the case	Medical	[b]	Regulations governing female sterilization only	No spousal consent required	Obstetrics and gynaecology departments of state health institutions Physician must consult with senior specialist in obstetrics and gynaecology before advising a woman to be sterilized	Sterilization is not encouraged because of its irreversibility

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Eastern Europe *(continued)*								
Hungary	1961	No specific provision, whether a sterilization on a consenting patient were considered an offence to the law dealing with intentional infliction of a corporal injury would depend upon the existence and degree of the "social danger" of the act in the circumstances of the individual case	Seemingly medical reasons only	b	b	b	b	—
Poland	1969	Legal under certain conditions	On request and justified by physician	b	b	Strong emphasis on fully informed and mature consent of the person concerned	Regular hospitals and clinics of the State Health Service	—
Romania	1968	No specific provision, but the law dealing with intentional infliction of a corporal injury possibly in force for sterilization performed on purely contraceptive grounds	b	b	b	b	b	—
Northern Europe								
Denmark	1973	Legal	On request	*25 years old and* domiciled in Denmark Under 25 years for eugenic reasons, if the parents, due to mental or physical defects, are unfit to give proper care to children If social conditions make it desirable to prevent the birth of children	*Broad possibilities* of vicarious sterilization of the husband or "de facto spouse"	No spousal consent required If persons incapable of giving informed consent, application has to be submitted by guardian specially designated for the purpose If a person is under 25 years, authorization of a special	State or communal hospitals or clinics attached to such institutions Approved private hospitals Vasectomies may be performed also by specially licensed physicians (since 1976)	—

						committee is required. Possibility to appeal from the committee's decision		
Finland	1970	Legal for some specific reasons after authorization of the State Medical Board	Eugenic Serious limitations of the capacity of the person concerned to care for a child Socio-economic Extremely small possibility of preventing pregnancy by other means	18 years old except for particular congenital reasons	Vicarious sterilization is strongly emphasized	No spousal consent required If the person requesting sterilization is married Spouse must be informed and couple must be advised "as to which of the two should preferably be sterilized—from the standpoint of the family and the society"	Approved hospitals by licensed physicians	—
Iceland	1975	Legal	On request	25 years old Under 25 years, for eugenic reasons, social conditions, physical or mental health of parents Report of two specialist physicians and approval of the chief medical officer are required for persons under 25 years	Vicarious sterilization drawn by regulations	No spousal consent required for sterilization of an incompetent person requested by legal guardian, has to be approved	Hospitals approved for that purpose by the Minister of Health	—
Ireland	1861	No specific legal provisions; law dealing with an intentional infliction of a corporal injury is in force but seemingly physicians are not prosecuted under this provision	[b]	[b]	[b]	Written consent of both spouses required in practice	[b]	Male sterilization is carried out in one family planning clinic and on a very limited scale in some hospitals. Female sterilization is virtually unobtainable unless on medical grounds, when it is performed in a few hospitals

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Northern Europe *(continued)*								
Norway	1977	Legal	On request	25 years old and domiciled in the country Under 25 years, therapeutic reasons, eugenic reasons, mental health of parents, social conditions Under 18 years not allowed unless particularly imperative reasons Authorization from a sterilization board required for persons under 25 years; possibility to appeal to a Sterilization Council	No provisions for vicarious sterilization of the spouse if he or she is younger than 25 years	For persons under 20 years, or suffering from mental illness, guardian's consent is required	Public hospitals or approved private hospitals Sterilization of men may also be performed in other establishments, if approved for the purpose	—
Sweden	1975	Legal	On request	25 years old and Swedish national or domiciled in Sweden Under this age, authorization of the National Board of Health and Welfare is required under the following dispositions: Genetic reasons; Health indications (for women) in conjunction with an application for sex determination Minimum age: 18 years	No sex differentiation	Applicant must be accurately informed of the nature and consequences of the operation and maintains his or her request to be sterilized No spousal consent required	For women, only in hospitals or approved institutions	—
United Kingdom	1972	Voluntary sterilization is a lawful medical act Vasectomy legal	Family planning reason	No statutory requirement of a minimum age Seemingly, steriliza-	Only male sterilization regulated by law	Spousal consent not required by law but in practice	Any available facilities Free of charge if carried out under	Widely practised and considered a valuable form of contraception

		(England and Wales)		tion of a minor if performed for non-therapeutic reasons would be a violation of a basic human right			the National Health Service	
	1960s	Female sterilization not regulated by statute but considered legal						
Southern Europe								
Albania	1977	No specific provisions, but to cause intentionally loss of the function of an organ constitutes the crime of grave corporal injury, if "socially dangerous" in the circumstances	b	b	b	b	Institutions of State Health Care	—
Greece	1950	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization	Therapeutic	b	b	b	b	—
Holy See	...	...	...	...	...	...	...	—
Italy	1978	Legal	Matter to be decided between patient and physician	b	b	b	b	Until recently, sterilization was reported to be of little importance and as having been used as means of birth control
Malta	1854	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and seemingly applicable to sterilization	b	b	b	b	b	—
Portugal	1886	Law dealing with intentional infliction of a corporal injury is in force and applicable to sterilization	Therapeutic	b	b	b	b	Currently, no information about the interpretation of the law following recent political change in the country
San Marino	...	...	...	...	...	...	...	—

(England and Wales)	1960s	Female sterilization not regulated by statute but considered legal		tion of a minor if performed for non-therapeutic reasons would be a violation of a basic human right		the National Health Service	
Southern Europe							
Albania	1977	No specific provisions, but to cause intentionally loss of the function of an organ constitutes the crime of grave corporal injury, if "socially dangerous" in the circumstances	b	b	b	Institutions of State Health Care	—
Greece	1950	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and applicable to voluntary sterilization	Therapeutic	b	b	b	b	—
Holy See	...	...	...	...	...	...	...	—
Italy	1978	Legal	Matter to be decided between patient and physician	b	b	b	b	Until recently, sterilization was reported to be of little importance and as having been used as means of birth control
Malta	1854	No specific provision, but law dealing with intentional infliction of a corporal injury is in force and seemingly applicable to sterilization	b	b	b	b	b	—
Portugal	1886	Law dealing with intentional infliction of a corporal injury is in force and applicable to sterilization	Therapeutic	b	b	b	b	Currently, no information about the interpretation of the law following recent political change in the country
San Marino	...	...	...	...	...	...	...	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Southern Europe *(continued)*								
Spain	1963	Illegal, "anyone who castrates or sterilizes another should be punished by imprisonment"	b	b	b	b	b	—
Yugoslavia	1977 1978	Legal in Slovenia Legal in Croatia	On request	35 years old Under 35 years, for therapeutic reasons, genetic reasons Upon decision of a Commission Under the Croatian law, minors presumably cannot be sterilized	b	Only at the request of the person concerned For legally incompetent person, at the request of parents or guardian, upon decision of a Commission	Eligible hospitals or in specially authorized medical establishments In Croatia, female sterilization must be performed in hospitals that have a gynaecology and obstetrics department	—
Western Europe								
Austria	1974	Legal under certain conditions	On request	25 years old Under this age if "the sterilization is not contrary to good morals or other reasons" Seemingly not permitted under 18 years	No sex differentiation	Spousal consent not required	Performed as any other surgery by a physician on a consenting person	Denominational hospitals refuse to perform sterilization for non-medical reasons
Belgium	1867	No specific provisions. Law dealing with intentional infliction of a corporal injury was in force but, due to the reversal of views on family planning and after the decision of the Committee of Ministers of the Council of Europe on Legislation affecting fertility and family planning	On request	Mature consenting person	No sex differentiation	Spousal consent required in practice	General surgery facilities	Practised occasionally Official negative view on voluntary sterilization prevails

		(1975), voluntary sterilization can hardly be considered to be against "public order" or public policy						
France	...	No specific provisions. Law dealing with an intentional infliction of a corporal injury was in force but, due to the reversal of views on family planning and after the decision of the Committee of Ministers of the Council of Europe on Legislation affecting fertility and family planning (1975), the doctrine criminalizing voluntary sterilization performed for family planning purposes may have lost its basis	In an absence of any legal regulation, voluntary sterilization would be a matter to be decided between patient and physician	[b]	No sex differentiation	[b]	[b]	Sterilizations appear to be widespread
Germany, Federal Republic of	...	No specific provisions. A governmental bill of 1972 introducing regulation of voluntary sterilization has not been voted on in the Parliament but several decisions of the Federal Supreme Court held that sterilization was not unlawful	Medical reasons Genetic reasons Serious social reasons equivalent to "on request"	Mature person at least 25 years old	No sex differentiation	Spousal consent not required	[b]	—
Liechtenstein	...	...	...	...	...	...	...	—
Luxembourg	1978	Seemingly legal since a comprehensive law on fertility-related issues provided that the regional	[b]	[b]	[b]	[b]	[b]	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Western Europe *(continued)*								
		Counselling Centres, to be established and subsidized by the Government, shall provide information on . . . "different methods of contraception and voluntary sterilization".						
Monaco	1967	No specific provision, but law dealing with an intentional infliction of a corporal injury is not interpreted as applicable to a sterilization operation on a patient's request	[b]	[b]	[b]	[b]	[b]	—
Netherlands	1866	No specific provision, but voluntary sterilization is considered lawful as part of medical practice	On request (social indications)	[b]	No sex differentiation	Spousal consent not required	Regular medical facilities under medical insurance schemes Free of charge to all persons with either compulsory or voluntary medical insurance	—
Switzerland	. . .	No specific provision. Seemingly, law dealing with an intentional infliction of a corporal injury is not applicable to voluntary sterilization	On request, but tendency in medical practice to require in individual cases that the person concerned have either two or three children In principle, sterilization of women over 30 with two healthy children is approved by the Medical	[b]	No sex differentiation	Spousal consent required	In cases with medical indication, charges are paid by the health insurance	

			Society without further evaluation of the patient					
Western South Asia *(part)*								
Cyprus	1959	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force	b	b	b	b	b	—
Israel	...	No specific provisions, but seemingly, law dealing with an intentional infliction of a corporal injury is in force	In general, sterilization is acceptable to medical profession only in cases of multiparae over the age of 30 and in cases where medically indicated	b	Few vasectomies Mainly female sterilizations by minilaparotomy	Written, informed consent from both spouses	Some hospitals	—
Turkey	1965–1967	Sterilization for family planning purposes is a crime	Therapeutic Hereditary diseases	b	b	b	b	—
Northern America								
Canada	1975	No specific provision, but voluntary sterilization is currently considered a lawful form of birth control: "Everyone is protected from criminal responsibility for performing a surgical operation for the benefit of the patient if it is reasonable to perform it having regard to all circumstances of the case"	On request (doctors should decide whether to perform a sterilization operation just as they would decide about any other request for surgical treatment)	b	No sex differentiation	No spousal consent required	b	As the practice of family planning, sterilization became relatively common
United States of America	...	Legal in all states	On request	18 or 21 years	No sex differentiation	Few states require spousal consent In exceptional cases where a minor would apply for sterilization, parental consent is usually necessary Consent of legal representative of	In some states, in hospital Public hospitals may not refuse to perform sterilizations for family planning reasons Private hospitals are entitled to such refusals	Widely practised as a method of family planning

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
						legally incompetent adult is also required		
Union of Soviet Socialist Republics								
Byelorussian SSR	...	...	...	...	...	...	...	—
Ukrainian SSR	...	...	...	...	...	...	...	—
USSR	...	No specific provision; law dealing with an intentional infliction of a corporal injury is in force. Whether this provision can be applied to a sterilization operation requested by a patient may be determined by the application of the socialist legal concept of "social dangerousness"	Therapeutic	[b]	[b]	[b]	[b]	Voluntary sterilization is not used as a method of family planning
			C. *Area of responsibility of the Economic Commission for Latin America*					
Caribbean								
Bahamas	...	...	...	...	...	...	...	—
Barbados	1868	No specific provision, but law dealing with an intentional infliction of a corporal injury is interpreted as not applicable to voluntary sterilization	On request	[b]	[b]	[b]	[b]	Voluntary sterilization services are widely available but not widely used
Cuba	1968–1979	Legal under certain conditions	On request but the woman must have several children	32 years	No sex differentiation; but although the female sterilization is regulated by the Ministry of Health, no regulations have been issued for male sterilization	Informed consent and legally competent patient	Hospitals of the National Health System	—
Dominica	...	...	...	...	...	...	...	—

Dominican Republic	...	No specific statutory provisions; law dealing with an intentional infliction of a corporal injury may not be interpreted as applicable to sterilization operations (regulations issued by the Ministry of Public Health authorizing contraceptive female sterilizations)	On request Therapeutic reasons Eugenic reasons	Women are to be 40 years of age; 40 years or over with at least one child; 35 years or over with three or more children; 30 years or over with five or more children; 25 years or over with six or more children	Only female sterilization regulated by the Ministry of Health	"Free and voluntary" consent required	Mainly public hospitals	—
Grenada	...	No specific provisions; law dealing with an intentional infliction of a corporal injury is not applicable to voluntary sterilization because done in good faith, for the purposes or in the course of medical or surgical treatment	b	b	b	Consent for surgical treatment may be given even against the will of the person concerned by the parents or guardian of a person younger than 18	b	—
Haiti	1835	No specific provision; but seemingly, law dealing with an intentional infliction of a corporal injury is in force	b	b	b	b	b	—
Jamaica	1953	No specific provisions; law dealing with an intentional infliction of a corporal injury is not applied to surgical practice, including sterilization	On request	Patients over 35 years old are preferred	Male sterilization is rare in practice	Spousal consent not required by law but encouraged in medical practice	Tubal ligations are performed free of charge in government hospitals	Seemingly widely practised
Saint Lucia	...	...	...	...	...	...	...	—
Saint Vincent and the Grenadines	...	...	...	...	...	...	...	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Caribbean *(continued)*								
Trinidad and Tobago	1950	No specific provisions; law dealing with an intentional infliction of a corporal injury may not be applicable to sterilization operations on request, since the country has a government family planning programme	On request	Age not considered important	Only sterilizations of women are reported	Spousal consent required in practice	[b]	—
Middle America								
Costa Rica	1970	No specific provisions; law dealing with an intentional infliction of a corporal injury is not interpreted to be applicable to voluntary contraceptive sterilization	[b]	[b]	[b]	[b]	Hospitals and private clinics	—
El Salvador	1974-1977	No specific provisions; law dealing with an intentional infliction of a corporal injury can hardly be applicable to sterilization of consenting patients, as in 1974 the Ministry of Health and Social Welfare issued regulations governing voluntary sterilizations	[b]	[b]	Vasectomy and female sterilization	[b]	[b]	Sterilization is practised with the support of the Ministry of Health and Social Welfare, which has requested equipment for clinics for vasectomy and for female sterilization
Guatemala	1936	No specific provisions; law dealing with an intentional infliction of a corporal injury cannot be applied to voluntary sterilization	[b]	[b]	No sex differentiation	Spousal consent required	State and private institutions Facilities operated under the Association for Family Welfare	The Government has authorized various methods of family planning; voluntary sterilization is one of them

Honduras	1964	Law dealing with an intentional infliction of a corporal injury is not applicable, since medical Fundamental Law provides that voluntary sterilization could be performed under certain conditions	On request	[b]	[b]	Written authority of the person concerned Decided by three competent physicians	[b]	—
Mexico	1931	No specific provisions; law dealing with an intentional infliction of a corporal injury is not interpreted to be applicable to voluntary surgical sterilization	On request	Age of majority	No sex differentiation	Spousal consent required medical practice	Hospitals, sanitoriums and clinics approved by the Ministry of Health and Welfare	The Ministry of Health and Welfare prohibits any type of publicity in support of voluntary sterilization outside the official family planning programmes
Nicaragua	1949	Seemingly, law dealing with an intentional infliction of a corporal injury is applicable to sterilization operations	[b]	[b]	[b]	[b]	[b]	—
Panama	1941	Legal under certain conditions	On request if she has at least five living children and difficult social and economic conditions Health reasons Eugenic reasons Sterilization has to be authorized by the Sterilization Board	In practice, 26 years	The law regulates female sterilization only Virtually no vasectomies	Spousal consent required in practice	Hospitals and clinics	—
Temperate South America								
Argentina	1921	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization	[b]	[b]	[b]	[b]	[b]	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Temperate South America *(continued)*								
Chile	1975	Sterilization is not to be considered a method of fertility regulation and on other than medical grounds might be considered a crime of corporal injury	Therapeutic reasons only	b	b	Written consent by the couple required	Hospitals	Physicians were prohibited from performing non-therapeutic sterilization by the Chilean Sanitary Code In 1974, the Ministry of Health authorized sterilization on socio-economic grounds In 1975, a resolution of the Minister of Health repealed "all earlier provisions on the subject"
Uruguay	. . .	No specific provision; law dealing with an intentional infliction of a corporal injury is in force but there is a provision on justification by the injured person's consent: "causing bodily injury with the consent of the injured person is not punishable. . ."	b	b	b	b	b	—
Tropical South America								
Bolivia	1972	Law dealing with an intentional infliction of a corporal injury is in force, but it is a less punishable offence to cause a corporal injury to another person with his or her consent	b	b	b	b	b	—

Brazil	1940–1969	Law dealing with an intentional infliction of a corporal injury is in force but seemingly not applicable to surgical operation, including tubal ligation	On request (in practice) The surgeon usually requests opinion of three other physicians	[b]	No sex differentiation but mostly female sterilization	Spousal consent required in medical practice	Few public hospitals in Rio de Janeiro perform sterilization free	Contraceptive voluntary sterilization is practised
Colombia	1936	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force, but Colombian legal practice does not apply that provision to voluntary sterilizations performed on request	On request	35 years and have more than two children, with at least one child of each sex	Vasectomy practised by the Family Planning Association (Profamilia)	Spousal consent required in medical practice	The private association Profamilia has urban clinics as well as mobile programmes, which are intended to reach out into the rural areas The Ministry of Health performs sterilization in its regional hospitals	Sterilization is widely practised
Ecuador	1938	Law dealing with an intentional infliction of a corporal injury is in force but this provision may not be interpreted as applicable to sterilization operation performed on consenting patients, as the Medical Ethics Code of Ecuador permits contraceptive sterilization in certain cases	On request Medical reasons Eugenic reasons	25 years (women) and must have at least three living children	No sex differentiation	[b]	[b]	—
Guyana	1949	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force but cannot be applied to sterilization operation on consenting patients, as such acts constitute criminal offences only if committed "unlawfully and maliciously"	[b]	[b]	[b]	[b]	[b]	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Temperate South America *(continued)*								
Paraguay	1909	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization	b	b	b	b	b	—
Peru	1924	No specific provisions; law dealing with an intentional infliction of a corporal injury is in force; but voluntary sterilizations performed by specialist and done with full consent of the patient are not prosecuted	b	b	b	Spousal consent required in practice	Private clinics and hospitals To be performed by surgeons and urology specialists	—
Suriname	...	...	...	...	...	...	...	—
Venezuela	1971	The Code of Medical Ethics provides that sterilization operations may be performed only for medical or eugenic reasons	Medical reasons Eugenic reasons	b	b	b	b	—
			D. *Area of responsibility of the Economic Commission for Western Asia*					
Western South Asia[c]								
Bahrain	1955	Law dealing with an intentional infliction of a corporal injury is in force and applicable to contraceptive sterilization	b	b	b	b	b	—
Democratic Yemen	1969	No legal information, but Islamic religious law is opposed to sterilization unless per-	b	b	b	b	b	—

		formed for health and eugenic reasons						
Iraq	1969	No legal information, but Islamic religious law is opposed to sterilization unless performed for health and eugenic reasons	[b]	[b]	[b]	[b]	[b]	—
Jordan	1963	No specific provisions. As the Criminal Code does not include any prohibition covering voluntary sterilization, the operation may be performed lawfully, but the Islamic religion of the community is opposed to sterilization unless performed for eugenic or health purposes	Medical reasons Eugenic reasons	Usually 30 years	Female sterilization only	Spousal consent required in medical practice	Performed by specialized physicians in government or private hospitals	—
Kuwait	1960	No legal information, but Islamic religious law is opposed to sterilization unless performed for health and eugenic reasons	Medical reasons Eugenic reasons	[b]	Female sterilization only	Consent of both spouses required	[b]	—
Lebanon	1963	Law dealing with an intentional infliction of a corporal injury is in force; but in practice, contraceptive sterilizations are performed	On request	Minimum age for women, 30 years, and must have at least three children	Both male and female sterilizations performed	Spousal consent required in medical practice	[b]	Promoted by the Family Planning Association
Oman	1966	Since 1966, the main source of law had been Islamic religious law, which is opposed to voluntary sterilization	[b]	[b]	[b]	[b]	[b]	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Western South Asia *(continued)*								
Qatar	1971	No information on the legal status of voluntary sterilization, but presumably law dealing with an intentional infliction of a corporal injury is in force and applicable to contraceptive sterilization	b	b	b	b	b	—
Saudi Arabia	...	No specific provisions and no criminal code. The basic legal source is the Islamic religious law, which is opposed to voluntary sterilization	Medical reasons Eugenic reasons	b	b	b	b	—
Syrian Arab Republic	1949	Law dealing with an intentional infliction of a corporal injury is in force and seemingly applicable to voluntary sterilization. Islamic law deals with matters of personal status	b	b	b	b	b	—
United Arab Emirates	...	...	...	...	...	...	...	...
Yemen	...	The main source of law is Islamic religious law. Thus, voluntary sterilization is illegal	b	b	b	b	b	—
E. *Area of responsibility of the Economic and Social Commission for Asia and the Pacific*								
China								
China	...	Legal without medical indications and promoted as an extensively	On request	b	Tubal ligations more frequent than vasectomies	No spousal consent	Publicly funded health services for state employees	Very widely practised as method of family planning

		used method of birth control					Co-operative services for the rest of the population Free as part of planned birth service	
Japan								
Japan	1948	Legal for genetic reasons Life of mother (endangered by pregnancy or delivery) Mother has several children and her health seems to be seriously affected by the delivery	Genetic Life of woman Health of woman	Minor can be sterilized for genetic reasons	Tubal ligations more frequent than vasectomies	Spousal or partner's consent is requested	To be performed by surgeon in hospitals and clinics	Widely practised mainly for protection of the mother's life and health
Other East Asia								
Democratic People's Republic of Korea	1950	Possibly applicable to the law dealing with an intentional infliction of corporal injury	b	b	b	b	b	—
Mongolia	1960	No specific provision; applicable to the law dealing with intentional infliction of a corporal injury	b	b	b	b	b	Sterilization for family planning purposes does not seem to be practised
Republic of Korea	1973	No specific provision, but law dealing with intentional infliction of a corporal injury cannot be applied	On request as a method of family planning	b	Both tubal ligations and vasectomies	Spousal consent not required by law but in practice	Public health centres Private clinics Financial assistance for those adopting sterilization as a fertility control measure	Officially encouraged and widely practised
Eastern South Asia								
Burma	1963	Voluntary sterilization, even therapeutic, is a crime, if it is performed without authorization of a board. The person who consented to his/her sterilization commits an offence as well	b	b	b	b	b	—
Democratic Kampuchea	...	...	...	...	...	...	...	—

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Other East Asia *(continued)*								
Indonesia	1946–1978	Neither specific provision nor clarified interpretation of the criminal code, family law or guide-lines of state policy. Indonesia has had an Association for Voluntary Sterilization since 1974	Usually on medical grounds	[b]	Both tubal ligations and vasectomies	Written spousal consent	Hospitals and clinics	—
Lao People's Democratic Republic	1922–1965	Law of 1922, extensively amended in 1965, is in force but no information	...	...	...	...	...	To a certain extent, supported by Government at an earlier time, but Government minimized its support
Malaysia	1948	No specific provision, but law dealing with intentional infliction of a corporal injury is in force except if done in good faith	Medical socio-economic family planning	[b]	Tubal ligations more frequent than vasectomies	Spousal consent required in medical practice	Physicians working in the state health care service In private office Those working for the National Family Planning Board	Practised as a method of family planning
Philippines	1976	Legal by presidential decree	On request	[b]	[b]	Spousal consent required	Public and private hospitals and clinics Medical fees regulated	—
Singapore	1974	Legal	[b]	[b]	[b]	Spousal consent not required Consent of the person concerned and of a parent or guardian for those under 21 and unmarried	Registered practitioner Government hospital or approved institution	Intensively promoted by the Government, including a system of incentives/disincentives
Thailand	1962	Administrative regulations of the Ministry of Public	Economic and living conditions (to be determined by	[b]	Both male and female sterilization	Spousal consent required	Government hospitals and health centres	As a method of fertility control, widespread in the

		Health regulate voluntary sterilization incorporated in the national family planning programme	the director of the hospitals) Eugenic Family limitation motives					country. In practice, it is required that the couple have two or more living children and that if they have only two, the younger should be at least one year old
Viet Nam	...	No legal information	...	...	...	...	...	It is reported that in 1977 a comprehensive programme was initiated, including both male and female sterilization, generally for maternal and child care reasons
Middle South Asia								
Afghanistan	1976	No specific provision; applicable to law dealing with intentional infliction of a corporal injury	[b]	[b]	[b]	[b]	[b]	—
Bangladesh	1976	Legal since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to voluntary sterilization	On request, but couples are advised to have at least two children	[b]	Vasectomies more frequent than tubal ligations	No information	Clinics set up by the Government or hospitals for female sterilization Mobile clinics	Strongly promoted by the State and widely practised
Bhutan	...	...	...	...	...	...	...	—
India	1860	Legal, criminal code provides penalties for intentionally causing "hurt" but nothing if it is caused to any person for which benefit it is done in good faith	On request	Male: no less than 25 years Female: no less than 20 years. No more than 45 years	Both vasectomies and tubal ligations are performed	Voluntary informed consent is a prerequisite	Government institutions Institutions of local hospitals Voluntary organizations recognized for the purpose of family planning	Strongest governmental support since voluntary sterilization is recognized as one of the most important methods of slowing population growth and improving the socio-economic situation of many families

TABLE 44 *(continued)*

Geographical region and country	*Date of law*[a]	*Legality*	*Grounds*	*Age*	*Type of sterilization*	*Consent*	*Facilities/incentives*	*Remarks*
Middle South Asia *(continued)*								
Iran	1976	Legal under certain conditions[d]	On request but unmarried persons have to be over 30 years Married people: either has two or more children or both partners are over 25 years	[b]	[b]	Spousal consent required	Fully equipped hospitals and clinics	The number of sterilizations is small Situation in force before Iran became an Islamic Republic in 1979
Maldives	...	...	...	...	...	...	...	—
Pakistan	1860	Legal, since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to sterilization for family planning purposes	On request, but woman must have at least three children, one of whom must be a boy	[b]	[b]	Spousal consent required for female sterilization	Post-partum clinics	For many years promoted by Government
Nepal	1963	No specific provision, but there is no law prohibiting voluntary sterilization or laying down any conditions for it. Sterilization is an integral part of the national family planning programme	On request	[b]	[b]	[b]	[b]	—
Sri Lanka	1883	No specific provision, but legal since law dealing with intentional infliction of a corporal injury is interpreted so as not to be applicable to voluntary sterilization on request of a patient	Family planning motive of a consenting patient	[b]	[b]	[b]	Hospitals and clinics Cost covered by the Government's family planning programme	Widely practised Incentive schemes to encourage it in some areas of the country
Australia-New Zealand								
Australia	...	Legal, but no specific statutory provision. The current uncertain	No specific ground	[b]	Both vasectomies and tubal ligations are performed	Spousal consent usually requested by physician	Clinics and hospitals	—

		legal situation may inhibit some physicians from proceeding						
New Zealand	1977	Legal	On request	Only adults	Both vasectomies and tubal ligations are performed	No other person can consent to a sterilization on behalf of a minor Unlawful to condition, a loan, or employment, fringe benefits or a disposition of a property on a person's sterility	In-patients and out-patients facilities in appropriate institutions	Widely practised
Melanesia								
Papua New Guinea	1899	No specific provision but anyone performing sterilization at a patient's request is exempted from criminal responsibility	[b]	[b]	[b]	[b]	[b]	No specific information about sterilization but a nation-wide expansion of the family programme was approved by the Government
Solomon Islands	...	...	...	...	...	...	...	—
Micronesia-Polynesia								
Fiji	1945	No specific provision, but law dealing with intentional infliction of a corporal injury is not construed so as to prohibit voluntary sterilization	On request	Probably restricted to married people	Both tubal ligations and vasectomies are performed	Both spouses, written consent required before a medical officer	Family planning clinics and other medical facilities	—
Kiribati	...	...	...	...	...	...	...	—
Nauru	...	...	...	...	...	...	...	—
Samoa	...	...	...	...	...	...	...	—
Tonga	...	...	...	...	...	...	...	—
Tuvalu	...	...	...	...	...	...	...	—

Sources: Compiled from replies to United Nations Population Policy Inquiries; Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat; United Nations Fund for Population Activities, *Survey of Laws on Fertility Control* (New York, 1979); and Jean-Paul Sardon, "La stérilisation dans le monde. II. Données statistiques", *Population* (Paris), vol. 34, No. 3 (May-June 1979), pp. 607-636.

[a] Or of an amendment to the law.
[b] The law or amendment currently in force does not refer to this aspect.
[c] Excluding Cyprus, Israel and Turkey.
[d] The laws legalizing voluntary sterilization on both medical and social grounds have now been repealed.

TABLE 45. GOVERNMENTS' PERCEPTIONS OF THE ACCEPTABILITY OF CURRENT INTERNATIONAL IMMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Immigration significant			*Immigration not significant*		
Too low (1)	*Satisfactory (2)*	*Too high (3)*	*Immigration desired (4)*	*Situation satisfactory (5)*	*Total*
		A. *Area of responsibility of Economic Commission for Africa*			
		Eastern Africa			
—	Uganda Zimbabwe	Djibouti Somalia	—	Burundi Comoros Ethiopia Kenya Madagascar Malawi Mauritius Mozambique Rwanda Seychelles United Republic of Tanzania Zambia	16
		Middle Africa			
Equatorial Guinea	Zaire	Gabon	—	Angola Central African Republic Chad Congo Sao Tome and Principe United Republic of Cameroon	9
		Northern Africa			
—	Libyan Arab Jamahiriya	Sudan	—	Algeria Egypt Morocco Tunisia	6
		Southern Africa			
South Africa	—	—	—	Botswana Lesotho Swaziland	4
		Western Africa			
—	Liberia	Ghana Ivory Coast	—	Benin Cape Verde Gambia Guinea Guinea-Bissau Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo Upper Volta	16
TOTAL 2	5	6	—	38	51
		B. *Area of responsibility of Economic Commission for Europe*			
		Eastern Europe			
—	—	—	—	Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania	6

TABLE 45 (*continued*)

Immigration significant			*Immigration not significant*		
Too low (1)	*Satisfactory* (2)	*Too high* (3)	*Immigration desired* (4)	*Situation satisfactory* (5)	*Total*
		B. *Area of responsibility of Economic Commission for Europe* (continued)			
		Northern Europe			
—	Norway Sweden	United Kingdom		Denmark Finland Iceland Ireland	7
		Southern Europe			
—	—	San Marino	—	Albania Greece Holy See Italy Malta Portugal Spain Yugoslavia	9
		Western Europe			
—	Austria Germany, Federal Republic of Liechtenstein Luxembourg Monaco Switzerland	France Netherlands	—	Belgium	9
		Western South Asia (part)			
Israel	—	—	—	Cyprus Turkey	3
		Northern America			
—	Canada	United States of America	—	—	2
		Union of Soviet Socialist Republics			
—	—	—	—	Byelorussian SSR Ukrainian SSR USSR	3
TOTAL 1	9	5	—	24	39
		C. *Area of responsibility of Economic Commission for Latin America*			
		Caribbean			
—	—	Bahamas	—	Barbados Cuba Dominica Dominican Republic Grenada Haiti Jamaica Saint Lucia Saint Vincent and the Grenadines Trinidad and Tobago	11
		Middle America			
—	—	Costa Rica	—	El Salvador Guatemala Honduras Mexico Nicaragua Panama	7
		Temperate South America			
Argentina	—	—	—	Chile Uruguay	3

TABLE 45 *(continued)*

Immigration significant			Immigration not significant		
Too low (1)	*Satisfactory (2)*	*Too high (3)*	*Immigration desired (4)*	*Situation satisfactory (5)*	*Total*
		C. *Area of responsibility of Economic Commissions for Latin America* (continued)			
		Tropical South America			
—	—	Venezuela	Bolivia Ecuador Guyana	Brazil Colombia Paraguay Peru Suriname	9
TOTAL 1	—	3	3	23	30
		D. *Area of responsibility of Economic Commission for Western Asia*			
		Western South Asia[a]			
Saudi Arabia	Bahrain Lebanon Oman Qatar	Kuwait United Arab Emirates	Iraq	Democratic Yemen Jordan Syrian Arab Republic Yemen	12
TOTAL 1	4	2	1	4	12
		E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*			
		China			
—	—	—	—	China	1
		Japan			
		—	—	Japan	1
		Other East Asia			
				Democratic People's Republic of Korea Mongolia Republic of Korea	3
		Eastern South Asia			
—	—	Malaysia Thailand	—	Burma Democratic Kampuchea Indonesia Lao People's Democratic Republic Philippines Singapore Viet Nam	9
		Middle South Asia			
—	Bhutan	Nepal Pakistan	—	Afghanistan Bangladesh India Iran Maldives Sri Lanka	9
		Australia-New Zealand			
Australia	—		—	New Zealand	2
		Melanesia			
—	—	—	—	Papua New Guinea Solomon Islands	2
		Micronesia-Polynesia			
—	Nauru	Samoa	—	Fiji Kiribati Tonga Tuvalu	6
TOTAL 1	2	5	—	25	33
		Developed countries			
1	9	5	—	24	39
		Developing countries			
5	11	16	4	90	126
TOTAL 6	20	21	4	114	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 46. GOVERNMENTS' POLICIES WITH RESPECT TO INTERNATIONAL IMMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Government policies in favour of:				
Higher rate	*Maintaining current rate but subject to strict control*	*Curbing immigration in future but maintaining already established immigrant population*	*Immigration perceived to be not demographically significant and desirable or not desirable*	*Total*
	A. *Area of responsibility of Economic Commission for Africa*			
		Eastern Africa		
—	Djibouti Uganda Zimbabwe	Somalia	Burundi Comoros Ethiopia Kenya Madagascar Malawi Mauritius Mozambique Rwanda Seychelles United Republic of Tanzania Zambia	16
		Middle Africa		
Equatorial Guinea	Zaire	Gabon	Angola Central African Republic Chad Congo Sao Tome and Principe United Republic of Cameroon	9
		Northern Africa		
—	Libyan Arab Jamahiriya	Sudan	Algeria Egypt Morocco Tunisia	6
		Southern Africa		
South Africa			Botswana Lesotho Swaziland	4
		Western Africa		
—	Liberia	Ghana Ivory Coast	Benin Cape Verde Gambia Guinea Guinea-Bissau Mali Mauritania Niger Nigeria Senegal Sierra Leone Togo Upper Volta	16
TOTAL 2	6	5	38	51
	B. *Area of responsibility of Economic Commission for Europe*			
		Eastern Europe		
—	—	—	Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania	6
		Northern Europe		
—	—	Norway Sweden United Kingdom	Denmark Finland Iceland Ireland	7
		Southern Europe		
—	—	San Marino	Albania Greece Holy See Italy Malta Portugal Spain Yugoslavia	9

TABLE 46 *(continued)*

	Government policies in favour of:				
	Higher rate	*Maintaining current rate but subject to strict control*	*Curbing immigration in future but maintaining already established immigrant population*	*Immigration perceived to be not demographically significant and desirable or not desirable*	*Total*
B. *Area of responsibility of Economic Commission for Europe* (continued)					
			Western Europe		
	—	—	Austria France Germany, Federal Republic of Liechtenstein Luxembourg Monaco Netherlands Switzerland	Belgium	9
			Western South Asia (part)		
	Israel	—	—	Cyprus Turkey	3
			Northern America		
	—	Canada United States of America	—	—	2
			Union of Soviet Socialist Republics		
	—	—	—	Byelorussian SSR Ukrainian SSR USSR	3
TOTAL	1	2	12	24	39
C. *Area of responsibility of Economic Commission for Latin America*					
			Caribbean		
	—	Bahamas	—	Barbados Cuba Dominica Dominican Republic Grenada Haiti Jamaica Saint Lucia Saint Vincent and the Grenadines Trinidad and Tobago	11
			Middle America		
	—	Costa Rica	—	El Salvador Guatemala Honduras Mexico Nicaragua Panama	7
			Temperate South America		
	Argentina	—	—	Chile Uruguay	3
			Tropical South America		
	Bolivia Ecuador Guyana	—	Venezuela	Brazil Colombia Paraguay Peru Suriname	9
TOTAL	4	2	1	23	30
D. *Area of responsibility of Economic Commission for Western Asia*					
			Western South Asia[a]		
	Saudi Arabia	Bahrain Lebanon Oman Qatar	Kuwait United Arab Emirates	Democratic Yemen Iraq Jordan Syrian Arab Republic Yemen	12
TOTAL	1	4	2	5	12

TABLE 46 *(continued)*

Government policies in favour of:					
Higher rate	*Maintaining current rate but subject to strict control*	*Curbing immigration in future but maintaining already established immigrant population*	*Immigration perceived to be not demographically significant and desirable or not desirable*		*Total*
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*					
		China			
—	—	—	China		
		Japan			
—	—	—	Japan		1
		Other East Asia			
—	—	—	Democratic People's Republic of Korea Mongolia Republic of Korea		3
		Eastern South Asia			
—	—	Malaysia Thailand	Burma Democratic Kampuchea Indonesia Lao People's Democratic Republic Philippines Singapore Viet Nam		9
		Middle South Asia			
—	Bhutan	Nepal Pakistan Iran	Afghanistan Bangladesh India Maldives Sri Lanka		9
		Australia-New Zealand			
Australia	—	—	New Zealand		2
		Melanesia			
—	—	—	Papua New Guinea Solomon Islands		2
		Micronesia-Polynesia			
—	Nauru Samoa	—	Fiji Kiribati Tonga Tuvalu		6
TOTAL 1	3	5	24		33
		Developed countries			
1	2	12	24		39
		Developing countries			
8	15	13	90		126
TOTAL 9	17	25	114		165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secetariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 47. GOVERNMENTS' PERCEPTIONS OF THE ACCEPTABILITY OF CURRENT INTERNATIONAL EMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Emigration significant			*Emigration not significant*		
Too low (1)	*Satisfactory* (2)	*Too high* (3)	*Emigration desired* (4)	*Situation satisfactory* (5)	*Total*
		A. *Area of responsibility of Economic Commission for Africa*			
		Eastern Africa			
—	Comoros Malawi Mauritius Mozambique	Seychelles Somalia	Rwanda	Burundi Djibouti Ethiopia Kenya Madagascar Uganda United Republic of Tanzania Zambia Zimbabwe	16
		Middle Africa			
—	Angola Chad	—	—	Central African Republic Congo Equatorial Guinea Gabon Sao Tome and Principe United Republic of Cameroon Zaire	9
		Northern Africa			
Algeria	Egypt Morocco Tunisia	—	—	Libyan Arab Jamahiriya Sudan	6
		Southern Africa			
—	Lesotho Swaziland	Botswana	—	South Africa	4
		Western Africa			
—	Cape Verde Mali Mauritania Senegal	Guinea Upper Volta	—	Benin Gambia Ghana Guinea-Bissau Ivory Coast Liberia Niger Nigeria Sierra Leone Togo	16
TOTAL 1	15	5	1	29	51
		B. *Area of responsibility of Economic Commission for Europe*			
		Eastern Europe			
—	—	—	—	Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania	6
		Northern Europe			
—	—	Finland Ireland	—	Denmark Iceland Norway Sweden United Kingdom	7
		Southern Europe			
Portugal	Malta	Greece Italy Spain Yugoslavia	—	Albania Holy See San Marino	9

TABLE 47 *(continued)*

Emigration significant			*Emigration not significant*		
Too low (1)	*Satisfactory (2)*	*Too high (3)*	*Emigration desired (4)*	*Situation satisfactory (5)*	*Total*
		B. *Area of responsibility of Economic Commission for Europe* (continued)			
		Western Europe			
Netherlands	—	—	—	Austria Belgium France Germany, Federal Republic of Liechtenstein Luxembourg Monaco Switzerland	9
		Western South Asia (part)			
Turkey	—	Cyprus	—	Israel	3
		Northern America			
—	—	—	—	Canada United States of America	2
		Union of Soviet Socialist Republics			
—	—	—	—	Byelorussian SSR Ukrainian SSR USSR	3
TOTAL 3	1	7	—	28	39
		C. *Area of responsibility of Economic Commission for Latin America*			
		Caribbean			
—	Barbados Cuba Dominican Republic Grenada Haiti	Jamaica Trinidad and Tobago	—	Bahamas Dominica Saint Lucia Saint Vincent and the Grenadines	11
		Middle America			
—	El Salvador Nicaragua	Honduras Mexico	—	Costa Rica Guatemala Panama	7
		Temperate South America			
		Uruguay		Argentina Chile	3
		Tropical South America			
—	—	Bolivia Colombia Paraguay Suriname	—	Brazil Ecuador Guyana Peru Venezuela	9
TOTAL —	7	9	—	14	30
		D. *Area of responsibility of Economic Commission for Western Asia*			
		Western South Asia[a]			
—	Democratic Yemen Yemen	Jordan	Syrian Arab Republic	Bahrain Iraq Kuwait Lebanon Oman Qatar Saudi Arabia United Arab Emirates	12
TOTAL —	2	1	1	8	12
		E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*			
		China			
—	—	—	—	China	1
		Japan			
—	—	—	—	Japan	1
		Other East Asia			
Republic of Korea	—	—	—	Democratic People's Republic of Korea Mongolia	3

TABLE 47 *(continued)*

Emigration significant			*Emigration not significant*		
Too low (1)	*Satisfactory* (2)	*Too high* (3)	*Emigration desired* (4)	*Situation satisfactory* (5)	*Total*
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)					
		Eastern South Asia			
—	Democratic Kampuchea Viet Nam	—	Malaysia	Burma Indonesia Lao People's Democratic Republic Philippines Singapore Thailand	9
		Middle South Asia			
Pakistan	Nepal Sri Lanka	Afghanistan	—	Bangladesh Bhutan India Iran Maldives	9
		Australia-New Zealand			
		New Zealand		Australia	2
		Melanesia			
—	—	—	—	Papua New Guinea Solomon Islands	2
		Micronesia-Polynesia			
—	Tonga	Fiji	—	Kiribati Nauru Samoa Tuvalu	6
TOTAL 2	5	3	1	22	33
		Developed countries			
2	1	7	—	29	39
		Developing countries			
4	29	18	3	72	126
TOTAL 6	30	25	3	101	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 48. GOVERNMENTS' POLICIES WITH RESPECT TO INTERNATIONAL EMIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Government policies in favour of:				
Higher rate	*Maintaining current rate*	*Curbing emigration in future*	*Emigration perceived to be not demographically significant and desirable or not desirable*	*Total*
	A. *Area of responsibility of Economic Commission for Africa*			
		Eastern Africa		
—	Comoros Malawi Mauritius Mozambique Seychelles	Somalia	Burundi Djibouti Ethiopia Kenya Madagascar Rwanda Uganda United Republic of Tanzania Zambia Zimbabwe	16
		Middle Africa		
—	Angola Chad	—	Central African Republic Congo Equatorial Guinea Gabon Sao Tome and Principe United Republic of Cameroon Zaire	9
		Northern Africa		
Algeria	Egypt Morocco Tunisia	—	Libyan Arab Jamahiriya Sudan	6
		Southern Africa		
—	Lesotho Swaziland	Botswana	South Africa	4
		Western Africa		
—	Mali Mauritania Senegal	Guinea Upper Volta	Benin Cape Verde Gambia Ghana Guinea-Bissau Ivory Coast Liberia Niger Nigeria Sierra Leone Togo	16
TOTAL 1	15	4	31	51
	B. *Area of responsibility of Economic Commission for Europe*			
		Eastern Europe		
—	—	—	Bulgaria Czechoslovakia German Democratic Republic Hungary Poland Romania	6
		Northern Europe		
		Finland Ireland	Denmark Iceland Norway Sweden United Kingdom	7
		Southern Europe		
Portugal	Malta	Greece Italy Spain Yugoslavia	Albania Holy See San Marino	9
		Western Europe		
Netherlands	—	—	Austria Belgium France Germany, Federal Republic of Liechtenstein Luxembourg Monaco Switzerland	9

TABLE 48 *(continued)*

Government policies in favour of:					
Higher rate	*Maintaining current rate*	*Curbing emigration in future*	*Emigration perceived to be not demographically significant and desirable or not desirable*		*Total*
		B. *Area of responsibility of Economic Commission for Europe* (continued)			
		Western South Asia (part)			
Turkey	—	Cyprus	Israel		3
		Northern America			
—	—	—	Canada United States of America		2
		Union of Soviet Socialist Republics			
—	—	—	Byelorussian SSR Ukrainian SSR USSR		3
TOTAL 3	1	7	28		39
		C. *Area of responsibility of Economic Commission for Latin America*			
		Caribbean			
—	Barbados Dominican Republic Grenada Haiti	Cuba Jamaica Trinidad and Tobago	Bahamas Dominica Saint Lucia Saint Vincent and the Grenadines		11
		Middle America			
—	El Salvador Nicaragua	Honduras Mexico	Costa Rica Guatemala Panama		7
		Temperate South America			
—	—	Uruguay	Argentina Chile		3
		Tropical South America			
—	—	Bolivia Colombia Paraguay Suriname	Brazil Ecuador Guyana Peru Venezuela		9
TOTAL —	6	10	14		30
		D. *Area of responsibility of Economic Commission for Western Asia*			
		Western South Asia[a]			
—	Democratic Yemen Yemen	Jordan	Bahrain Iraq Kuwait Lebanon Oman Qatar Saudi Arabia Syrian Arab Republic United Arab Emirates		12
TOTAL —	2	1	9		12
		E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*			
		China			
—	—	—	China		1
		Japan			
		—	Japan		1
		Other East Asia			
Republic of Korea			Democratic People's Republic of Korea Mongolia		3

TABLE 48 *(continued)*

Government policies in favour of:				
Higher rate	*Maintaining current rate*	*Curbing emigration in future*	*Emigration perceived to be not demographically significant and desirable or not desirable*	*Total*
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)				
		Eastern South Asia		
—	Viet Nam	Democratic Kampuchea	Burma Indonesia Lao People's Democratic Republic Malaysia Philippines Singapore Thailand	9
		Middle South Asia		
Pakistan	Nepal Sri Lanka	Afghanistan	Bangladesh Bhutan India Iran Maldives	9
		Australia-New Zealand		
—	—	New Zealand	Australia	2
		Melanesia		
—	—	—	Papua New Guinea Solomon Islands	2
		Micronesia-Polynesia		
—	Tonga	Fiji	Kiribati Nauru Samoa Tuvalu	6
TOTAL 2	4	4	23	33
		Developed countries		
2	1	7	29	39
		Developing countries		
4	27	19	76	126
TOTAL 6	28	26	105	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 49. GOVERNMENTS' POLICIES CONCERNING INTERNAL MIGRATION AND CONFIGURATION OF SETTLEMENT, ACCORDING TO PERCEPTION OF ACCEPTABILITY OF SPATIAL DISTRIBUTION OF POPULATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT, JULY 1980

Geographical region and country	Perception of over-all acceptability of spatial distribution			Policies concerning basic trends in internal migration				Policies concerning modification of rural and urban configuration of settlement				Total number of countries
	Appropriate	Partially appropriate	Inappropriate	Accelerate	No intervention	Decelerate	Reverse	No modification	Rural configuration	Urban configuration	Rural and urban configuration	
A. Area of responsibility of Economic Commission for Africa												
Eastern Africa												
Burundi	—	x	—	—	x	—	—	—	x	—	—	
Comoros	—	x	—	—	x	—	—	x	—	—	—	
Djibouti	—	x	—	—	—	—	x	—	x	—	—	
Ethiopia	—	—	x	—	—	x	—	—	x	—	—	
Kenya	—	—	x	—	—	x	—	—	—	—	x	
Madagascar	—	—	x	—	—	x	—	—	x	—	—	
Malawi	—	x	—	—	—	x	—	—	—	—	x	
Mauritius	—	—	x	—	—	x	—	—	—	—	x	
Mozambique	—	—	x	—	—	—	x	—	—	—	x	
Rwanda	—	—	x	—	x	—	—	—	x	—	—	
Seychelles	—	—	x	—	—	x	—	x	—	—	—	
Somalia	—	—	x	—	—	x	—	—	x	—	—	
Uganda	—	x	—	—	—	x	—	x	—	—	—	
United Republic of Tanzania	—	—	x	—	—	x	—	—	—	—	x	
Zambia	—	—	x	—	—	x	—	—	x	—	—	
Zimbabwe	—	x	—	—	—	x	—	—	x	—	—	
Middle Africa												
Angola	—	—	x	—	—	—	x	—	—	—	x	
Central African Empire	—	—	x	—	—	—	x	—	x	—	—	
Chad	—	x	—	—	x	—	—	x	—	—	—	
Congo	—	—	x	—	—	x	—	—	x	—	—	
Equatorial Guinea	—	—	x	—	—	—	x	—	x	—	—	
Gabon	—	—	x	—	—	x	—	—	—	—	x	
Sao Tome and Principe	—	—	x	—	—	x	—	—	—	—	x	
United Republic of Cameroon	—	—	x	—	—	x	—	—	x	—	—	
Zaire	—	—	x	—	—	x	—	—	—	—	x	
Northern Africa												
Algeria	—	—	x	—	—	x	—	—	—	—	x	
Egypt	—	—	x	—	—	x	—	—	—	—	x	
Libyan Arab Jamahiriya	—	x	—	—	—	x	—	—	—	—	x	
Morocco	—	—	x	—	—	x	—	x	—	—	—	
Sudan	—	—	x	—	—	x	—	—	x	—	—	
Tunisia	—	x	—	—	—	x	—	—	—	—	x	
Southern Africa												
Botswana	—	—	x	—	—	x	—	—	—	—	x	
Lesotho	—	x	—	—	x	—	—	x	—	—	—	
South Africa	—	x	—	—	—	—	x	—	—	—	x	
Swaziland	—	—	x	—	—	x	—	x	—	—	—	
Western Africa												
Cape Verde	—	—	x	—	x	—	—	x	—	—	—	
Benin	—	—	x	—	x	—	—	—	x	—	—	
Gambia	—	x	—	—	—	x	—	x	—	—	—	
Ghana	—	—	x	—	—	x	—	—	—	—	x	
Guinea	—	x	—	—	x	—	—	x	—	—	—	
Guinea-Bissau	—	—	x	—	—	—	x	—	—	—	x	
Ivory Coast	—	—	x	—	—	x	—	—	—	—	x	
Liberia	—	—	x	—	—	x	—	—	—	—	x	
Mali	—	—	x	—	—	x	—	x	—	—	—	
Mauritania	—	—	x	—	—	x	—	—	x	—	—	
Niger	—	—	x	—	x	—	—	x	—	—	—	
Nigeria	—	—	x	—	—	x	—	x	—	—	—	
Senegal	—	—	x	—	—	x	—	—	—	—	x	
Sierra Leone	—	x	—	—	x	—	—	x	—	—	—	
Togo	—	—	x	—	—	x	—	—	—	—	x	
Upper Volta	—	—	x	—	x	—	—	—	x	—	—	
TOTAL	—	14	37	—	11	33	7	14	16	—	21	
		51			51				51			51

TABLE 49 *(continued)*

Geographical region and country	Perception of over-all acceptability of spatial distribution: Appropriate	Partially appropriate	Inappropriate	Policies concerning basic trends in internal migration: Accelerate	No intervention	Decelerate	Reverse	Policies concerning modification of rural and urban configuration of settlement: No modification	Rural configuration	Urban configuration	Rural and urban configuration	Total number of countries
B. *Area of responsibility of Economic Commission for Europe*												
Eastern Europe												
Bulgaria	—	x	—	—	—	x	—	—	—	x	—	
Czechoslovakia	x	—	—	—	—	x	—	—	—	x	—	
German Democratic Republic	x	—	—	—	—	x	—	—	—	x	—	
Hungary	x	—		—	—	x	—	—	—	x	—	
Poland	—	x	—	—	—	x	—	—	—	x	—	
Romania	—	x	—	—	—	x	—	—	—	x	—	
Northern Europe												
Denmark	x	—	—	—	x	—	—	x	—	—	—	
Finland	—	x	—	—	—	x	—	—	—	x	—	
Iceland	—	x	—		—	—	x	x	—	—	—	
Ireland	—	x	—	—	—	x	—	—	—	x	—	
Norway	—	x	—	—	—	x	—	x	—	—	—	
Sweden	x	—	—	—	—	x	—	—	—	x	—	
United Kingdom	—	x	—	—	—	—	x	—	—	x	—	
Southern Europe												
Albania	—	x	—	—	—	x	—	—	—	—	x	
Greece	—	x	—	—	—	x	—	—	—	x	—	
Holy See	x	—	—	—	x	—	—	x	—	—	—	
Italy	—	x	—	—	—	x	—	x	—	—	—	
Malta	x	—	—	—	x	—	—	x	—	—	—	
Portugal	—	x	—	—	—	x	—	—	—	x	—	
San Marino	x	—	—	—	x	—	—	x	—	—	—	
Spain	—	x	—	—	—	x	—	—	—	x	—	
Yugoslavia	—	x	—	—	—	x	—	—	—	x	—	
Western Europe												
Austria	—	x	—	—	—	x	—	x	—	—	—	
Belgium	x	—	—	—	x	—	—	x	—	—	—	
France	—	—	x	—	—	—	x	—	—	x	—	
Germany, Federal Republic of	—	x	—	—	—	x	—	x	—	—	—	
Liechtenstein	x	—	—	—	x	—	—	x	—	—	—	
Luxembourg	x	—	—	—	x	—	—	x	—	—	—	
Monaco	x	—	—	—	x	—	—	x	—	—	—	
Netherlands	—	—	x	—	—	—	x	x	—	—	—	
Switzerland	—	x	—	—	—	—	x	x	—	—	—	
Western South Asia (part)												
Cyprus	—	x	—	x	—	—	—	—	—	—	x	
Israel	—	x	—	—	—	x	—	—	—	—	x	
Turkey	—	—	x	—	—	x	—	—	—	x	—	
Northern America												
Canada	—	x	—	—	x	—	—	x	—	—	—	
United States of America	x	—	—	—	x	—	—	x	—	—	—	
Union of Soviet Socialist Republics												
Byelorussian SSR	—	x	—	—	—	x	—	—	—	—	x	
Ukrainian SSR	—	x	—	—	—	x	—	—	—	—	x	
USSR	—	x	—	—	—	x	—	—	—	—	x	
TOTAL	13	23	3	1	10	23	5	17	—	16	6	
		39			39				39			39
C. *Area of responsibility of Economic Commission for Latin America*												
Caribbean												
Bahamas	—	x	—	—	—	x	—	—	—	x	—	
Barbados	x	—	—	—	x	—	—	x	—	—	—	
Cuba	—	x	—	—	—	x	—	—	—	—	x	
Dominica	—	x	—	—	x	—	—	x	—	—	—	
Dominican Republic	—	—	x	—	x	—	—	x	—	—	—	
Grenada	—	—	x	—	—	x	—	x	—	—	—	
Haiti	—	—	x	—	—	x	—	—	x	—	—	
Jamaica	—	—	x	—	—	x	—	—	x	—	—	
Saint Lucia	—	x	—	—	x	—	—	x	—	—	—	

TABLE 49 *(continued)*

Geographical region and country	Perception of over-all acceptability of spatial distribution: Appropriate	Partially appropriate	Inappropriate	Policies concerning basic trends in internal migration: Accelerate	No intervention	Decelerate	Reverse	Policies concerning modification of rural and urban configuration of settlement: No modification	Rural configuration	Urban configuration	Rural and urban configuration	Total number of countries
C. *Area of responsibility of Economic Commission for Latin America* (continued)												
Caribbean *(continued)*												
Saint Vincent and the Grenadines	—	x	—	—	x	—	—	x	—	—	—	
Trinidad and Tobago	—	—	x	—	—	x	—	—	—	—	x	
Middle America												
Costa Rica	—	—	x	—	—	x	—	—	—	—	x	
El Salvador	—	—	x	—	—	x	—	x	—	—	—	
Guatemala	—	—	x	—	—	x	—	—	x	—	—	
Honduras	—	—	x	—	x	—	—	x	—	—	—	
Mexico	—	—	x	—	—	x	—	—	—	—	x	
Nicaragua	—	x	—	—	—	x	—	x	—	—	—	
Panama	—	—	x	—	—	x	—	—	—	—	x	
Temperate South America												
Argentina	—	—	x	—	—	x	—	—	—	—	x	
Chile	—	—	x	—	—	x	—	—	—	x	—	
Uruguay	—	—	x	—	—	x	—	—	—	x	—	
Tropical South America												
Bolivia	—	—	x	—	—	x	—	—	—	—	x	
Brazil	—	x	—	x	—	—	—	—	—	—	x	
Colombia	—	—	x	—	—	x	—	—	—	—	x	
Ecuador	—	—	x	—	—	x	—	—	x	—	—	
Guyana	—	—	x	—	—	x	—	—	—	—	x	
Paraguay	—	—	x	—	—	x	—	—	x	—	—	
Peru	—	—	x	—	—	x	—	—	—	—	x	
Suriname	—	—	x	—	—	x	—	—	—	—	x	
Venezuela	—	—	x	—	—	x	—	—	—	—	x	
TOTAL	1	7	22	1	6	23	—	9	5	3	13	
		30			30				30			30
D. *Area of responsibility of Economic Commission for Western Asia*												
Western South Asia[a]												
Bahrain	x	—	—	—	x	—	—	x	—	—	—	
Democratic Yemen	—	x	—	—	—	x	—	—	—	—	x	
Iraq	—	x	—	—	—	x	—	—	—	—	x	
Jordan	—	—	x	—	—	—	x	—	—	—	x	
Kuwait	x	—	—	—	x	—	—	x	—	—	—	
Lebanon	—	x	—	—	—	x	—	x	—	—	—	
Oman	—	x	—	—	—	x	—	—	x	—	—	
Qatar	x	—	—	—	x	—	—	x	—	—	—	
Saudi Arabia	—	x	—	x	—	—	—	—	—	—	x	
Syrian Arab Republic	—	x	—	—	—	x	—	—	x	—	—	
United Arab Emirates	—	x	—	—	—	x	—	—	—	—	x	
Yemen	—	x	—	—	x	—	—	x	—	—	—	
TOTAL	3	8	1	1	4	6	1	5	2	—	5	
		12			12				12			12
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific*												
China	—	x	—	—	—	—	x	—	—	—	x	
Japan	—	—	x	—	—	x	—	—	—	—	x	
Other East Asia												
Democratic People's Republic of Korea	—	x	—	—	—	x	—	—	—	—	x	
Mongolia	—	x	—	—	—	x	—	—	—	—	x	
Republic of Korea	—	x	—	—	—	x	—	—	—	x	—	
Eastern South Asia												
Burma	—	x	—	—	—	x	—	—	x	—	—	
Democratic Kampuchea	—	—	x	—	—	—	x	—	—	—	x	
Indonesia	—	—	x	—	—	x	—	—	x	—	—	
Lao People's Democratic Republic	—	—	x	—	—	—	x	—	—	—	x	

TABLE 49 *(continued)*

Geographical region and country	*Perception of over-all acceptability of spatial distribution*			*Policies concerning basic trends in internal migration*				*Policies concerning modification of rural and urban configuration of settlement*				*Total number of countries*
	Appropriate	*Partially appropriate*	*Inappropriate*	*Accelerate*	*No intervention*	*Decelerate*	*Reverse*	*No modification*	*Rural configuration*	*Urban configuration*	*Rural and urban configuration*	
E. *Area of responsibility of Economic and Social Commission for Asia and the Pacific* (continued)												
Eastern South Asia *(continued)*												
Malaysia	—	x	—	—	x	—	—	—	—	—	x	
Philippines	—	—	x	—	—	—	x	—	x	—	—	
Singapore	x	—	—	—	x	—	—	x	—	—	—	
Thailand	—	—	x	—	—	x	—	—	x	—	—	
Viet Nam	—	—	x	—	—	—	x	—	—	—	x	
Middle South Asia												
Afghanistan	—	x	—	—	x	—	—	—	—	—	x	
Bangladesh	—	x	—	—	—	—	x	—	x	—	—	
Bhutan	—	x	—	x	—	—	—	—	—	—	x	
India	—	—	x	—	—	x	—	—	—	—	x	
Iran	—	—	x	—	—	x	—	—	—	—	x	
Maldives	—	x	—	—	—	x	—	x	—	—	—	
Pakistan	—	—	x	—	—	x	—	—	—	—	x	
Nepal	—	—	x	—	—	x	—	—	x	—	—	
Sri Lanka	—	—	x	—	—	x	—	—	x	—	—	
Australia-New Zealand												
Australia	—	—	x	—	—	—	x	—	—	x	—	
New Zealand	—	x	—	—	x	—	—	x	—	—	—	
Melanesia												
Papua New Guinea	—	—	x	—	x	—	—	x	—	—	—	
Solomon Islands	—	x	—	—	x	—	—	x	—	—	—	
Micronesia-Polynesia												
Fiji	—	—	x	—	—	x	—	—	—	—	x	
Kiribati	—	x	—	—	—	—	x	—	—	—	x	
Nauru	x	—	—	—	x	—	—	x	—	—	—	
Samoa	—	—	x	—	x	—	—	x	—	—	—	
Tonga	—	x	—	—	—	x	—	x	—	—	—	
Tuvalu	—	x	—	—	—	x	—	x	—	—	—	
TOTAL	2	15	16	1	8	16	8	9	7	2	15	
		33			33				33			33
Developed countries	13	22	4	1	11	21	6	18	—	16	5	39
Developing countries	6	45	75	3	28	80	15	36	30	5	55	126
TOTAL	19	67	79	4	39	101	21	54	30	21	60	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 50. GOVERNMENTS' PERCEPTIONS OF THE ACCEPTABILITY OF SPATIAL DISTRIBUTION OF POPULATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT; STATISTICAL INFORMATION, JULY 1980

Area of responsibility of regional commission, geographical region and level of development	*Perception of over-all acceptability of spatial distribution*			
	Appropriate	*Partially appropriate*	*Inappropriate*	*Total*
ECA area				
Eastern Africa	—	6	10	16
Middle Africa	—	1	8	9
Northern Africa	—	2	4	6
Southern Africa	—	2	2	4
Western Africa	—	3	13	16
TOTAL	—	14	37	51
ECE area				
Eastern Europe	3	3	—	6
Northern Europe	2	5	—	7
Southern Europe	3	6	—	9
Western Europe	4	3	2	9
Cyprus, Israel and Turkey	—	2	1	3
Northern America	1	1	—	2
USSR	—	3	—	3
TOTAL	13	23	3	39
ECLA area				
Caribbean	1	5	5	11
Middle America	—	1	6	7
Temperate South America	—	—	3	3
Tropical South America	—	1	8	9
TOTAL	1	7	22	30
ECWA area				
Western South Asia[a]	3	8	1	12
TOTAL	3	8	1	12
ESCAP area				
China	—	1	—	1
Japan	—	—	1	1
Other East Asia	—	3	—	3
Eastern South Asia	1	2	6	9
Middle South Asia	—	4	5	9
Australia-New Zealand	—	1	1	2
Melanesia	—	1	1	2
Micronesia-Polynesia	1	3	2	6
TOTAL	2	15	16	33
Developed countries	13	22	4	39
Developing countries	6	45	75	126
TOTAL	19	67	79	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 51. GOVERNMENTS' POLICIES CONCERNING BASIC TRENDS IN INTERNAL MIGRATION, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT; STATISTICAL INFORMATION, JULY 1980

Area of responsibility of regional commission, geographical region and level of development	*Policies concerning trends in internal migration*				
	Accelerate	*No intervention*	*Decelerate*	*Reverse*	*Total*
ECA area					
Eastern Africa	—	3	11	2	16
Middle Africa	—	1	5	3	9
Northern Africa	—	—	6	—	6
Southern Africa	—	1	2	1	4
Western Africa	—	6	9	1	16
TOTAL	—	11	33	7	51
ECE area					
Eastern Europe	—	—	6	—	6
Northern Europe	—	1	4	2	7
Southern Europe	—	3	6	—	9
Western Europe	—	4	2	3	9
Cyprus, Israel and Turkey	1	—	2	—	3
Northern America	—	2	—	—	2
USSR	—	—	3	—	3
TOTAL	1	10	23	5	39
ECLA area					
Caribbean	—	5	6	—	11
Middle America	—	1	6	—	7
Temperate South America	—	—	3	—	3
Tropical South America	1	—	8	—	9
TOTAL	1	6	23	—	30
ECWA area					
Western South Asia[a]	1	4	6	1	12
TOTAL	1	4	6	1	12
ESCAP area					
China	—	—	—	1	1
Japan	—	—	1	—	1
Other East Asia	—	—	3	—	3
Eastern South Asia	—	2	3	4	9
Middle South Asia	1	1	6	1	9
Australia-New Zealand	—	1	—	1	2
Melanesia	—	2	—	—	2
Micronesia-Polynesia	—	2	3	1	6
TOTAL	1	8	16	8	33
Developed countries	—	11	22	6	39
Developing countries	4	28	79	15	126
TOTAL	4	39	101	21	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

TABLE 52. GOVERNMENTS' POLICIES CONCERNING CONFIGURATION OF SETTLEMENT, BY AREAS OF RESPONSIBILITY OF REGIONAL COMMISSIONS, GEOGRAPHICAL REGIONS AND LEVEL OF DEVELOPMENT; STATISTICAL INFORMATION, JULY 1980

Area of responsibility of regional commission, geographical region and level of development	*Policies concerning modification of rural and urban configuration of settlement*				
	No modification	*Rural configuration*	*Urban configuration*	*Rural and urban configuration*	*Total*
ECA area					
Eastern Africa	3	8	—	5	16
Middle Africa	1	4	—	4	9
Northern Africa	1	1	—	4	6
Southern Africa	2	—	—	2	4
Western Africa	7	3	—	6	16
TOTAL	14	16	—	21	51
ECE area					
Eastern Europe	—	—	6	—	6
Northern Europe	3	—	4	—	7
Southern Europe	4	—	4	1	9
Western Europe	8	—	1	—	9
Cyprus, Israel and Turkey	—	—	1	2	3
Northern America	2	—	—	—	2
USSR	—	—	—	3	3
TOTAL	17	—	16	6	39
ECLA area					
Caribbean	6	2	1	2	11
Middle America	3	1	—	3	7
Temperate South America	—	—	2	1	3
Tropical South America	—	2	—	7	9
TOTAL	9	5	3	13	30
ECWA area					
Western South Asia[a]	5	2	—	5	12
TOTAL	5	2	—	5	12
ESCAP area					
China	—	—	—	1	1
Japan	—	—	—	1	1
Other East Asia	—	—	1	2	3
Eastern South Asia	1	4	—	4	9
Middle South Asia	1	3	—	5	9
Australia-New Zealand	1	—	1	—	2
Melanesia	2	—	—	—	2
Micronesia-Polynesia	4	—	—	2	6
TOTAL	9	7	2	15	33
Developed countries	18	—	16	5	39
Developing countries	36	30	5	55	126
TOTAL	54	30	21	60	165

Sources: Compiled from replies to "Fourth Population Inquiry among Governments in 1978: review and appraisal of the World Population Plan of Action"; and from the Population Policy Data Bank of the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

[a] Excluding Cyprus, Israel and Turkey.

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