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The Population Policies of SAARC Countries: An Overview

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THE CONTEXT

Concept of Population Policy

A population policy is a deliberate attempt to spell out basic objectives and means to achieve a desired rate of growth of population by controlling the factors determining the size and the composition of human resources so as to contribute positively to economic development. A population policy in developing countries incorporates the idea of birth control as a measure to control fertility to reduce the growth rate of population, because the growth rate of population in developing countries is high (about 4 times than the developed countries). The government pursuance of population policies at the national level is to influence population size, growth, distribution and structure with the aim of coping with the problem of maladjustment between population trends and socio-economic facts.

Needs of Population Policy

World population growth was balanced by the nature in the early period of human settlement, but starts to increase after the agricultural revolution. Various population theories were propounded by different scholars. After 1950 world population starts to increase rapidly and at present it is increasing by 1.6 percent per annum, whereas the growth rate of more developed countries is only 0.6 percent and in developing countries have about 2.0 percent. The continental distribution and growth rate of population is not uniform. In almost all developing countries the population growth rate is high compared to GNP growth rate, and their natural resources are over exploited. Thus the government of the concerning countries all over the world have thought about a strong population policy to control the high growth rate of population in order to strike a balance between natural resources and population.

Official policy to reduce population growth rate by lowering fertility rate appeared in 1950s and at present almost all countries in the world are adopting population policy to reduce high rate of growth by lowering birth rate, improving health condition of the people, and managing spatial distribution of population etc. But the features of the policy are not the same in all countries.

POPULATION POLICY IN THE SAARC COUNTRIES

The need to establish an institution for cooperation in the South Asian Region was thought before 1980s. But the establishment of SAARC (an association of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka) was initiated in

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1981 with the Secretaries level meeting and it was strengthened in 1983 with the foreign Ministers level meeting. On the grounds of the Secretaries level and the Ministers level meetings the heads of the State of government of this region (SAARC) met in Dhaka, the capital city of Bangladesh in December 1985 and decided to establish the South Asian Association for Regional Cooperation (SAARC) with the objectives of to: promote welfare of the people; accelerate economic growth, social programmes, and cultural development; contribute mutual trust; provide opportunity to live in dignity; promote active collaboration and mutual assistance in the economic, social, cultural, technical and scientific fields; etc. The whole concept of SAARC is based on the principles of sovereign equity, territorial integrity, political independence, non-interference in internal affairs of other countries and mutual benefit of the region (Singh, 1987).

The population of SAARC is 20.8 percent of the world population, whereas it is 24.6 percent of the LDCs and 35.7 percent of the Asian population (1990). The annual growth rate in the world during 1985-90 was 1.6 percent, LDCs had 2.0 percent, Asia had 1.6 percent and SAARC had 1.9 percent or nearly equal to LDCs. All SAARC countries are developing countries with a per capita income of less than US$ 500.00. These countries are also not free from high and uneven growth rate. Thus all these countries adopted population policy as their necessity. This study is fully based on the publications of United Nations.

Population

Population Size

The population of Bangladesh was estimated 101147 thousand in 1985 and reached 115244 thousand in 1990 with 2.6 percent annual growth rate during 1985-90, and it is estimated that it will reach 219383 thousand in 2025 increasing by 1.9 percent during 1990-2025. Bangladesh is the second largest country of this region from the point of view of population size.

In 1990 population of Bhutan was 1596 thousand whereas it was 11417 thousand in 1985, and estimated that it will reach 2662 thousand in 2025 with 1.5 percent growth rate during 1990-2025, where as the present growth rate (1985-90) is 2.1 percent. The sex ratio is estimated 106.6, 107.1 and 108.5 respectively in 1985, 1990, and 2025.

India is the biggest and influencial country of this region, whose population was estimated 827152 thousand in 1990 and estimated that it will reach 1228829 thousand in 2025 by growing 1.1 percent per annum. India alone has 3.2 times more population than the total of other six countries of the SAARC. The countrywise difference is 7.4, 527.2, 4147.0, 44.8, 7.4 and 47.4 times more than Bangladesh, Bhutan, Maldives, Nepal, Pakistan and SriLanka respectively. The sex ratio is 107.0.

Maldives is the smallest country of the region. The land area is only 298 sq. km and the population size of Maldives in 1985 was 183 million and which will reach 432 thousand in 2025. The annual growth rate during 1985-2025 is estimated 2.2 percent.

Nepal comes at the fourth place in this region from the point of view of population size. The population of Nepal was estimated 16482 thousand, 18470

thousand respectively for the year 1985 and 1990, and it will reach 33946 thousand in 2025 by increasing 1.8 percent during 1990-2025. The sex ratio is increasing 105.3 in 1985 to 108.0 in 2025.

Pakistan occupies the third place with 100380 and 112226 thousand population in 1985 and 1990 respectively. The annual growth rate was 3.1 percent during 1980-85 and 2.3 percent during 1985-90 and expected to grow by 1.8 percent during 1990-2025. The sex ratio of Pakistan is nearly equal (108.0) in all estimated years which is high in the region.

SriLanka is the last country in the order of this region, but developed in all respect then other countries of the SAARC. The population of SriLanka was estimated 16205 thousand with sex ratio 102.2 in 1985 and 17451 thousand in 1990. It is estimated that it will reach 24443 thousand by increasing 1.0 percent per annum during 1990-2025, whereas the present growth rate is 1.5 percent and sex ratio is 101.0 which is lowest in the SAARC countries. This shows that the proportion of female in SriLanka is increasing.

Table 1 shows that among the SAARC countries India is the largest country in terms of population followed by Bangladesh, Pakistan, Nepal, Sri Lanka, and Bhutan. Maldives is the least populas country of this region. Looking at the growth rate during 1980-85 Maldives comes at the top (3.3 percent) followed by Pakistan (3.1 percent), Bangladesh (2.8 percent), Nepal (2.4 percent), Bhutan (2.1 percent), India (2.0 percent) and Sri Lanka (1.8 percent). But it is estimated that the growth rate of Pakistan will decline rapidly and it will be equal (1.8 percent) with Nepal during 1990-2025. Other countries will be in the same position.

Age / Sex Structure

Looking at the age structure of the SAARC, the proportion of dependents (below 15 years and 60 years and over) is found more than 40 percent for all countries of this region. The dependency ratio in Sri Lanka is found lowest among the SAARC countries, followed by India, Bhutan, Nepal, Pakistan and Bangladesh have the highest. But it is estimated that up to 2025 the dependency ratio for all countries may be the same. Data on age/sex structure for Maldives is not found. The sex ratio is also low in Sri Lanka compared to other countries of this region but the difference is not much. It ranges from 101.0 SriLanka to 108.0 Pakistan (Table 2 and 3).

APPROACH TO POPULATION PROBLEMS

With regard to the growth of population among the SAARC countries government of Bangladesh, India, Nepal, Pakistan and Sri Lanka had viewed that the growth rate is *too high* and it is necessary to intervene by the government to lower it (the population growth rate). Whereas the government of Bhutan realise that the present rate of growth is *too low* and while Maldives feel that the present growth rate is *satisfactory*.

The government of Bangladesh considers that population growth is a pressing national issue and a primary obstacle to socio-economic development. To end the vicious cycle of unemployment, poverty and malnutrition, population growth will have to be curtailed. To achieve this goal the government has embarked on an ambitious national population programme which takes a multi-sectoral approach integrating laws and socio-economic development programmes. Bangladesh has taken a policy of intervention to reduce the present growth rate and fertility rates. The government also felt that population policy is an integral component of the overall development efforts (UN,1987:43). The sex ratio is found 106 (1990) and expected to reach 107 in 2025.

The Indian government considers that the population growth is a serious problem particularly in relation to alleviating poverty. The main goals of demographic policy are to control population growth by reducing fertility, decrease morbidity and mortality by integrated health care programmes and enhance social and economic advancement mainly through industrial, agricultural and rural development programmes. Thus the government has accorded very high priority to intervention in regard to population growth (UN, 1989:63).

Nepalese government seeks to reduce population growth through both direct and indirect intervention in order to maintain a balance between population growth and economic development. The policy taken by the government is to control population growth through basic development reforms in the socio-cultural, economic and educational environment and maternal and child health and family planning programmes. The government seeks to reduce immigration and regulates hills to tarai migration to achieve a proper distribution of the population. The government also realises that high population growth has negative effects on national development (UN, 1989:199).

A reduction in the population growth rate is felt to be essential for improving the country's social and economic conditions, inadequate physical and social infrastructure in rural areas, high fertility and low literacy are considered to be the major obstacles to achieving economic progress. Thus efforts are made by the government of Pakistan to reduce illiteracy and unemployment, improve health condition and lower fertility through family planning programmes (UN, 1990:7).

Though SriLanka has the lowest fertility and mortality rate among the SAARC countries, yet the government recognizes the importance of a further reduction in fertility to enhance socio-economic development and has sought to strengthen and expand the delivery of family planning services, provide incentives for controlling population growth and increase population education. High priority is also accorded to comprehensive social welfare services (UN, 1990:115).

The government of Bhutan considered that the population growth rate is *too low*. The government felt that high population growth is necessary to supply required labour for its labour-intensive agricultural sector of the country, but the government has no explicit policy to increase population size. The government hopes that the population will grow to the desired level by declining mortality (especially child and infant). The government also hopes to fill job requiring skills with indigenous skilled workers rather

than foreign workers through improved education and training. Again the additional manpower is also expected to help tap much of the country's untapped natural resources as well help develop many sparsely populated regions (UN, 1987:63).

The government of Maldives has realised that the population growth rate is *satisfactory*. The population policy is regarded as a part of the overall economic development and development of population through improved family planning services along with improved health and education facilities and decreased urban concentration on Male Island (UN, 1989:155).

POPULATION POLICIES

Change in Population Size

The government of Bangladesh has formulated an explicit population policy to lower the present annual population growth rate 2.4 percent to 1.4 percent by the year 2000 by improving family planning services continuing the mass media campaign of population education and motivation integrating population programmes within primary health care and socio-economic development programmes and further improving the status of women (UN, 1987:44).

Bhutan has no explicit policy to increase the rate of growth though the government feels that population growth rate is *too low* to fulfil the need of indigenous manpower to carry out development objectives of the country (UN, 1987: 64).

Indian government has taken population control as primary development priority and commuted to reaching zero (O) population growth by the year 2050 through emphasizing the family welfare programmes and socio-economic reforms (UN, 1989:64) by which living standard of the people increases and population growth goes down.

Maldives a smallest country among the SAARC from the point of view of land area and population do not have well developed data base. The government feels that the current population growth is *satisfactory*. It has not adopted an explicit policy with regard to the rate of growth, but it was observed that there is a concern with the government about the increasing trend of population. Currently government has not taken any direct measures to influence change in population size and age structure but it is expected that growth rate of population will increase through programmes for maternal and child health and to eradicate communicable diseases (UN, 1989:155).

Government of Nepal has taken concern about growing population since the Fourth Five Year Plan (1970-75) and taken some policies to lower the population growth reducing levels of fertility, mortality, checking immigration and managing hill to tarai migration. The Seventh Five Year Plan (1985-90) has given emphasis on policies to increase domestic production, expand family planning services to satisfy the unmet demand and integrate population programmes in all projects related to the environment, agriculture, forestry and rural development. A target has been established to lower the rate of population growth 1.2 percent per annum by the year 2000 (UN, 1989: 199-200).

The high growth rate and high dependency burden (both youth and old) have had an adverse impact on social, economic and political conditions in Pakistan. Thus the objectives of the government is to lower population growth to balance with resources. The government plan placed emphasis on population policies to expand family planning services, reduce mortality and to improve educational opportunities for women (UN, 1990: 7-8).

There is an explicit intervention policy in SriLanka to reduce growth rate and to adjust the age structure by lowering fertility, infant and child mortality. The family health programme is an integral part of the expensive health and service delivery network that has facilitated the provision of family planning services throughout the country. Besides this the government has also included readjusting the spatial distribution pattern improving employment prospects and exceeding social security to rural workers (UN, 1990: 116).

Social security schemes have been adopted by all member countries but the nature and approach taken by all country is different from another.

Morbidity and Mortality Related Policies

In 1980-85 the crude death rate (CDR) was found lowest in SriLanka (6.6) followed by Maldives (12.0), India (12.2) and highest in Nepal (18.4), followed by Bhutan (18.1), Bangladesh (17.5) and Pakistan (15.3). In all SAARC countries except SriLanka average CDR is found high than the average of the developing countries of the world. Nepal and Bhutan have nearly double CDR than the Asian average. The order of the countries with respect to mortality during 1985-90 is also the same as of 1980-85. But the estimated CDR (2020-25) shows that Pakistan will have lowest than SriLanka, because in SriLanka CDR is expected to increase after 2000. The condition of Nepal will also some better than Bhutan. Regarding the Infant mortality (IMR) and life expectancy at birth (e^0) the order of the countries of this region is the same as of CDR (1980-85) in all estimated years. The life expectancy at birth (e^0) is highest in SriLanka and lowest in Bhutan and Nepal. In comparison with the world, LDCs and Asia, only SriLanka has the high and other countries of this region has low life expectancy at birth (Table 4).

Control of common, endemic and communicable diseases, provide safe drinking water to the people, sanitation, health education, Maternal and child health programmes, improvement of general health etc. are the common objectives of SAARC countries. MCH programmes have reserved much emphasis in all countries except Pakistan and SriLanka. All countries have specific policies to reduce morbidity and mortality. The notion 'Health care for all' is adopted by Bangladesh, India, Maldives, Nepal and SriLanka.

In Bangladesh provision of health care services is an integral part of both population control and socio-economic development. One of the main objectives of the government is to provide health care to all by the year 2000, which would narrow the gap between rural and urban areas and also enable people to live more productive lives. By improving MCH, the government hopes the idea of small family will be accepted.

To achieve this end MCH service units will be further expanded and extended, emphasizing immunization, control of diarrhoea, safe delivery and breast-feeding. Much emphasis is being placed on solutions to simple health problems, such as diarrhoea or related complic ns, which are the most common causes of death for infants. Teams of health workers have been sent to rural areas to educate mothers on preparing oral rehydration salts so that these deaths can be averted. It is felt that simple ailments could be diagnosed at the community level health care should be supported (UN, 1987: 44).

Reducing high mortality rates is the main policy concern related to population in Bhutan. The government include several health related objectives such as improvement of general health by preventive measures such as health education; improved hygiene and sanitation; provision of better nutrition; the prevention and control of common, endemic and communicable diseases; and the provision of better treatment facilities and services. Efforts are being made to provide protected drinking water to both urban and rural areas. Solid waste disposal and sanitation programmes have also been undertaken as well as a Maternity and Child Welfare Programme. Through a series of clinics, this programme will provide education and health care services to new and expectant mothers. Another measure is the expansion of the immunization programme to increase the proportion of population covered. Strategies have also been implemented to improve the health service infrastructure (UN, 1987:64).

The policy concentrates on reducing morbidity and mortality among children and mothers and on the equitable distribution of health services between urban and rural areas in India. By integrating health services into the overall programme of social services, an alternative model of health care service is being developed which emphasizes the preventive, primitive and rehabilitative aspects along with the curative aspect and is directed primarily at rural areas and the poorer segments of the population. A policy *Health for all by the Year 2000* has been adopted aiming to provide universal primary health care even in the remotest areas. In addition it stresses the need to view health and human development as vital for integrated national socio-economic development (UN, 1989:64).

The government of Maldives gives priority to maternal and child health services and the eradication of water-borne diseases in order to bring down the high rates of morbidity and mortality. The policy seeks the equitable distribution of health services through the primary health care approach, greater emphasis is being given to preventive facilities in the outer-lying Islands. It also seeks lower neo-natal, infant and maternal mortality through programmes of child spacing, nutrition and growth monitoring. Additional objectives include reducing the incidence of tetanus, pertussis, measles, tuberculosis, leprosy, malaria, and of diarrheal epidemics which regularly occur. Strategies to achieve *health for all* recognizes the need to develop governmental services, on the one hand and to mobilize the self-development capacity of the community on the other. Other priorities include the provision of safe drinking water and basic sanitation facilities, immunization against communicable diseases, the availability of essential medicines on each Island and the provision of child-spacing programmes (UN, 1989: 156).

The government of Nepal has emphasizes the reduction of mortality and morbidity through the expansion of health care facilities and the preventive aspects of health care. By the provision of basic Health services including environmental sanitation and nutritional supplies, the expansion of hospital facilities and malaria eradication programmes, the policies aim at reducing general and infant mortality and increasing life expectancy. Maternal and child health care services are given high priority in order to improve the health status of mothers and children and reduce the incidence of illness and death. They focus on oral rehydration, nutrition, immunization, basic and natal care and birth-spacing. Structural reorganization of the health care sector was undertaken in order to resolve the rural/urban imbalance and to provide basic health care services to a maximum number of people (UN, 1989: 200).

The Pakistan's government was committed to improving *health care for all* but especially among the population segments with the highest mortality and morbidity levels. Measures adopted by the government include the expansion of primary health-care services in rural areas, and expanded immunization programme, family planning and the training of traditional birth attendants to ensure one attendant for each of the country's villages and less developed urban areas. Other measures include expanding the provision of potable water supplies, initiating community based sanitation activities and the addition of Basic Health Council Areas (UN, 1990: 20).

The government of SriLanka is committed to achieving *health for all* mainly through primary health care, with emphasis on preventive activities. Intervention programmes have been implemented in nutrition surveillance, the provision of clean water, sanitation and hygiene education, improvements in primary health care and maternal and child health services, integrating family planning services and emphasizing community participation. Communication strategies have been developed as part of an expanded programme of child immunization for achieving universal coverage by 1990. A diarrheal disease control programme has been undertaken that includes establishing a plant to manufacture oral rehydration salts. Armed conflict in several districts has to a deterioration in health services and increase in communicable diseases and malnutrition. Consequently, the government was formulation promulgating programmes of rehabilitation (UN, 1990: 116).

Fertility Related Policies

High fertility rate is one of the major causes of population explosion in the world, especially in developing countries. In all the SAARC countries crude birth rate (CBR) as well as total fertility rate (TFR) is very high. At present only SriLanka is below than the average of world, LDCs and Asia in respect to TFR and CBR and estimated that it will keeps its place in 2020-25 also. India is also expected to decline TFR and CBR rapidly and will reach below the world, LDCs and Asian averages (Table 5).

The government's fertility policy in Bangladesh aims to reduce fertility and population growth and to improve maternal and child health and family well being. A voluntary family planning programme has existed since 1960s. The current programme is very comprehensive. It emphasizes maternal and child health, encourages

improvement in the status of women and late marriage emphasis on educating people on family planning technique and the national need for family planning and sets goals and targets related to family planning. Family planning ideas are published regularly and 95 percent of the population of Bangladesh has some knowledge of family planning: yet contraceptive use remains low. Target has been taken to increase the prevalence rate through mas media campaigns and directly supports access to all modern contraceptive methods. The network of delivery of family planning services is widened. The government also provides proper economic incentives. Acceptors of permanent and semi-permanent family planning methods are re-imbursed for transport costs and loss of wages sustained as a result of obtaining these methods. The government target is to reduce net reproduction rate by reducing TFR. Abortion is not legalised (UN, 1987:44).

The government of Bhutan has no explicit policy regarding fertility but it is aimed that family planning services is to provide through family welfare Programme to those living in high fertility and mortality areas and those living in poor conditions. The programme focuses primarily on maternal and child health, including the monitoring of maternal and child health conditions so that a nutritionally balanced diet can be recommended (UN, 1987: 64). Government's Five Year plan also recommended that the creation of a Family Planning Training Centre, direct support for contraceptives and sterilization. Although indication shows that abortion is permitted but no official information is available concerning its legality.

The government of India recognizes that with its large population it cannot wait for development to change the attitudes of couples towards smaller families, since the development process itself is stifled by high population growth. In 1977 policy was modified to eliminate all forms of compulsion in the family planning programme and to make it a family welfare programme embracing all aspects of family welfare — particularly, maternal and child health, nutrition, women's education and women's rights. The Seventh Five Year plan aims at establishing the two child family norm and attaining replacement level fertility by the year 2000. All methods of family planning are widely available. Financial incentives are provided to acceptors of sterilizations and the IUD by compensating for lost wages. New incentive schemes include primium-free insurance to those who limit and space child bearing and the provision of social security to aged couples with one child and no male off spring. The revamped family welfare campaign is based on five main principles: families should be limited to two children, the law that bars marriage for girls under age 18 should be enforced, families should not continually produce children until a son is born, all infants should be immunized in their first year and births should be spaced at intervals of three years (UN, 1989: 64).

Although the government of Maldives does not intervene to modify the present levels of fertility, some of its health programmes may influence fertility levels, such as the maternal and child health programmes. The family planning programme aims to improve the health of mothers birth spacing. All methods of contraception are permitted by law. The government provides direct support with respect to the use of modern methods of contraception. Efforts are being made to disseminate views on family planning at the community level, so as to foster a positive attitude towards the doctrine of small families for better standard of living. Training programmes and mass media

campaigns aim at improving couples awareness of family planning. Abortion is legal if the woman's life is at risk (UN, 1989: 156).

The government of Nepal has adopted a multisectoral approach to reduce high fertility levels. Emphasis is given to family planning services, maternal and child health, basic education and the status of women. The family planning programme focuses on couples aged 20-30 years by enhancing the use of temporary birth control methods through increased awareness and motivation. All family planning programmes include effective information, education and communication activities. Efforts are also being made to improve support services, including logistic, personnel, financial administration and programme management. Measures have been adopted to extent and strengthen family planning delivery services to all population segments so as to meet the unmet demand. These include training more physicians in family planning methods, provision of family planning services in district and zonal hospitals, a contraceptive retail sales project and strengthening the concentration of family planning services in densely populated areas. Birth control pills and condoms are available free of charge at all health centres. Abortion is permitted only on medical grounds and sterilization is legal for both men and women. The target is to reduce the total fertility rate to 2.5 by the year 2000 (UN, 1989: 200).

The government of Pakistan hopes to promote the small family norm through programmes aimed at socio-economic transformation, rural development, reducing infant and child mortality and the training of traditional birth attendants. The population welfare programme which was incorporated into the development plan sought to devise programmes based on local needs and to seek the involvement of target groups and NGOs. The government gives direct support for the provision of contraception and abortion is permitted only to save the life of mothers, while sterilization is available with the husband's consent to married women having at least two to three children (UN, 1990:8).

In SriLanka the policy is to lower fertility so as to reduce population growth and improve well being and health of the people. Family planning services are part of a comprehensive family health services and a range of subsidized clinical and contraceptive service is provided. The capacity of the existing maternal and child health, and family planning infrastructure is being enhanced particularly in rural and poor urban areas. With the wide acceptance of sterilization reversible methods and birth-spacing are being emphasized to encourage younger couples to practise family planning. Since 1988 financial incentives have been offered to women using the IUD. Emphasis is being given to linking information education and communication activities more closely to service delivery and interpersonal and group approaches. Abortion is permitted only to save the life of mothers (UN, 1990: 116).

Migration Related Policies

Besides the birth and death rate, the next and a major component of population change is net migration. If the level of immigration is high compared to emigration the population growth will be high and vis-a-vis. But data on net migration are not

available in the SAARC countries. The specific country policies regarding migration is discussed below.

The government of Bangladesh has expressed the desire to lower immigration levels in the future but does not have any official policies. On balance emigration is believed to have contributed positively to socio-economic development. Therefore, government would like to maintain current levels and has encouraged the temporary migration of workers to other countries (UN, 1987: 45).

Bhutanese government has no explicit policy regarding immigration, although it has expressed the desire to reduce the dependency on foreign workers. To attain this objective a large proportion of the budgetary allocation for the Fifth Five Year Plans is devoted to training the indigenous population for positions currently held by migrant workers. There is very little emigration and the government has no policy to alter the situation (UN, 1987:64).

Levels of immigration is insignificant in India. Thus there is no policies directed at international migration. The Emigration Act 1983 sought to protect the interests of emigrants which had been prone to exploitation by recruiting agents. Indians can not take up work abroad without receiving a certificate of clearance from the Protector of Emigrants (UN, 1989: 64).

In Maldives, the government view regarding immigration is *satisfactory*. Thus there is no known policy statement concerning the levels of immigration and emigration which are viewed as insignificant (UN, 1989: 156).

The population policy of Nepal aims to control immigration. The measures includes issuing citizenship certificates to distinguish nationals from foreigners (non-nationals) and prohibiting foreigners from acquiring property in Nepal. The policy on emigration aims at increasing the emigration of unskilled manual workers and agricultural workers and decreasing the professional and skilled workers. Policies and programmes of Nepal are based on the findings of the task force created to study internal and international migration by the then National Commission on Population in 1983 (UN, 1989: 200).

While the government of Pakistan has a policy to maintain the level of immigration, there is some fear of job competition from highly skilled immigrants. Immigration ceilings have been established in terms of specific skills rather than numbers of admissions. Concerning emigration the government has not formulated a specific policy beyond the usual visa and passport controls (UN, 1990: 8).

The SriLankan government has a policy to halt immigration. Concerning emigration measures aims at facilitating labour emigration as it alleviates unemployment and remittances are a major source of foreign exchange. The government regulates recruitment, protects the interests of overseas migration and acts as an intermediary between migrants and recruitment agencies. To reduce the *brain drain*, qualified professionals in government employment are entitled to a leave of absence of

up to three years to work abroad, after which they must return to their former posts (UN, 1990: 116-117).

Spatial Distribution and Urbanization

The population in all SAARC countries are not distributed evenly. The percentage of urban population to the total population rages from 5.3 percent (Bhutan) to 32 percent (Pakistan). The percentage of urban population in all SAARC countries is low compared to world average. But Pakistan has slightly more urban population than Asian average (29.9 percent) in 1990. The urban growth rate is more than double than rural growth rate for all countries of the region except SriLanka, Where rural as well as urban growth rate is nearly equal during 1980-90.

Looking at the population density Bhutan (33 per sq. km) is the lowest among the SAARC countries and also less than average of Asia, LDCs and world as well, whereas other countries of this region have highest density than the average of world (39), LDCs (51) and Asia (111) in 1990 (Table 6).

There is some concern that the quality of rural life will eventually contribute to a mass exodus to the urban areas. To prevent this the government has instituted strategies to promote small towns and intermediate cities as well as rural development. It is feared that excessive urbanization will further aggravate the already fragile urban infrastructure and network of social services (UN, 1987: 45).

However, Bhutan has no overall population distribution policy goals with about 5 percent urban population. Most spatial distribution projects are gared towards rural development. There has been some concern about increased rural to urban migration and the government hope that its programmes will slow down the increase. Another measure to further integrate the economy is an improved road network enabling more isolated farmers to reach the markets. Planning at the urban level has taken place to combat the negative cosequences of urban development. The objective is to provide basic amenities, such as roads, water sanitation, drainage and electricity (UN, 1987: 65).

In India the policy aims at slowing down the metropolitan growth, promoting small towns and intermediate cities, and adjusting the spatial distribution pattern by agricultural and rural development and industrial location policies. To develop industries in less developed areas, enterprise oriented public infrastructure subsidies, grants, loans and tax incentives are provided. In the Five Year Plans integrated technological advancement, rural development and employment generation have been emphasized. Although there is no national urbanization policy, the Five Year Plans have emphasize urbanization as an important aspect of economic and social development. Urban development schemes aims to provide adequate infrastructure and facilities in small, medium and intermediate sized towns to strengthen those market centres and equip them to serve as growth and service centres for rural areas (UN, 1989: 65).

The spatial distribution and urbanization policy of Maldives aims at decreasing the level of migration to Male and at balancing the population density and socio-economic progress between Male and the Atolls. Priority is given to development of

Atolls in order to attract migrants form over crowed areas. The government has formulated an overall development policy for the Atolls. The Atolls Development Advisory Board implements development policies and allocates government resources and services to the Atolls. The measures include provision of health, education and training services, construction of fisheries, implementation of agricultural development programmes and development of transport and communication systems. The government had under consideration in 1985 a proposal to shift both population and economic activity to some of the nearby Islands. For Male itself a town plan has been developed (UN, 1989: 156).

The spatial distribution policy of Nepal aims at reducing hill to tarai migration. To adjust the distribution of population, a programme of allocative investment was undertaken benefiting the least developed areas of the country. The government envisages a long-term policy for the development of the hill region, so as to provide adequate employment opportunities there. Measures are being taken to promote rural markets and growth centres. Appropriate programmes of land utilization in the hills and tarai have been launched to optimize the use of natural and land resources. In addition resettlement schemes have been implemented. A new dimension was added to local development with the Decentralization Act 1982, which provides for the continuation of decentralization in formulation and implementing policies for socio-economic development at the local level. (UN,1989: 201). At present the government of Nepal has planned to spend 70 percent of its development budget in rural areas to attract the rural people.

Rural development is seen as a major tool in readjusting the pattern of internal migration in Pakistan. Targets have been formulated for rural development including rural electrification, pure drinking water facilities, sanitation, health care centres, construction of rural roads and farm to market roads, etc. The government has also the policy to improve and develop urban squatter settlements. These initiatives are being supplemented by local development schemes to enhance the role of people's participation in the development of local areas (UN, 1990:9).

The government policies in SriLanka aim to decelerate internal migration, curb urbanization, maintain the rural population and relocate population from crowded urban areas. Measures includes the provision of adequate urban services and other infrastructure in new towns and communities, establishing new industries away from urban centres, and state-sponsered land settlement schemes. The objective is to resettle people from the densely populated south-west by providing and developing land, particularly for the landless and unemployed in the dry zone in the north, east, and south-east parts of the country. The Mahaweli River Development Scheme aims to improve food self-sufficiency, generate hydroelectricity, create one million new jobs and resettle people by relocation and spontaneous migration (UN, 1990: 117).

Status of Women

Fertility and mortality (especially child and infant) of all countries largely depends upon the status of women in the society. Generally status of women and fertility as well as mortality have negative corelation (as the status of women increases

in the society fertility as well as child and infant mortality will declined). Thus the policy planners should consider the status of women.

In Bangladesh the status of women is improving and several measures like raising the legal age of marriage have been implemented to this end. Seventy percent females are married by the age 20. Though the legal age at marriage is 18 years by reaching age 20 years seventy percent females are married. The government is also trying to encourage female participation in the labour force (UN, 1987: 45).

In Bhutan women are enjoying equal status with men. They possess property rights, have equal job opportunities and can seek divorce. Information on the minimum age at marriage and the mean age at first marriage for women is not available (UN, 1987: 65).

The government of India stresses the corelation between population policies and women's status in terms of their health and nutrition, age at marriage, literacy and employment. For the social and economic emancipation of women, a strategy was developed which emphasizes health, education and employment. The minimum age at marriage has been raised to 18 years for girls. To promote female employment a major step has been the expansion and diversification of education and training opportunities and legislative measures ensuring the protection of benefits for working women. The female mean age at first marriage was 18.7 years in 1981 (UN, 1989: 65).

The measures taken by the government to improve the socio-economic status of women are integrated into population policies, including family planning and population planning. Women in Maldives have a privileged status in society, enjoying equal pay with men and higher literacy rates. To enhance the involvement of women in development activities a National Women's Committee was established in 1977. The activities of this committee includes encouraging women in leadership; training them in managerial, supervisory, income generating and vocational skills; and involving them in development planning. The information regarding the minimum legal age of marriage and mean age at first marriage is not available (UN, 19890:157).

The government of Nepal considers improving women's status to be an integral part of the development process and one of the most effective measure for lowering population growth. Incentive schemes are initiated to improve women's education and employment opportunities; scholarships to the girls students; skill oriented training; co-operatives and quota systems. The goal is to raise the social and economic status of women to make them self-relient and to gain their participation in development programmes. The minimum age at marriage with the consent of parents is 18 years and without consent is 21 years for girls, whereas the mean age at first marriage was 17.1 years in 1981 (UN, 1989: 201).

A Women's' Division within the Cabinet was established in 1979, since then this division became a responsible body to formulate the policies and laws to meet the special needs of women in Pakistan. The Sixth Five Year Plan of the country stressed an integrated approach to improving the status of women and targeted areas that were hindering women such as illiteracy, constant motherhood and the primitive organization of work. In 1989 it was announced that the Women's Division would soon establish centres of excellence at various universities in Pakistan to keep students informed of

women's development programmes. Female mean age at first marriage in 1981 is found 19.8 years (UN, 1990: 9).

In SriLanka women have equal rights including those concerning property and inheritance. The government has taken steps to increase female participation in education, productive employment and other spheres. The Women's Bureau has directed and co-ordinated programmes for integrating women into the development process, such as providing leadership training in community development, income generating activities and health improvement. The government has increased the role of women in population activities, particularly in service delivery and communication. The minimum legal age of marriage for women is 12 years, but mean age at first marriage is 24.4 years (move than double than the legal age of marriage) in 1981 which is the highest among the SAARC countries (UN, 1990: 177).

CONCLUSION

A population policy is a strategy for achieving a particular pattern of demographic change. To formulate the population policy requires an assessment and an evaluation of the expected consequences of current trends, when the expected consequence differ from the desired result, than it is necessary to intervene by the government to alter the course of demographic events.

In the world official Population policy was appeared in 1950s and at present almost all countries in the world especially in developing countries are adopting it, to reduce the high rate of growth of population.

The concept of SAARC, officially recognized from the Dhaka summit in December 1985. This region occupies about 21 percent population of the world population and about 36 percent of the Asian population. All the countries of the SAARC are developing countries characterised by high and uneven growth rate. Thus all the governments of this region adopted population policy as their necessity. In general the nature of the policy is agreeable in the countries of the region.

Table 1

Estimated Population and its Growth Rate in SAARC Countries

Country	Land Area	Population (estimated in '000)			Annual Growth Rate		
	Sq. Km	1985	1990	2025	1980-85	1985-90	1990-2025
Bangladesh	144000	101147	115244	219383	2.8	2.6	1.9
Bhutan	47000	1417	1569	2662	2.1	2.1	1.5
India	3166829	758927	827152	1228829	2.0	1.7	1.1
Maldives	298	183	-	432	3.3	-	2.2 (1985-2025)
Nepal	147181	16482	18470	33946	2.4	2.3	1.8
Pakistan	796095	100380	112226	209976	3.1	2.3	1.8
SriLanka	65610	16205	17451	24443	1.8	1.5	1.0
Total							

Source: Centre for Nepal and Asian Studies, *CNAS Year Review 1987*, CNAS, TU. and United Nations,*World Demographic Estimates and Projections 1950-2025*, United Nations, New York.

Table 2

Percentage of Population and Dependency Ratio in SAARC Countries

Countries and Year		Percentage of Population			Dependency Ratio		
		0-14 Yrs	15-59 Yrs	60 Yrs and above	Youth	Old	Overall
Bangladesh	1985	45.7	49.5	4.8	92.3	9.7	102.0
	1990	44.5	51.0	4.6	87.3	9.0	96.3
	2025	28.4	64.5	7.1	44.0	11.0	55.0
Bhutan	1985	40.0	54.6	5.4	73.3	9.9	83.2
	1990	39.3	55.2	5.5	71.2	10.0	81.2
	2025	27.4	64.0	8.6	42.8	13.4	56.2
India	1985	36.8	56.4	6.8	65.2	12.1	77.3
	1990	34.5	58.2	7.3	59.3	12.5	71.8
	2025	21.3	64.3	14.4	33.1	22.4	55.5
Maldives	1985						
	1990	NA	NA	NA	NA	NA	NA
	2025						
Nepal	1985	43.3	51.7	5.0	83.7	9.7	93.4
	1990	42.1	52.8	5.1	79.7	9.6	89.3
	2025	28.6	64.1	7.3	44.6	11.4	56.0
Pakistan	1985	43.6	51.9	4.5	84.0	8.7	92.7
	1990	43.0	52.4	4.6	82.1	8.8	90.9
	2025	27.1	64.7	8.2	41.9	12.7	54.6
SriLanka	1985	34.1	58.8	7.1	58.0	12.1	70.1
	1990	33.6	58.6	7.8	57.3	13.3	63.4
	2025	21.6	61.2	17.2	35.3	28.1	63.4

Source: Calculated from *World Demographic Estimates and Projections*, 1950-2025. United Nations, New York.

Table 3

Estimated Sex Ratio for SAARC Countries

Countries	1985	1990	2025
Bangladesh	106.4	106.4	106.7
Bhutan	106.6	107.1	108.5
India	107.2	107.0	104.0
Maldives	NA	NA	NA
Nepal	105.3	105.9	108.0
Pakistan	107.8	108.0	108.0
Sri Lanka	102.2	101.0	97.0

Source: Same as of Table 2.

Table 4
Crude Death Rate, Infant Mortality Rate and Life Expectancy at Birth in SAARC Countries

Countries	1980-85			1985-90			2020-25		
	CDR	IMR	e^0	CDR	IMR	e^0	CDR	IMR	e^0
Bangladesh	17.5	128.2	47.8	15.6	119.0	49.6	8.4	53.4	62.5
Bhutan	18.1	138.7	45.9	16.7	128.0	47.9	9.6	61.4	61.8
India	12.3	110.0	55.4	10.9	99.0	57.9	7.7	35.0	71.6
Maldives	12.0	82.0	53.0	-	-	-	-	-	-
Nepal	18.4	138.7	45.9	16.7	128.0	47.9	9.0	61.4	61.8
Pakistan	15.3	120.0	50.0	13.8	109.0	52.1	7.2	43.0	66.3
Sri Lanka	6.6	39.0	68.9	6.1	33.0	70.0	7.5	13.0	77.2
World	10.5	78.0	59.5	9.9	71.0	61.1	8.2	30.0	70.5
LDCs	10.8	88.0	57.3	10.0	79.0	59.1	7.6	33.0	69.5
Asia	9.8	83.0	59.1	9.1	74.0	61.1	8.0	26.0	72.1

Source: Same as of Table 2.

Table 5
Total Fertility Rate, Crude Birth Rate and Contraceptive Prevalence Rate in SAARC Countries

Countries	1980-85		1985-90		2020-25		Contraceptive
	TFR	CBR	TFR	CBR	TFR	CBR	Prevalence Rate*
Bangladesh	6.1	44.8	5.5	71.7	2.5	20.9	25.0 (1985)
Bhutan	5.5	38.4	5.3	37.0	2.5	19.2	NA
India	4.3	31.7	3.7	28.1	1.9	14.8	34.0 (1980)
Maldives	-	44.0	-		-	-	-
Nepal	6.3	41.7	5.8	39.4	2.5	20.6	15.0 (1986)
Pakistan	5.8	43.0	5.3	40.4	2.3	18.9	7.6 (1984/85)
Sri Lanka	3.4	28.3	2.9	24.2	1.8	13.3	62.0 (1987)
World	3.5	27.1	3.3	26.0	2.4	17.7	-
LDCs	4.1	31.0	3.7	29.4	2.4	18.6	-
Asia	3.5	27.2	3.1	25.4	2.1	15.7	-

Source: United Nations *World Demographic Estimates and Projections, 1950-2025*, UN. New York.

* World Population Policy, Vol. I, 1987, Vol. II, 1989 and Vol. III, 1990, United Nations, New York.

Table 6

Percentage Distribution and Growth Rate of Population by Rural and Urban Areas in SAARC Countries

Countries	1985		1990		2025		Population Density Per Sq. Km.		
	Rural	Urban	Rural	Urban	Rural	Urban	1985	1990	2025
Bangladesh	88.1	11.9	86.4	13.6	64.1	35.9	702	800	1524
	(2.4)	(5.5)	(2.2)	(5.5)	(0.1)	(3.7)			
Bhutan	95.5	4.5	94.7	5.3	81.0	19.0	30	33	57
	(1.9)	(5.1)	(1.9)	(5.5)	(0.3)	(4.3)			
India	74.5	25.5	72.0	28.0	46.4	53.6	231	252	375
	(1.4)	(3.7)	(1.1)	(3.6)	(-0.6)	(2.2)			
Maldives	79.8	20.2	-	-	58.2	41.8	614	-	1449
	(3.4)	(3.0)	-	-	(1.6)	(4.6)			
Nepal	92.3	7.7	90.4	9.6	69.4	30.6	117	131	241
	(2.0)	(7.2)	(1.9)	(6.9)	(0.1)	(3.8)			
Pakistan	70.2	29.8	68.0	32.0	43.3	56.7	125	140	261
	(2.6)	4.3)	(1.6)	(3.7)	(-0.4)	(2.5)			
Sri Lanka	78.9	21.1	78.6	21.4	57.4	42.6	247	266	373
	(1.9)	(1.4)	(1.4)	(1.8)	(-0.8)	(2.6)			
World	59.0	41.0	57.4	42.6	39.9	60.1	36	39	60
	(1.2)	(2.4)	(1.1)	(2.4)	(0.2)	(2.3)			
LDCs	68.8	31.2	66.4	33.6	43.5	56.5	47	51	87
	(1.4)	(3.4)	(1.2)	(3.5)	(0.3)	(3.0)			
Asia	71.9	28.1	70.0	29.9	47.2	52.8	102	111	164
	(1.4)	(2.8)	(1.1)	(3.0)	(-0.4)	(2.8)			

Note: Figures in Parenthesis refers the annual growth rate. The growth rate represents the period 1980-85, 1985-90, and 1990-2025 respectively.

Source: Same as of Table 2.

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