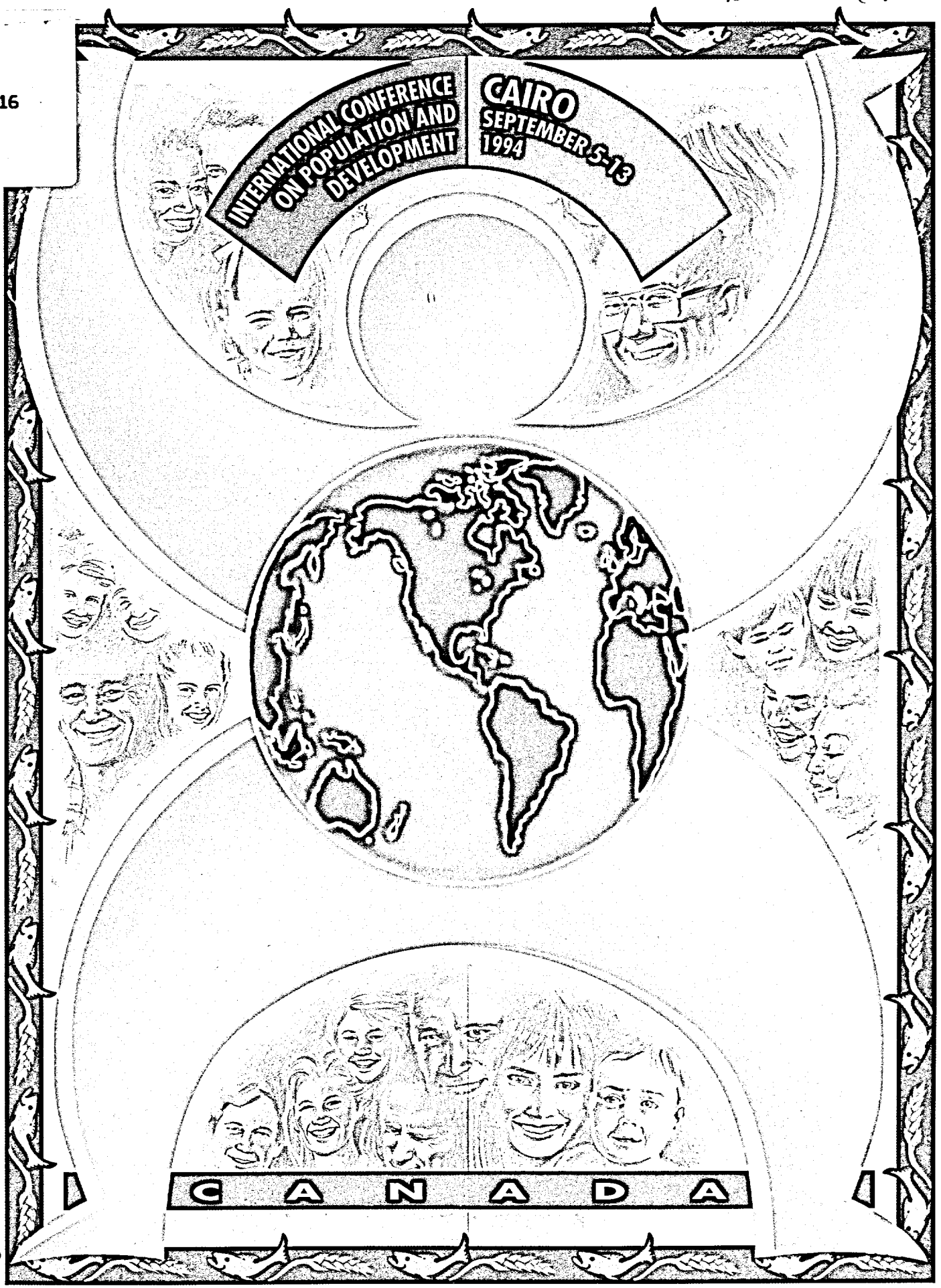

National Report on Population

NATIONAL REPORT ON POPULATION

CANADA

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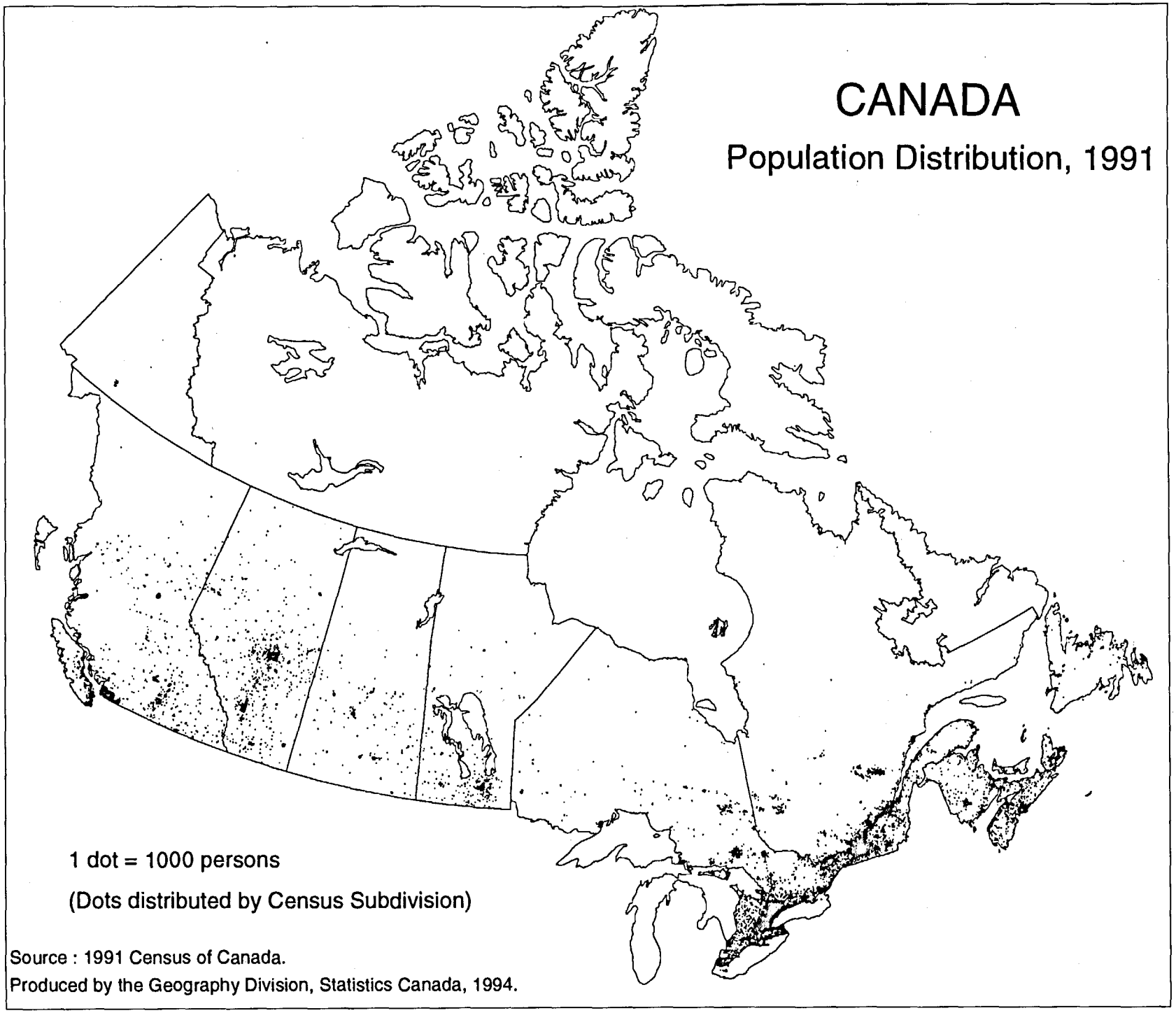

CANADA
Population Distribution, 1991
1 dot = 1000 persons
(Dots distributed by Census Subdivision)
Source : 1991 Census of Canada.
Produced by the Geography Division, Statistics Canada, 1994.

FOREWORD

This National Report on Population is submitted as part of Canada's preparations for the International Conference on Population and Development to be held in Cairo in September 1994. Through the sharing of the information in this report, Canada wishes to contribute to the preparation of an analysis and synthesis of the varied experiences of countries which may serve as a useful tool for the design and modification of future population and development strategies.

INTRODUCTION

Canada occupies a land mass that is among the largest of any country in the world. Yet its population is scarcely half that of the United Kingdom, whose territory is a small fraction of Canada's. A glance at a demographic map also confirms the extremely uneven way in which its population is distributed. The overwhelming majority of Canadians live in the southern portion of the country, mostly concentrated within a relatively short distance of the long border separating it from the United States. The vast hinterland to the north is sparsely settled, with huge tracts inhospitable for physical and climatic reasons to permanent human settlement on a large scale. The sheer physical size of the country, combined with the uneven pattern of settlement, has obvious implications in a wide variety of public policy areas, notably the cost of maintaining adequate transportation and communications infrastructures, and for meeting the objective of providing quality services to people wherever they may live.

Ethnically, culturally and linguistically, Canadians are a diverse people. Aboriginal inhabitants comprise roughly 3 percent of the population, while the balance is made up of the descendants of the original French-speaking European settlers, of English-speaking colonists who followed, and then of waves of migrants from all quarters of the globe. Since 1951, foreign-born Canadians have accounted for around 16 percent of the total population, with their concentration ranging considerably higher in the large urban centres which attract the most immigrants. However, while through this period the proportion of foreign to native-born has remained quite steady, the composition of the immigration movement has changed from one dominated by Europeans to one where Asians, Latin Americans, and Africans represent about 65 percent, with Asian predominating. It is reasonable to conclude that the growing diversity of Canada's population will result in a continued call for greater attention to culturally sensitive programs in the health and social service sector generally.

Canada is a federal state composed of 10 provinces and two territories. It has two official languages, English and French, and is governed as a parliamentary democracy. In common with other industrialized nations, Canada has not adopted explicit population policies. Instead, Canada has articulated separate groups of policies, programmes and legislation concerning employment, immigration, health, income security and

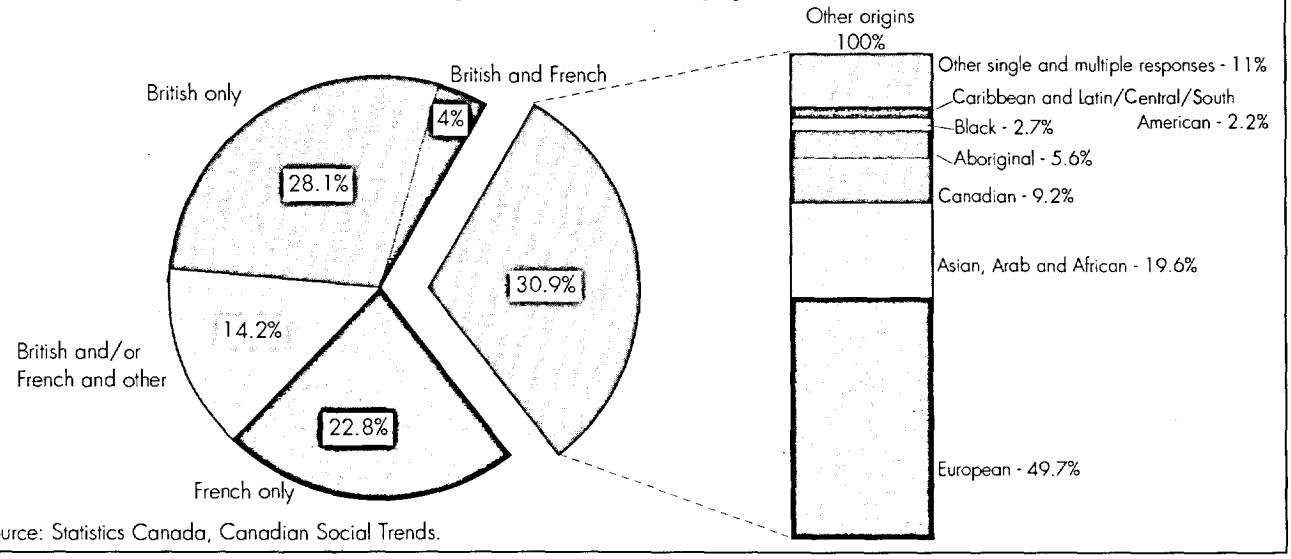
social welfare which constitute the main elements of implicit population policies. A possible exception to this general absence of an explicit overarching approach to demographic issues should be noted in the case of Quebec. With its seven million people, Quebec represents one-quarter of Canada's population. As a province, desiring to preserve its linguistic uniqueness, Quebec has always placed demography among its chief concerns. While the rest of Canada's population is 80 percent English-speaking, Quebec's is 82 percent French-speaking. In addition, 85 percent of Canada's Francophones live in Quebec. As North America's only Francophone society, Quebec has always viewed demography as central to its concerns as it has sought to preserve its relative importance within Canada. Its governments have adopted specific policies concerning families and immigration that are quite different from the other provinces.

On the basis of the size of its economy and average income per capita, Canada ranks among the most prosperous of the world's developed countries. National statistics, however, mask sharp regional disparities in wealth and employment opportunities. A crucial challenge of Canadian federalism is the alleviation of regional inequities through fiscal policies and economic programs aimed at assisting the less prosperous provinces.

A similar observation applies in the health field. Canada enjoys a well-founded reputation for the outstanding quality of its health-care system, in terms both of professional standards and accessibility. On a national basis, its record in reducing maternal and infant mortality is exemplary. Nevertheless, the situation can certainly not be described as universally satisfactory. Access to health services is often a problem for those residing far from major centres, especially for native people living in remote settlements. Among aboriginal people, life expectancy rates, although improving, fall short of national levels. And the same holds true to a lesser degree among lower-income groups generally, where there is a special requirement for disease-prevention programs and services geared to fostering healthy living habits. The challenges involved in adequately addressing the interrelationships between ill health and poverty are among the most important confronting Canada today.

Many of the programs outlined in the following pages are currently the subject of comprehensive reviews and public consultation processes as announced by the federal government early in 1994. These include income-security programs, the health-care system and immigration. In addition, Canada has embarked on a thorough foreign-policy and defence review, including foreign-aid policy. As reflected in this report, several provinces provided information on their programs and initiatives. As well, it should be noted that several provincial governments have begun reviews of their social programs.

Ethnic composition of Canada's population, 1991



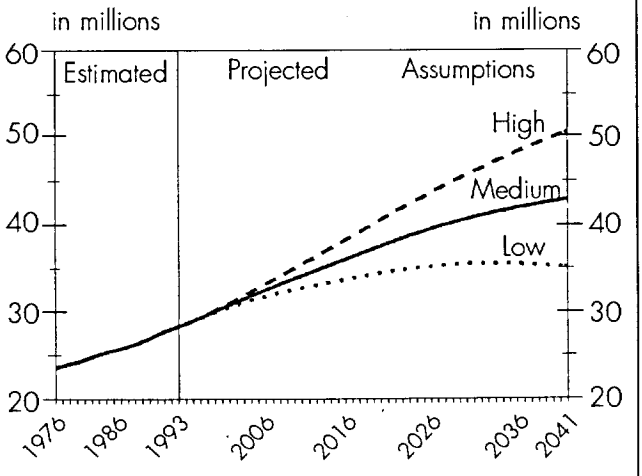
Source: Statistics Canada, Canadian Social Trends.

DEMOGRAPHIC CONTEXT

Population Size and Growth

Canada's population is currently estimated at 29 million. Although historically subject to significant fluctuations, reflecting, in particular, surges in immigration flows, annual population growth in the past two decades has gradually declined relative to that registered in the "baby-boom" period of the fifties, when exceptionally high fertility rates pushed annual growth to 3 percent. At the same time, it is noteworthy that in comparison to other Organization for Economic Co-operation and Development (OECD) nations, Canada's rate of population growth remains strong: at 1.1 percent between July 1992 and July 1993, it was one of the highest in the group.

Canada's Total Population, 1976-2041



Source: Statistics Canada, Demography Division.

Since reaching a peak in 1959, the fertility rate has been declining. Notwithstanding a recent modest reversal in this general trend and higher rates for groups such as aboriginal people, it continues (at about 1.7 percent) well below the replacement level. Assuming this phenomenon persists, immigration will become an increasingly important factor determining population growth in the years to come. Depending on the projection assumptions chosen, Canada's population is expected to reach the range of 32 to 35 million by the year 2011.

The loss of momentum in Canada's population growth resulting from lower fertility rates would not, even in the absence of migration, halt a slow expansion continuing until about 2006. This is attributable to the relatively high number of women of childbearing age among Canadians over the period. Thereafter, as noted, unless fertility levels increase dramatically, the size and pace of Canada's population growth will be largely a matter of immigration volume.

Quebec's population development has been different from that of Canada as a whole. At one time it was able to maintain a growth rate equal to that of the other provinces. This ceased to be the case during the 1960s. Having lost the advantage of its high birth rate, receiving proportionately fewer immigrants than the rest of Canada and with a deficit in migratory interchange among provinces, it was no longer able to maintain a growth rate equal to that of the rest of Canada, and its demographic weight was on the decline.

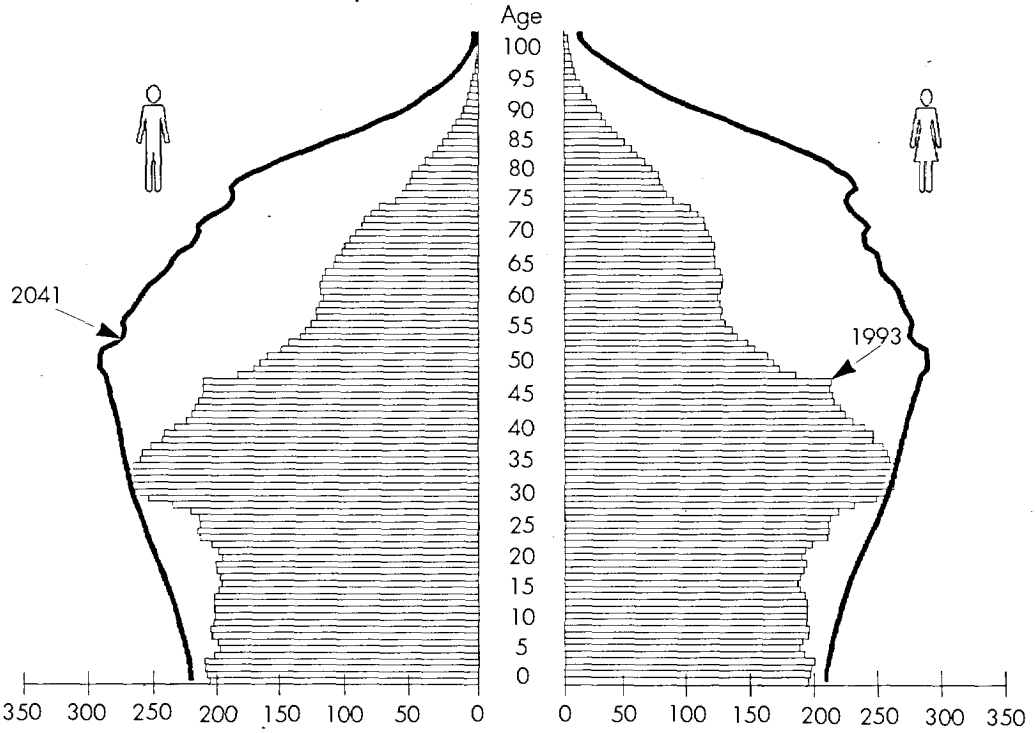
Structure

Changes in age structure are a major factor shaping the characteristics of tomorrow's society. In Canada's case, the ageing of its population is accelerating as a necessary consequence of the decline in fertility combined with improvements to health. In this, the Canadian situation is now more similar to that of most other OECD countries. That was not always the case; 20 years ago, for example, the number of persons in Canada aged 65 and over represented about 8 percent of the total population, at the low end of the scale in comparison to other OECD nations. Today, the corresponding figure is about 12 percent, approximately average for the group. Under reasonable assumptions, the proportion of Canadians aged 65 and over will double in the next 35 years or so, to roughly 25 percent of the population, and the proportion of people aged 85 and over will quadruple.

The extent to which this phenomenon will represent a burden on social programs, the capacity of Canadian society to adjust to the challenges involved, and the changes to public policies that may be called for, are all currently subjects of study and debate.

As far as public expenditures are concerned, the impact of the ageing population falls principally on three major social programs: health, education and pensions. Clearly, an analysis of the future "affordability" of these costly programs is beyond the scope of this report. The whole field is immensely complex and strewn with uncertainties. Among the latter are such crucial questions as the policies that may be adopted by federal and provincial governments in response to their fiscal situations, or the assumptions to be applied regarding the trend of female participation in the labour force (which has risen from one third of the male rate in 1960 to nearly four fifths in 1993) and the effect this will exert on dependency ratios. Nevertheless, some authorities (including experts at Statistics Canada) argue that the public costs of an ageing Canadian society may not be the central issue. What may be predicted with some confidence is that significant shifts in the relative costs of social programs will occur. Thus, it is likely that in 50 years education could come to represent only about 20 percent of the expenditures on the three major social programs, as compared to some 40 percent today. This expenditure does not include adult education, training and lifelong learning, which could possibly experience significant growth.

Population of Canada, 1993 and 2041



Source: Statistics Canada, Demography Division.

The prospect that the elderly will account for an unprecedented proportion of society will demand from Canadians unprecedented responses across the political, economic and social spectrum. It will affect the approach to health care, with, among other things, greater emphasis accorded to the prevention of, and care of those with chronic disease. More flexible retirement policies and alternative living arrangements will become increasingly desirable. It will be necessary to learn how best to take full advantage of the experience and energies of a larger cohort of healthy older people who are equipped to make a valuable contribution in the workplace and in other fields. Innovations in pension strategies will be inevitable. Above all, stereotypes about the place of older people will need to be replaced by attitudes and policies favouring new and creative roles for them in the Canadian society of the future. At the level of government, and among opinion-makers generally, the challenges involved in addressing this profound demographic change effectively are receiving increasingly systematic attention.

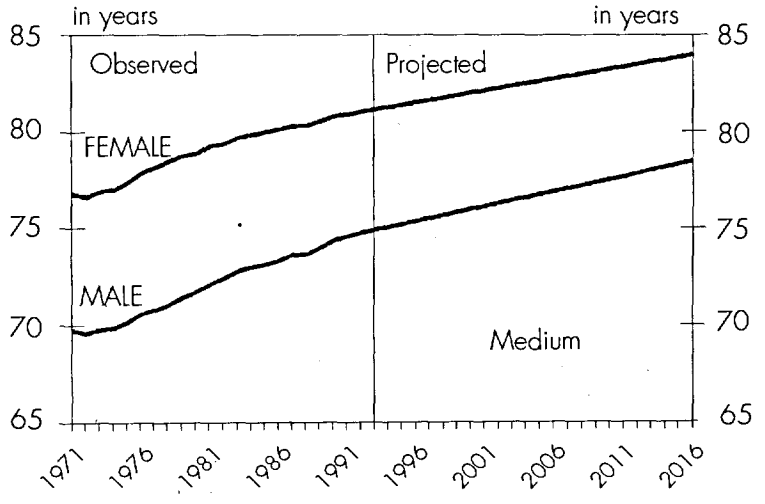
Quebec, for its part, will be faced with another considerable challenge. If birth rates remain at current levels, and if the numbers of immigrants from the various countries of origin received there remain the same in the medium and long term, the resultant ethno-cultural diversification will present a major challenge to the province in terms of language.

Mortality

Over the decade 1980-90, the mortality rate fell by an average of 1.5 percent annually for men and 1.3 percent in the case of women. This has yielded a current life expectancy of 74 years for men, and 81 years for women. The comparable figures in 1931 were 61 and 64. Since 1950, infant mortality has declined steeply. From a level of 41.5 per thousand, it currently stands at about six deaths per thousand live births.

Among Canadian adults, the majority of deaths are due to chronic diseases. Coronary heart disease ranks first, followed among men by lung cancer and stroke; and, among women, by stroke and breast cancer. Lung cancer remains one of the leading preventable causes of death in Canada. Reflecting the changes in smoking habits between men and women, deaths due to lung cancer have shown little change during the past decade; although death rates for men have been declining slightly but regularly, female deaths due to lung cancer are on the rise. Generally speaking, mortality due to chronic disease has decreased over the past 15 years. Exceptions to this trend include deaths due to malignant melanoma and prostate cancer. Among respiratory illnesses, pneumonia is the chief cause of death.

Life Expectancy at Birth, Canada, 1971-2016



Source: Statistics Canada, Health Statistics Division and Demography Division.

OVERVIEW OF THE HEALTH CARE AND SOCIAL WELFARE SYSTEM

Canadians are justly proud of the accessibility and quality of the health-care services they enjoy. This century has witnessed steady progress in the evolution of Canadian public-health programs, and today the system ranks among the finest in the world. More particularly, in the period following World War II, great strides were made toward the establishment of the current system, under which Canadians benefit from universal access to publicly funded insurance, which covers the cost of all necessary hospital and medical treatment.

The same era saw a dramatic increase in measures directed to income maintenance and other social services. These include notably an old-age security program providing a flat rate pension to all people aged 65 and over, the Canada Pension Plan introduced in 1966, which is compulsory for all employed Canadians and protects them and their families against loss of income in the event of retirement, disability and death; child benefit programs designed to assist lower-income families; and the Unemployment Insurance Program.

Constitutionally, the provinces have primary responsibility for delivering health and welfare services. However, the federal government plays a central role in establishing national standards and, through its spending power, in participating in the funding of the system through transfer payments administered under federal-provincial agreements. An important function of these arrangements is to ensure the application of national standards. Federal health legislation, for example, sets out basic principles and conditions for payment of federal contributions to the operation of the provincial plans. These include criteria stipulating that provincial plans must be administered on a non-profit basis; that they must be comprehensive in their coverage; that they extend to all legal residents of each province; and that they must be portable. It should be noted that within this framework the provinces and territories have often taken the initiative in developing and implementing innovative policies and programs which reflect their particular priorities. The federal government also funds national income-security and health-protection programs. It provides sustaining grants to voluntary organizations, which work in partnership with all levels of government to play a vital role in assisting families, youth, seniors, disabled persons and native people.

In addition, the federal government ensures the provision of community health services to Indian people living on reserves, and to Inuit. Although there has been a substantial improvement over the last twenty years, a wide gap continues to exist between the health status of Indians and Inuit and that of other Canadians. This problem is being tackled through a variety of special initiatives addressing such issues as solvent, alcohol and drug abuse, AIDS, and mental health problems. In consultation with Indians and Inuit, work is proceeding toward the transfer of control of the management and delivery of health services to Indian and Inuit communities. The transfer proces serves as an important element of the federal government's commitment to enhancing Indian and Inuit control over their own affairs. Discussions among aboriginal groups, provincial, territorial and federal governments are ongoing about aboriginal self-government. At the provincial and territorial level, the

Government of the Northwest Territories has adopted and is vigorously pursuing the Primary Health Care approach advocated by The World Health Organization (WHO). Government policies have emphasized the development and incorporation of additional health workers into the health system as providers of care and the empowerment of communities in the management of their health services through the creation of regional health boards. In the case of the Province of Ontario, it is working in partnership with Aboriginal organizations to develop strategies to address family violence and health issues through a comprehensive, holistic framework for dealing with the physical, mental, emotional and spiritual health of Aboriginal people in Ontario. The Province of Quebec has noted that, in terms of health, living conditions are clearly improving, thanks to the establishment of health facilities in each community, and to better housing conditions and sanitary infrastructures. However, many communities in all parts of Canada are still facing high rates of mortality, infection, suicide and drug and alcohol consumption. Economically, natives are turning increasingly toward development focused on the surrounding economic markets and networks.

As a percentage of gross domestic product (GDP), health care accounted for about 10 percent in 1991, or roughly US$57 billion annually. Spending on health absorbs up to one third of provincial budgets. To put these substantial figures in perspective, Canada's nearest neighbour, the United States, has been devoting some 13 percent of GDP to health care, or over $2800 per capita. Organizational simplicity resulting in lower administrative costs is a major factor in controlling overall expenditures within the Canadian system. For patients, this simplicity translates principally into a single source of insurance and funding — the public purse; for physicians, into a single negotiated fee schedule and relief from billing problems.

In Canada, there is currently about one doctor for every 450 people. The ratio of hospital beds to population stands at an average of seven beds per 1000. Although this ratio has remained fairly constant over the last decade, a shift has occurred in the mix of short-stay versus long-stay beds; an increase in the latter has been caused by the need to care for the growing number of elderly patients. The human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) remains a major public health concern in Canada, and the National AIDS Strategy provides a framework for action in AIDS prevention and control.

The National AIDS Strategy was announced in June 1990, with funding for the first phase totalling $112 million over three years. This phase has resulted in the creation of the basic infrastructure required to address HIV/AIDS issues, including: a better definition of the epidemiology of HIV transmission; a national capacity to facilitate the testing of new drugs entitled the Canadian HIV Trials Network; an improved capacity for international co-operation; and a cross-Canada, community-based network to deliver prevention education, health promotion, community care and support initiatives more effectively and efficiently than could be done by governments alone.

The Strategy was renewed in March 1993, with a financial commitment of $203.5 million over five years. This phase reflects the evolving nature of AIDS, and emphasizes the need to strengthen and enhance existing partnerships — between governments, non-governmental organizations (NGOs), the private sector and the community.

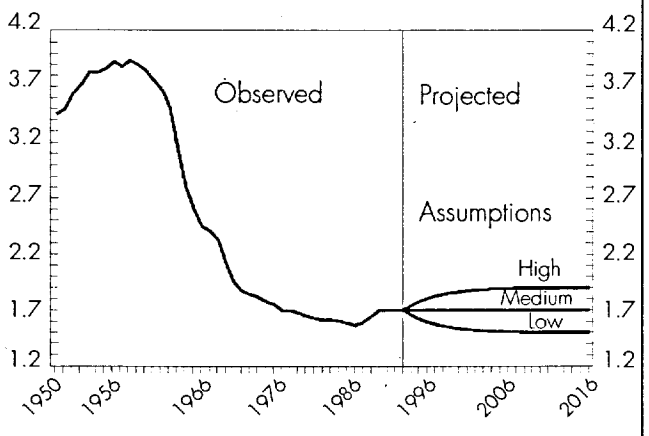
Canada has been involved in the development of multilateral HIV/AIDS prevention and control policies since the establishment of the World Health Organization Special Program on AIDS, and continues to contribute to international efforts to combat the disease. Canada has consistently advocated an integrated intersectoral approach to AIDS issues, the adoption of non-discriminatory measures against people with HIV infection and AIDS, and a greater inter-agency co-ordination on AIDS matters within the United Nations (UN) system.

A cardinal principle that has shaped Canada's health-care system, which continues to inform the approach to policy, is one of partnership among levels of government, NGOs, and volunteer organizations. Recent initiatives, corresponding to a shift in focus toward disease prevention and the promotion of healthier lifestyles, have all depended on utilizing this approach to the fullest advantage. They include strategies to combat substance abuse and smoking, to promote health and the environment, and to prevent HIV/AIDS. To implement these initiatives, partnerships were developed among federal, provincial and territorial authorities, NGOs, health providers and research organizations.

FAMILY PLANNING AND SEXUAL AND REPRODUCTIVE HEALTH

Fundamental to Canada's approach to the field of family planning is the recognition of the right of free individual choice concerning the number and spacing of children. Family planning is situated within the larger context of sexual and reproductive health. It has evolved from a concentration on the number and spacing of children to encompass the protection of sexual health, the promotion of healthy sexuality, the prevention of reproductive tract diseases, and care in the form of appropriate treatment and services. Canada does not currently have either quantitative fertility nor family-planning targets. The provision of sexual and reproductive health services falls primarily within the jurisdiction of provincial governments, and delivery varies regionally.

Number of Children per Women
Canada, 1950-2016



Source: Statistics Canada, Health Statistics Division and Demography Division (Total Fertility Rate).

In Canada, there have been no legal restrictions on the use of contraceptives since 1969. The quality of contraceptive drugs and medical devices is regulated under the Food and Drugs Act. The restrictions on abortion previously existing in the Criminal Code were removed in 1988, and there are currently no restrictions on abortion other than those imposed by standards of medical practice. Every province and territory in Canada currently provides for insured coverage of medically necessary abortions, although access varies both within and between individual provinces.

In keeping with Canada's approach to family planning and sexual and reproductive health, governments generally provide information about the purpose and methods of family planning, the prevention of sexually transmitted diseases and the promotion of healthy sexuality. These programs also promote research concerning sexual and reproductive health, and the prevalence and prevention of sexually transmitted diseases and their negative sequelae. The federal government is also providing financial assistance to selected national offices and toward activities of national voluntary associations active in the field of sexual and reproductive health.

A Royal Commission on New Reproductive Technologies was established in 1989 to "...inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the

public interest, recommending what policies and safeguards should be applied." The Commission's work had two main components: firstly, the gathering of information and consulting about the issues surrounding reproductive technologies and, secondly, research and evaluation. Its report, which was published late in 1993, provides interested Canadians and their governments with an ample base of information and analysis for further consideration of the important questions involved.

The concerns surrounding reproductive technology are not confined to the care and treatment of the estimated 7 - 10% of Canadians unable to conceive and bear children when they wish. The causes of infertility are sometimes known and can be prevented — in cases, for example, resulting from sexually transmitted diseases. Generally Canadian reproductive health indicators reflect a high standard of care and access to services. However, statistics for sexually transmitted diseases and unintended pregnancies indicate that there are significant gaps in addressing healthy sexuality in certain populations such as adolescents, isolated individuals and aboriginal people.

Awareness is growing that environmental and workplace hazards affect reproductive health in both men and women. Although it is known that the reproductive system is sensitive to the toxic effects of hazardous chemicals, very few chemicals have been adequately studied in this regard. More research is required to assess the specific impact of potential hazards on reproductive health. More research is also needed to evaluate the effects of combinations of chemicals over the long term, taking into account individual biological make-up and lifestyle.

The federal government seeks to provide leadership and expertise by acting as a catalyst to promote co-operation among governments, professional groups, health-care organizations and the voluntary sector. Recent initiatives in the field of reproductive and sexual health include the development of sexual health education guidelines, as well as the distribution of publications on sexually transmitted diseases, adolescent reproductive health, and guidelines to prevent child abuse.

In addition, a federal/provincial/territorial advisory committee on population health has recently been established to advise the Conference of Deputy Ministers of Health on national and interprovincial strategies that should be pursued to improve the health status of the Canadian population, and to encourage a more integrated approach to health programs.

FAMILIES

Societal changes affecting the family have had an impact on the development of programs in the field of maternal and child care and support to youth. Since the turn of the century, Canadian families have undergone dramatic changes. The interdependent and largely self-sufficient family is now a thing of the past. In today's industrialized, overwhelmingly urbanized and mobile society, the typical family has not only become much smaller but has radically altered in other respects as well. For example, less than 14 percent of Canadian families now conform to the traditional pattern of two parents and one breadwinner. In more than 60 percent of two-parent families, both parents work outside the home. The number of single-parent families is on the rise (now 13 percent) and most of these are headed by women. Of women with children under the age of six, 58 percent are in the labour force. One half of all divorces involve families with children, while the rate of marriage continues to decline with a corresponding increase in common-law unions.

Family violence is a matter of great contemporary concern. Violence or abuse, whether it be physical, sexual, psychological or financial, affects all groups, but women, children and seniors are particularly vulnerable. It is being increasingly recognized that adolescents are also a high-risk group. The first federal initiative to address family violence, taken in 1988, concentrated on raising awareness of the need for preventive measures, and the creation of more effective protection and treatment services for victims.

A second four-year initiative was launched in 1991 to mobilize individuals and communities to prevent violence and, by forming partnerships, to improve the capacity of the health, social service, and justice systems to help victims and stop offenders. It also focusses on establishing shelters for abused women; sharing resources and knowledge; and creating a database on the extent of violence. Special attention is being devoted to the needs of those most vulnerable, or those for whom services are less accessible, including the disabled, minority groups, aboriginal people, and people living in remote and rural areas. The costs of many of the services involved in these projects are shared by the federal and provincial governments through the Canada Assistance Plan, which also funds foster homes and special-care establishments such as shelters for the victims of family violence and rape crisis centres. In 1993, the Canadian Panel on Violence Against Women released its findings and made recommendations for action.

An example of provincial efforts in this area is the Wife Assault Prevention Initiative and the Sexual Assault Prevention Initiative coordinated by the Ontario Women's Directorate. At present, the two initiatives fund 68 programs in nine ministries. The initiatives deliver programs in three areas - services, public education, and prevention and justice. Currently, the Government of Ontario is reviewing the two initiatives with a view to integrating them into a Violence Against Women Prevention Strategy that will address this issue in a coordinated, accountable and accessible manner.

The special challenges involved in caring for and protecting children in today's world are being met through a broad range of services provided by both government and non-governmental sources. The federal government supports a broad-ranging program, undertaken in 1992, to advance the interests of children. This initiative, called Brighter Futures, is based on four principles: early intervention, partnerships among all sectors of society, the primary importance of children and parents, and the targeting of support to those in greatest need.

In addition to federal funding for the program, a number of support services are cost-shared with the provinces through the Canada Assistance Plan. Municipalities are also engaged in support of families, providing community centres and a variety of outreach programs. As well, several voluntary organizations are devoting increased efforts to meeting the needs of children, furnishing homemakers and home support counselling, rehabilitation and adoption services. Of special importance are measures to protect abused or neglected children. Reflecting a growing trend toward collaboration between NGOs in pursuit of a specific objective, the Canadian Coalition for the Rights of Children unites more than 50 organizations in the common cause of support for children's rights.

An example of provincial efforts in this area is Quebec's family policy which rests on the following principles: recognition of the family as a basic collective value, cohesion and stability of the family, parental responsibility and the interests of the child. Its government takes the reality of the family into account in a number of areas, including economic support for the costs of child rearing, housing, organization of work, relations between school and family, social and health services, and family law.

AN OVERVIEW OF THE IMMIGRATION PROGRAM

The Government of Canada has begun a thorough review of all immigration policies and programs. To place this review in context and to provide background for the outline of existing immigration programs and policies that follows, it is appropriate to consider the following excerpts from a statement by the Minister of Citizenship and Immigration in presenting the Annual Report to Parliament, Immigration Plan 1994:

> "Immigration policy represents one of the most important and complex challenges facing Canada today. It is, perhaps more than any other area of public policy, closely tied to our history — to the development of our values, our cultural diversity, the regional and economic dynamics of our nation. It will, in the long run, help to determine the character of our country in the years ahead."
>
> "I am committed to an open and progressive immigration policy. Canada's immigration policy should not be about closing doors to those who need our help. It should not be about barring the way to those who can help our country grow stronger. Our government is determined to maintain a dynamic immigration program — a program that will achieve the fundamental social, humanitarian and economic objectives set out in the Immigration Act."
>
> "Periodically throughout our history — especially during economic downturns — there have been calls to slam the door shut to immigration. That sentiment, at times, has been translated by governments into restrictive laws and policies. I believe that such sentiments indicate a lack of vision of what this country can become. I believe that if such sentiments had prevailed in the past, Canada would be a much lesser country than it is now. Canada would not have flourished and progressed if we had locked ourselves into a restrictive mind-set that excluded the people who have helped make us grow and prosper."
>
> "The Government's election campaign document (the Red Book) identified a pressing need to develop effective international means to manage the displacement of over 20 million people by war, persecution and natural disasters. The root causes of such movements — racial, religious and ethnic intolerance, poverty, and political repression — must be dealt with through concerted multilateral action."
>
> "I believe it is vital that we develop co-operative approaches to address this need. In response to increasing migration pressures, many countries have acted alone and simply closed their front doors — only to find more people trying to gain entry illegally through back doors. This approach also increases, unfairly, the number of people who arrive on the doorsteps of those nations whose doors are still open."

"More international co-operation is needed in order to resolve these matters. For many years, Canada was recognized as a leader in fostering international co-operation to help refugees. I want Canada to maintain our position of leadership on this critical humanitarian issue. That is why we continue to advocate strongly in the international arena for the need to maintain support for the role of the United Nations High Commissioner for Refugees."

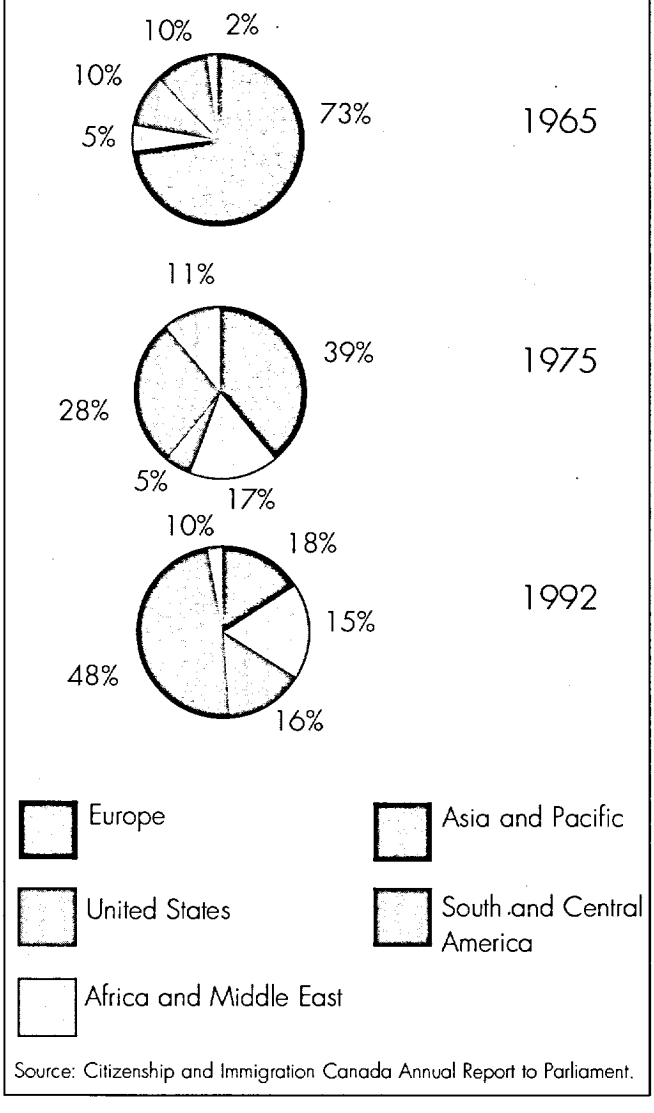
Canada and the World

Growing numbers worldwide are looking to the developed world for aid and, increasingly, for safe haven and economic opportunity. A number of factors have combined to compel or encourage an estimated 100 million people to seek better lives in other countries, often outside regular immigration channels. The impact of "migration pressures" in Europe and North America, while pronounced, is only beginning to be felt. In addition to contributing to the protection of refugees, Canada will increasingly be called upon to participate in international efforts to address the root causes that push people from their homes. With a long experience of enlightened stewardship in refugee matters, and a sustained policy of managed immigration, Canada is uniquely positioned to assume a leadership role.

As the United Nations High Commissioner for Refugees (UNHCR) has noted, the irregular migration flows the international community is experiencing are complex. As a result, it is becoming more difficult to distinguish between refugees in need of protection and migrants motivated by other factors. Irregular migration challenges us to alleviate socio-economic conditions that compel people to leave their countries, as well as to avert conflicts and human rights abuses that produce refugees.

The government takes the view that two basic responses are required of governments in the face of the challenge of irregular migration. Firstly, active immigration programs and refugee protection systems are needed to manage migration effectively, efficiently and in a humanitarian way when it does occur. Canada is one of the few countries in the world today that operates a planned and active immigration program. Hundreds of thousands of people from all corners of the world are provided with a "legal" opportunity each year to make a new life for themselves and their families in Canada. Each year we afford protection and an opportunity for permanent resettlement in Canada to thousands of the world's refugees. We also provide funding to the UNHCR, and co-operate with other nations under its auspices, to relieve the suffering of many thousands more of the world's refugees who have been forced to leave their homes for safety and protection.

IMMIGRATION BY SOURCE AREA: 1965, 1975 AND 1992



Source: Citizenship and Immigration Canada Annual Report to Parliament.

Secondly, because the limitations of a purely curative approach to the problems created by irregular migration are increasingly obvious, governments must increasingly

turn their attention to prevention. They must pool their energies and co-ordinate their actions to improve the conditions that are leading to the increase in irregular migration. Basically, they must work together to improve the "stay" option in countries with high emigration potential.

This will require new efforts and new approaches to long-standing challenges of development, human rights protection, population stabilization, military/arms spending and environmental protection all of which have an impact, direct or indirect, on emigration pressures and forced migration. Comprehensive and co-ordinated strategies are needed to make the "stay" option a viable alternative to flight. Given the range of internal and external factors fuelling irregular migration, such strategies, if they are to succeed, will require the co-ordinated application of a broad range of foreign and development policy interventions, including trade, aid and good governance initiatives. It is in everyone's interest to work toward a future when everyone has the choice of staying in their homeland with the hope of a secure, safe and sustainable future.

Federal-Provincial Relations for Immigration

While the federal government exercises primary responsibility for immigration, it shares jurisdiction in this area with the provinces. Under the Immigration Act, the following are stipulated:

- requires consultations with provinces on immigration levels and on settlement measures;
- provides for federal-provincial agreements to facilitate the formulation, co-ordination and implementation of immigration policies and programs; and
- limits the authority of the federal government to the extent that provinces have selection powers (currently, Quebec is the only province with such powers).

Immigration agreements are currently in place with seven provinces (all but Ontario, British Columbia and Manitoba), dating from the period 1978-85. They establish formal mechanisms for the provinces to express their views about levels, research and general immigration policies. In addition to these mechanisms, the agreement with Alberta provides for a larger consultative role and for co-ordination between federal and provincial settlement activities. In February, 1991, Quebec signed the most comprehensive agreement to date. The Accord specifically gives Quebec sole responsibility for selecting independent immigrants (with joint responsibility for selecting assisted relatives) and refugees abroad, as well as for providing basic integration services (linguistic, cultural, economic) for permanent residents of Quebec.

In December 1990, the Quebec government adopted a policy of immigration and integration, followed by an action plan in June 1991. The policy rests on the following objectives: demographic recovery of Quebec, economic prosperity, perpetuation of the French fact and openness to the rest of the world. From this perspective, its selection of immigrants aims to increase the percentage of immigrants who already know French; maximize economic spinoffs by the selection of independent immigrants; uphold family reunification and international adoption; receive refugees under the principle of international solidarity; and increase immigration volumes in accordance with needs and ability to receive. To this end, it has developed a series of instruments, including increased presence of its immigration services in about ten countries, and targeted itinerant missions enabling it to adjust its selection to suit the pace of international migratory movements.

Review of Canadian Immigration Program

Objectives

There are three main objectives of the immigration program set out in the Immigration Act. These are:

- family reunification;
- fulfilling Canada's international legal obligations and compassionate and humanitarian traditions with respect to refugees; and

- fostering a strong and viable economy in all regions of Canada.

These objectives are supported by the three main components of immigration: family class, refugees, and independent (economic) immigration.

Selection Criteria

The immigration program is subject to the Canadian Charter of Rights and Freedoms. This means that immigrants must be selected without discrimination regarding race, national or ethnic origin, colour, religion or sex. All selection criteria are universal: an applicant in one part of the world is assessed against the same criteria applying to his or her particular immigrant class as an applicant in any other part of the world. All immigrants, regardless of the type of application, must be in good health and of good character. In addition, applicants must meet the criteria relevant to their specific category.

Family Class

Family class applicants are "self-selected" — that is, they may qualify to come to Canada on the basis of their close relationship with a family member already in Canada, who agrees to sponsor the applicant for up to 10 years. The sponsorship undertaking is an enforceable agreement to provide the necessities of life. Sponsors, other than sponsors of spouses and their dependent children, must meet minimum income requirements. No one can sponsor if he or she is in default of another sponsorship undertaking.

Refugees and Designated Class Members

Successful in-Canada refugee claimants are eligible to be granted permanent resident status. In addition, refugees and members of designated classes — people in refugee-like situations — are admitted from abroad. Their ability to become successfully established in Canada is assessed by an informal review of the factors in the immigrant selection system.

Refugee Women

In recognition of the special problems faced by refugee women, Canada has developed and promoted international measures designed to respond to their needs. For example, Canada was the first country to institute a special refugee program, known as "Women at Risk". This program assists refugee women in particular need of protection.

Skilled Workers

The independent immigrant selection system, or "point" system as it is often called, assesses factors such as age, education, knowledge of one or both of Canada's official languages, specific vocational preparation, job training, occupation, arranged employment or designated occupation.

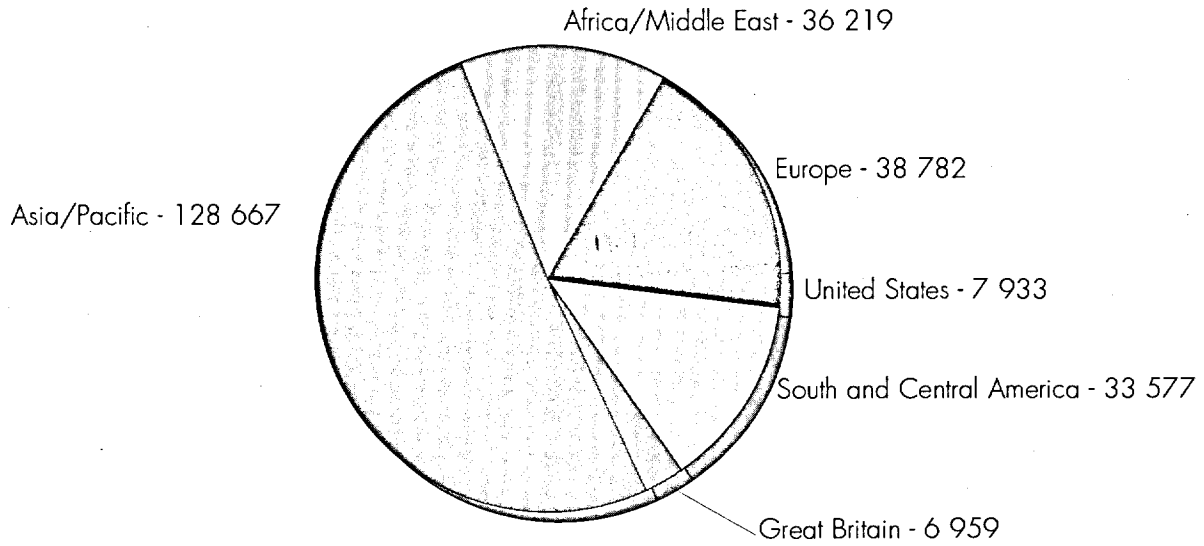
Business Immigrants

Business immigrants comprise investors, entrepreneurs and self-employed persons. Investors and entrepreneurs are admitted on the basis of an approved investment, or the applicant's ability and commitment to manage a business that will create or maintain jobs for Canadians. Self-employed persons, a small part of the program, are required to contribute significant economic or other benefits to Canada; there is no job-creation requirement.

Immigrant Sources and Destinations

In 1965, about 85 percent of immigrants to Canada came from Europe and the United States. Today, people from those areas represent about 20 percent of immigration, while about 50 percent come from Asia. The change reflects the non-discriminatory nature of immigration policy, which is consistent with the Charter as well as changing pressures to migrate. The share of Canada's immigrants from various world areas reflects, more or less, those areas' shares of the world population, although Asia is slightly under-represented and South and Central America are slightly over-represented.

Immigrants Landings by World Area - January to December 1993



Source: Citizenship and Immigration Canada.

Principal Source Countries

The top five source countries for immigration in 1993 were Hong Kong, India, Philippines, Taiwan, and People's Republic of China.

Provincial Destinations

Ontario is the original destination of about half the immigrants to Canada followed by Quebec and British Columbia; the Prairies; and the Atlantic region and the Territories. Ontario is also an important secondary destination; up to eight percent of immigrants who first go to other provinces eventually move to Ontario.

Metropolitan Destinations

About 60 percent of immigrants settle in three cities: Toronto, Montreal and Vancouver. Ottawa-Hull, Edmonton and Calgary account for almost another 10 percent. In all provinces but Ontario, the major metropolitan area receives some 90 percent of the province's newcomers. Toronto receives about 57 percent of immigrants destined to Ontario.

Immigrant Integration

An essential part of a successful immigration program is the effective integration of newcomers into Canadian society. Integration is a two-way process that requires adaptations on the part of newcomers and acceptance and accommodation by Canadians. In 1993, an exercise was initiated to examine the best ways to achieve integration. This work will continue, and more opportunities for involvement of interested and affected parties will be provided. Preliminary feedback from the many partner groups that were approached as part of the review exercise has resulted in a number of new policy directions, which will be pursued over the coming years.

For its part, the Quebec government has introduced the concept of the "social contract," an expression of the reciprocal obligations of immigrants and the society. Immigrants and members of cultural communities are expected to adhere to the democratic values of Quebec society on the one hand, and on the other, to be willing to understand their host society and to develop a sense of belonging to it. The society and its government must in turn recognize each person's right to live in accordance with his or her own values. They undertake to promote attitudes favourable to immigration and to the diverse

origins of immigrants, and to uphold rapprochement among communities. This moral contract is now part of Quebec's activities in matters of selection, reception and integration.

Our knowledge base of information about how best to facilitate integration will be expanded through new research and demonstration projects. Policy work will promote co-operation in addressing the question of labour market access for newcomers, particularly with respect to the problems associated with barriers to recognition of foreign skills and basic labour market orientation needs. More emphasis will be placed on public education policies concerning integration and immigration in general. Government leadership in this area can go a long way toward creating a more welcoming environment for new arrivals. The potential for further co-operation in the area of immigrant integration and newcomer settlement between the federal government and provincial governments will be developed. This work will focus on the elimination of any overlaps in services and better role clarification in the interest of good client service. Finally, the links between immigrant integration and the process of citizenship acquisition will be better defined. It should be noted that under the Canada-Quebec Accord, the federal government has withdrawn from providing integration services in Quebec, which is now the responsibility of that province. Under the Accord, services provided by Quebec must correspond to those offered in the rest of the country.

INTERNATIONAL CO-OPERATION IN THE FIELD OF POPULATION

Perspectives on Major Population and Development Issues

Population growth, movements and composition shape the very nature of a society's development. Population dynamics, in turn, are conditioned by the environmental, social, economic and political contexts. Efforts to better understand these complex relationships must be pursued, and this knowledge must be integrated into strategies for sustainable development.

People are the core of development, its driving force and primary beneficiaries. Satisfying human needs and improving people's quality of life are the fundamental thrust of development. At the same time, rapid population growth is a serious challenge to sustainable development and improved quality of life for both individuals and groups. Rapid population growth can delay or even reverse essential social development, and puts pressure on the economic infrastructure, employment-generating capacities and efforts to combat poverty. It exerts pressures on the bio-physical environment that will be compounded as developing countries increase their standards of living and per-capita consumption.

Population pressures are most effectively addressed by the mutually reinforcing effects of social development (such as female education, improved women's health, modern labour force participation and decreased infant and child mortality), and quality family-planning services. Family-planning services furnish the information and technology needed to realize reproductive choices.

In the past, the major population challenge was the creation of demand for family-planning services. Presently, the expressed need for family-planning services in developing countries outstrips the supply. This imbalance between need for services and supply of resources will grow considerably over the next decades, as large numbers of children and young adults move into their reproductive years. Meeting this need would have a significant impact on addressing population pressures. It would facilitate the achievement of sustainable development objectives, and would contribute to improving the situation and status of women.

It has become clear over the last two decades that the quality of family-planning services needs to be improved and expanded to reflect the broader context of reproductive health care. The latter also includes education and counselling on sexuality and infertility; prevention, screening and treatment of diseases and infections of the reproductive tract (in particular sexually transmitted diseases which increase susceptibility to AIDS); prenatal care; supervised delivery; post-partum care; promotion of breastfeeding; and infant health care.

While AIDS might have significant impact on some segments of the population in some geographic areas, it will have a limited impact on overall population growth in developing countries. AIDS, however, has clearly defined the social and human costs of not including reproductive health services such as the screening and treatment of sexually transmitted diseases in previous family planning programmes. In addition to their

relationship with AIDS, sexually transmitted diseases (STDs) are a serious problem in themselves; prevention, diagnosis, and treatment of STDs should be associated with family planning programs.

Improvements in the quality of services, oriented to meeting clients' broader needs, has led to increased demand and continued use of family planning. There is growing evidence that population programs focusing on helping people meet their own reproductive goals, rather than on attaining national demographic targets, could be more successful than target-driven programs.

Because population growth is the cumulative result of individual reproductive choices and behaviours, it is not solely a macro-issue critical to sustainable development. It is just as critically a human rights, health and gender issue.

Both men and women have a fundamental human right to raise a family and to control their own reproductive behaviour, and services should be made available to both sexes. Changing attitudes and behaviours of men, including youths, regarding their responsibility for their sexual behaviour and its consequences for themselves, their partners and children should be part of the overall objectives of population programs. Nevertheless, the immediate costs of insufficient access to family planning and reproductive health services are still borne mainly by women. Primary and secondary education for girls is a critical factor influencing fertility behaviour, but unplanned adolescent pregnancy too often ends their education. Smaller family size and better-spaced births can make it possible for women, their families and communities to achieve higher returns from female education and employment.

CIDA's policy on Women in Development has been in place since 1984. In 1992, the Agency adopted a new Women In Development Policy Framework for the 1990s. Its goal is to strengthen the full participation of women as equal partners in the sustainable development of their societies. Its objectives closely mirror and complement those on population: to increase women's participation in economic, political and social processes; to improve women's income levels and economic conditions; to ameliorate women's access to basic health and family-planning services; to increase women's levels of educational achievement, and to protect and promote the human rights of women.

Infant mortality levels in developing countries are still about 10 times as high as Canada's, but the comparable maternal mortality levels are dramatically worse: they can be 100 times as high. Effective family-planning and reproductive health services lower the mortality of both mothers and children by reducing high-risk births and women's recourse to unsafe abortions. Unsafe abortions not only lead to high maternal mortality, but also leave even larger groups of women with serious health problems. CIDA does not promote abortion as a method of family planning, but recognizes that women require complete access to the full range of safe reproductive health care services.

Population Co-operation Policies and Priorities

Policy Statement on Population and Sustainable Development:

In the context of its policy on population and sustainable development, CIDA's objectives are:

- to promote a better understanding of the impact of population dynamics on progress toward sustainable development;
- to support the development of policies and strategies aimed at addressing pressures of population on sustainable development;
- to support the provision of comprehensive client-oriented reproductive health care for women, men and adolescents centred on high quality family planning services that include information, education and communication components; and
- to support development programs that emphasize health, education and income generation for women, in order to foster population levels consistent with sustainable development.

To achieve these objectives, CIDA uses a multi-pronged approach:

1. dialogue with our partners in Canada, in the donor community and in developing countries regarding population dynamics, policies and programs;

2. in-house capacity strengthening to better integrate population considerations into CIDA policies and programs;

3. support to capacity development initiatives in developing countries related to data collection and analysis, policy formulation and program design at national and regional levels;

4. support to information, education and communication programs on population issues;

5. support to programs and activities related to reproductive health care, on the following basis:

   a) CIDA promotes family planning based on free and informed choice, enabling individuals to exercise, in a safe and responsible manner, their reproductive rights;

   b) CIDA provides support to culturally sensitive, client-oriented and high quality family planning programs that build toward full reproductive health care, with due attention to the role and responsibility of men;

   c) CIDA does not promote abortion as a method of family planning, but recognizes that women require complete access to the full range of safe reproductive health care services.

   d) CIDA promotes respect for human rights in the provision and development of contraceptive drugs and devices, giving primary consideration to user safety and client needs, with due regard to licensing regulations in countries of use.

6. utilization of various service delivery channels public, private and voluntary sector; given the necessity to relate directly to community needs, nongovernmental organizations, both national and international can play a very critical role in population cooperation.

7. continued support to population-related programming conducive to sustainable development, particularly the education of girls and women and other measures enabling women to exercise wider choices and have greater control over their lives.

Programming and resources allocation decisions with regard to population assistance will be made through CIDA corporate planning cycle exercise.

Co-ordination

CIDA will continue to pursue co-ordination with other donors, both at the international and country levels. CIDA will also work more closely with its Canadian partners, namely Canadian NGOs that are already active in population issues, and those Canadian universities that have considerable expertise in capacity development in demography, health and associated social sciences. Several Canadian provinces also have development assistance programs involving NGOs active in population and development issues. In the years to come, Quebec will continue to contribute to international co-operation programs to improve the status of women and the health and living conditions of less developed countries, to regulate migration, to integrate immigrants and to develop policies and programs suited to countries experiencing population aging.

Trends and Experiences in International Population Co-operation

Canada has provided population assistance since the early 1970s over the full range of population activities: family planning and maternal/child health; basic data collection and analysis; institution building and research in demography and population/development relationships. CIDA's assistance for population grew significantly from the early 1970s through the late 1980s — from $1.5 million in 1970-71 to $12 million in 1980-81 and to a peak of more than $50 million in

1988-89. Initially, support was channelled predominantly through multilateral and international NGO channels, with bilateral assistance growing considerably in the 1980s. Since 1988-89, support has fluctuated, largely according to bilateral program/project cycles. With overall cuts to the Official Development Assistance (ODA) budget in recent years, population assistance declined 30 percent in absolute terms in 1991-92, as well as in relative terms, but has since remained stable.

During the 1970s, population assistance was channelled mainly through the United Nations Population Fund, the International Planned Parenthood Federation and the International Union for the Scientific Study of Population. Bilateral support was also provided to women's income-generating programs in Bangladesh within the larger context of the Bangladesh population program. During the 1980s, support to these organizations and programs continued and expanded to cover a larger number of international and Canadian NGOs. Institutional support to the Latin American Demographic Centre began and continues. Bilateral support in Bangladesh expanded to more direct support for family-planning services, including provision of contraceptive supplies and capacity development in associated logistics and monitoring, and salary support for female family-planning workers. As well, CIDA was an active member of the World Bank Donor Consortium, first via parallel financing and later as a co-financier. During this period, a number of multi-bilateral projects, in both Asia and Africa, were also supported.

In the late 1980s and early 1990s, institutional support to research and education in population and development and to family-planning management information systems in the Sahel was provided to the Centre for Applied Research on Population and Development, and considerable support was made available to the African Census program in a number of Sahelian countries. In Bangladesh, CIDA continued its support to health and family-planning service management and delivery, and developed a gender strategy for the Health and Population program that was adopted by the Government and the Donor Consortium. CIDA also provides assistance to refugees and internally displaced persons. Within CIDA, the International Humanitarian Assistance Program and the Food Aid Centre respond to appeals from UN agencies, the Red Cross movement and specialized Canadian NGOs to provide emergency relief and food aid to victims of conflicts and natural disasters. Funding is provided to refugees and internally displaced persons for care and maintenance and repatriation. In 1993-94, assistance to refugees and internally displaced persons totalled some $135 million.

Since 1970, the International Development Research Centre's (IDRC) total investment in projects explicitly related to population and development research has been over $42 million. The largest category of spending between 1970 and 1972 was on understanding and evaluating the diverse elements that contribute to successful family-planning programs. The highest expenditure period for IDRC of population-related research occurred in the mid-1980s. By 1989, in the face of growing budgetary constraints, priorities for research were being debated across IDRC. At present, population issues are addressed on a cross-sectoral basis within the context of the six themes of IDRC's Corporate Research Framework, namely: Integrating Environmental, Social and Economic Policies; Technology and the Environment; Food Systems Under Stress; Information and Communication for Environment and Development; Health and the Environment; and Biodiversity.

Over its 23-year history, IDRC has supported research on a variety of aspects of population dynamics and their impact in diverse contexts. It has encouraged the discussion of population issues, not just in a demographic framework but within the wider and more complex matrix of people and their social, cultural and physical environments. Major research areas have included the relationship between socio-economic and population variables, a large part of which has been directed to issues such as the determinants of fertility and mortality, and research into the consequences of emerging patterns of migration.

In the 1970s, IDRC emphasized descriptive research to increase awareness of population trends and problems. Census methodologies were established and/or improved in several countries, especially in Africa. Training in quantitative analysis skills was carried out and

networks were established. During the mid-1980s, two areas that drew significant support were "population and agriculture" and "population and health." Studies that were supported developed concepts and methods for the diagnosis of emerging problems and the assessment of policy initiatives. Innovative anthropological, survey and demographic techniques were also investigated.

IDRC's earlier interest in census methodologies has been rekindled more recently through the REDATAM (Retrieval of Data for Small Areas by Microcomputer) project in Chile, which has resulted in the development of a quantitative population database composed of information from more than one source. Various national agencies for statistics and planning in Latin America, the Caribbean and Southeast Asia have shown interest in this innovative package. In IDRC's Health Sciences Division, "population" as a discrete area for attention is part of the division's "reproductive choice" focus. The most significant population-related project currently being undertaken by IDRC is that on the development of a contraceptive vaccine at India's National Institute of Immunology.

Future Policies and Priorities for International Population Assistance

The policies and priorities for international population assistance of the Government of Canada are currently being considered as part of a comprehensive review of foreign-policy including foreign-aid policy. Nonetheless the population sector has been an important one for Canada and is one that can be expected to remain a priority.

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