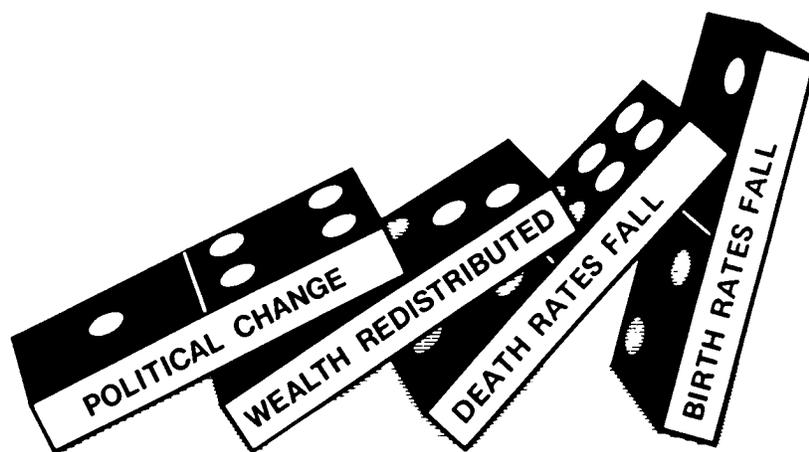


Equity as the Sustainable Solution to Population Growth and AIDS

In this chapter we look at two controversial subjects which relate to a sustainable future for the world's children: the growing global population, and the spread of the HIV virus/AIDS. Attempts have been made to stem the increase of both population and AIDS through technological measures which tend to blame poor and high-risk groups while seeking "behavioral change." In reality, however, it is the imbalance of wealth and power—the exploitation of the weak by the strong—which lies behind both rapid population growth and the rapid spread of AIDS. Only by combating the inequities of society, from the family to the international level, can we hope to achieve a sustainable equilibrium between humanity and the environment and to stem the spread of AIDS.

Is Population Control an Answer to Today's Global Crises?



Take care of the people's problems, and the "population problem" will take care of itself.

– a popular slogan of the 1970s

Nearly all Northern countries that have achieved population stabilization have done so through promoting better quality of life rather than explicitly trying to reduce population growth.

– *Population Policies Reconsidered: Health, Empowerment and Rights*, Harvard School of Public Health, 1994³¹⁰

The high rate of population growth in underdeveloped countries has been called "the most solemn problem in the world."³¹¹ It was the theme of the International Conference on Population and Development (ICPD) held in September, 1994, in Cairo, Egypt. Arguments were put forth that the planet has reached—and in some areas exceeded—its "carrying capacity." Speakers equated the major crises of our times to the rapidly increasing population. These crises included world hunger, growing poverty, landlessness and urban drift, mushrooming squatter settlements, growing crime and violence, huge numbers of refugees, resurgence of cholera, inadequate coverage of health and education systems, and deterioration of the global environment.

Since most growth of the world's population takes place in the Third World, there was a tendency to define the core problem as "the poor have too many children." It was suggested that the ultimate solution to the population crisis, and thus many of the current crises facing

humanity, might require reduction of poverty. But for more immediate action, there was a strong call to step-up family planning (i.e. fertility control) initiatives targeting poor countries and communities.

Rapid population growth is often blamed on the introduction of modern health services, which lower child death rates without a corresponding drop in fertility rates. Many high-level planners insist that *all health services in poor communities must have a strong family planning component*. (In some countries health care providers have been required to recruit monthly quotas of birth control *acceptors*. This has led to many abuses, including unsolicited sterilizations, and refusal to attend sick children until mothers agree to contraception or sterilization.) As pointed out by the progressive women's movement, this disproportionate emphasis on family planning can be counterproductive. For many socially disadvantaged families, having many children is an economic asset, providing the security that society

does not deliver.³¹² In both rural and urban areas children contribute to family income from an early age, and provide support and care in times of parental unemployment, sickness, and old age.

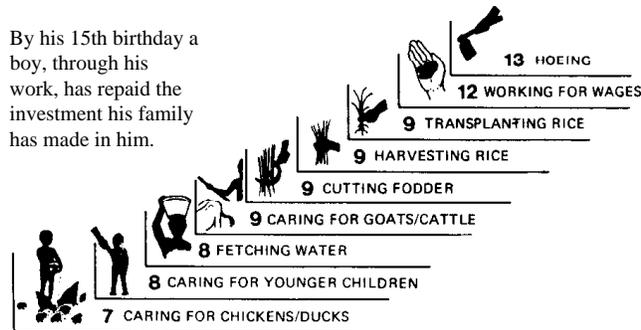


Fig. 3-22 Age of child when activity is started
Should Children in an “Exploding Population” Be Allowed to Die?

Some prominent scientists even question the validity of promoting Child Survival interventions in poor, rapidly growing populations. For example, Dr. Maurice King, an early pioneer of Primary Health Care, agrees that when child mortality rates decline as part of an overall improvement in living standards (as has historically happened in the Northern countries), fertility rates also tend to decline. However, he asserts that when child mortality is provisionally reduced through selected vertical interventions such as ORT and Immunizations which leave poor living conditions unchanged, fertility rates remain high. The combination of lowered mortality and high fertility leads to rapid population growth, which in turn accelerates land scarcity, depletion of ecological reserves, unemployment, malnutrition, and further deterioration of living conditions. King calls this downward spiral the *Demographic Trap*. He warns that, “The life of a child in a trapped community may be preserved technologically in the short term, but only for a miserable and malnourished future and an early death.”³¹³ King strongly criticizes UNICEF for its Child Survival strategy which, he asserts, focuses too much on life-saving interventions without adequately addressing family planning or quality of life.

Redefining the celebrated WHO definition of health, King suggests that “Health is a *sustainable* state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” He asserts that in trapped communities, where “no adequately sustaining measures are possible, such de-sustaining measures as oral rehydration should not be introduced on a public scale, since they increase the man-years of human misery, ultimately from starvation.” Needless to

say, the implications of King’s assertion—to let destitute children die for the sake of the future common good—has led to protests by UNICEF and has triggered heated international debate. Some of Maurice King’s observations are well-founded. Isolated efforts to lower child mortality through selected technological interventions—when promoted in ways that do nothing to improve children’s quality of life—often do amount to merely postponing death and prolonging misery. As we pointed out in Chapter 6, a divergence between morbidity and mortality rates is being seen in a number of countries that have practiced selective child survival strategies. This predictably foreshadows slowdowns and reversals in reduction of child death rates (see p. 40). These patterns provide strong evidence that to achieve a *sustainable state of health* within a society, a comprehensive rather than a selective approach to health care is needed: one that gets at the social and economic roots of poor health, high mortality, and high fertility.

However, King’s assertion that promotion of technologies such as ORT and immunization should be withheld from “demographically trapped” countries and communities is unconscionable. Every child—rich or poor, strong, weak, or disabled—has the same right to live, grow, be healthy, and realize her full potential. Potentially life-saving technologies such as ORT and



Why bother immunizing children only to then starve them?

immunization must be introduced in all communities in need. However, they should be introduced as part of a comprehensive approach which can help families and communities work decisively toward guaranteeing that the full range of all children's—and all people's—basic needs and rights are met.

In virtually all the impoverished communities King speaks of as *demographically trapped*, people are also trapped by powerlessness and oppression. Problems of squalor, landlessness, underemployment, and social deterioration which are often blamed on *overpopulation* frequently resolve themselves—as they did in Cuba—when land, resources, and services are more fairly distributed. Accordingly, when societies begin to make sure that the basic needs of the whole population are met, low income families can afford to have fewer children and see advantages in doing so. Hence population growth rates begin to decline. This decline is evident in many Northern industrialized countries. Those European countries that have adequate minimum wages, universal health care, and equitable social security have approached zero population growth.

By contrast, the United States, for all its enormous wealth, also has colossal inequities (see page 110). Not surprisingly, the USA has a higher birth rate than other Northern industrialized countries which are much more equitable in terms of meeting all of their citizens' basic needs. What is more, as inequity in the US grows, the total fertility rate has been climbing: from 1.8 in 1980 to 2.1 in 1992.³¹⁴

Low population growth rates in some poor countries : examples

We saw that the four states in the *Good Health at Low Cost* study (see page 114) and also Cuba have dramatically reduced child mortality and greatly improved children's overall health and quality of life. They have done this by guaranteeing that all people's basic needs are met.

It is of interest to note that several studies which consider population trends point out that these same five countries with relatively low income inequality (especially China, Kerala, and Cuba) also have substantially reduced their birth rates.³¹⁵ Costa Rica's most rapid decline in child mortality coincided with its greatest decline in birth rate. After 1980 and structural adjustment, however, both mortality and fertility declines halted. Today Costa Rica has a total fertility rate of 3.2, higher than Colombia and Panama.³¹⁶

Some of these countries with low income disparity have had strong family planning programs, while others have not. China has forcefully pushed its "one family, one child" population policy (with frightening results in terms of human rights violations, including widespread killing of female fetuses and baby girls by parents who want a boy). However, Kerala, Sri Lanka, and Costa Rica all have relatively low fertility rates (compared to the average of Third World countries), in spite of less aggressive family planning campaigns.

For example, Kerala—despite being one of the poorest states in India—has not only achieved lower under-five mortality rates and longer life expectancy than other states in India, it also has achieved the country's lowest fertility rate.³¹⁷ (In 1986 Kerala had a birth rate of 22 per 1000 women of child-bearing age, compared to 32 for India as a whole, and 43 as the average for 37 "low income" countries. See figure 3–19.)³¹⁸ Population scientist John Ratcliffe concludes that:

The Kerala experience . . . clearly supports the theoretical perspective that low levels of fertility result from public policies that effectively increase levels of social justice and economic equity throughout society.³¹⁹

Cuba also provides an excellent example of how increased equity coincides with falling birth rates. During the Batista dictatorship, when the gap between rich and poor was enormous and people had few social guarantees, Cuba, like other Latin American countries, had a high fertility rate. As we discussed on page 112, after the overthrow of Batista the revolutionary government introduced one of the world's most equitable systems in terms of meeting all citizens' basic physical needs (if not always their political rights). Social guarantees included: universal, high quality health care and education, universal employment opportunities; adequate housing and sanitation for all; full care for the elderly, equal rights and opportunities for women, etc. Although the "New Cuba" made a variety of contracep-



Fig. 3-23³²⁰

tive methods available, for years it had no policy to promote family planning. Yet during the first decade of the Revolution, the birth rate plummeted dramatically—far more than in those Latin American countries with strong family planning campaigns but few social guarantees for their impoverished masses.³²¹ Today Cuba, with a GNP per capita of only US \$3 per day, not only has the best health status in the developing world, but also the lowest birth rate.³²² Significantly, it now has a lower fertility rate than the United States.³²³

Socioeconomic factors, not birth control, as the chief determinant of birth rates

Many nongovernment organizations (NGOs) and popular movements interpret the current international spotlight on population as an attempt by the privileged elite to forestall global disaster without upsetting the *status quo*. They protest that citing over-population as a cause of under-development is a strategy which blames growing poverty, hunger, and environmental demise on the poor and hungry, rather than on those who consume far more than their share.

However, the wealthy countries and individuals put far more strain on resources and the environment than do the poor. The average person in the US and Europe consumes about 50 times as much of the world's energy and other resources, and creates 50 times as much garbage and toxic waste, as does a poor person in the South.

Aids in the Third World - A Disease of Poverty and Structural Injustice

Those at highest risk are those whose rights are least realized and whose dignity is least protected—from Blacks in the United States to Arabs in France to Koreans in Japan.

—Jonathan M. Mann, first director of WHO's AIDS program

[Mann] is speaking about political issues. I have my hands full with the scientific issues.

—William E. Paul, AIDS research director, US National Institute of Health

— both quotes: *The Boston Globe*, August 10, 1994³²⁶

Any discussion of the impact of economic and political structures on children's well-being (or on the problem of children's diarrhea in the 1990s) would be incomplete without looking at the growing problem of AIDS. On August 9, 1994 at the Tenth International Conference on AIDS, Jonathan M. Mann, first director of WHO's AIDS program, stated that "It is now evident

Progressive women's groups—especially those in the Third World—see the basic issue as one of *Reproductive Rights*. In this view it is not the growing world population but rather today's unfair global economic policies that are the primary cause of the spiraling human and environmental crises on our planet. All women should have control over their own fertility. A wide range of birth-control methods should be available to everyone. But fertility control should be the free decision of each couple or individual, never an obligation.³²⁴

John Ratcliffe has done some interesting macro studies of population trends, comparing fluctuations in growth rates of different countries at different times and under varying socioeconomic and political systems. His studies confirm that fertility rates are determined much more by societal factors than by the presence or relative aggressiveness of family planning initiatives.³²⁵

Those who are genuinely concerned about population growth (as distinct from those who harp on "population" to avoid confronting social injustice as the root cause of our global crises) need to take the above observations very seriously. What they imply is that: Population growth cannot be substantially reduced through family planning programs alone. The only way to bring about substantial and sustainable reduction of fertility rates is through far-reaching social change. Such change entails more equitable systems, with policies to guarantee that the basic needs of all persons are met. Only under conditions of social justice can most people afford—much less experience the advantages of—having fewer children.

that [the current global AIDS strategy is] manifestly insufficient to bring the pandemic under control." According to Mann, "Deep social problems—centering on sexual inequality, cultural barriers to open discussion of sexuality, and economic inequity—underlie the traffic in sex and drugs through which AIDS is often transmitted." Asserting that these underlying social problems must be addressed to contain the disease, Mann acknowledged that he was calling for an effort to "transform society in order to deal with AIDS."³²⁷

One study in Africa has concluded that the global recession and structural adjustment programs (SAPs) "further aggravate the transmission, spread and [inability to] control of HIV infection in Africa in two major ways: directly by increasing the population at risk through increased urban migration, poverty, women's powerlessness and prostitution, and indirectly through a decrease in health care provision."³²⁸ AIDS has hit certain Third World countries particularly hard, especially areas where poverty and income disparity are extreme. In sub-Saharan Africa it is estimated that 1 in every 40

adults is infected with HIV, and in some cities the rate is 1 in 3.³²⁹ In some African countries such as Zambia, up to 10% of the population is now thought to be HIV positive, including 20–25% of Zambian women aged 15 to 49.³³⁰ In Zimbabwe, one in four adults is infected.³³¹ At its current rate of increase, AIDS is expected to lower life expectancy by 25 years in some African countries.³³² In Uganda, for example, life expectancy has already dropped from 52 to 42 years because of AIDS. (Similarly, in Thailand life expectancy is predicted to drop from 69 years in 1994 to 40 years by 2010.³³³) AIDS is projected to kill between 1.5 and 2.9 million African women of reproductive age by the year 2000,³³⁴ having left more than 5 million African children motherless.³³⁵

AIDS is taking an especially heavy toll on Africa's children. Congenital transmission – i.e., from mother to fetus—is the second most common way the HIV virus is spread in Africa, after heterosexual contact. More and more children are being born with HIV. In some areas of Africa, 25% to 30% of pregnant women attending antenatal clinics are HIV positive.³³⁶ By 1991, some 500,000 infants in sub-Saharan Africa had the HIV virus.³³⁷ By the year 2000, that figure is expected to reach 11 million.³³⁸ In Zimbabwe, AIDS has been the major cause of child deaths in urban hospitals since 1989.³³⁹

In large regions of Africa AIDS is contributing to the reversal of child survival gains. The following figures, cited in an article by Sanders and Sambo, make this clear:

The United Nations projected that in 1990, the under-5 mortality rate (U5MR) in east and central Africa would have declined from 158 per 1,000 live births, to 132 by the year 1999 without the impact of AIDS. The U5MR, however, is already between 165 and 167 in 1990 as a result of the additional impact of AIDS and is predicted to rise to 189 by the year 2000.³⁴⁰

If present trends continue, AIDS will soon be the leading cause of child death in many other African countries. And although we have stressed the situation in Africa, in 1995 for the first time more people are believed to have contracted HIV in Asia than anywhere else.³⁴¹ Like diarrhea in its life-threatening form, AIDS is largely a disease of poverty and social injustice. (Indeed, in communities where diarrhea claims many children's lives, chronic diarrhea is often the first and most prevailing symptom of AIDS. Because of the severe wasting associated with chronic gastrointestinal distress, AIDS in Africa is referred to as *slim disease*.)

If we look at the “hot spots” of AIDS in the Third World—sub-Saharan Africa, Thailand, Brazil, Haiti, Honduras—we see that they tend to be in places where the gap between rich and poor is greatest, where the rights of women and children are most flagrantly violat-

ed, where social conditions are deteriorating, and where minimum wages have fallen so low that destitute people are forced into alternatives of income generation that they would not otherwise choose.

Poverty-driven migrant labor and the spread of AIDS

Some observers attribute the rapid spread of HIV in Africa at least in part to SAPs [Structural Adjustment Programs], which increased migration and urbanization, drove more people into poverty, forced women into prostitution, while at the same time depriving health ministries of enough money to provide health care and prevention.

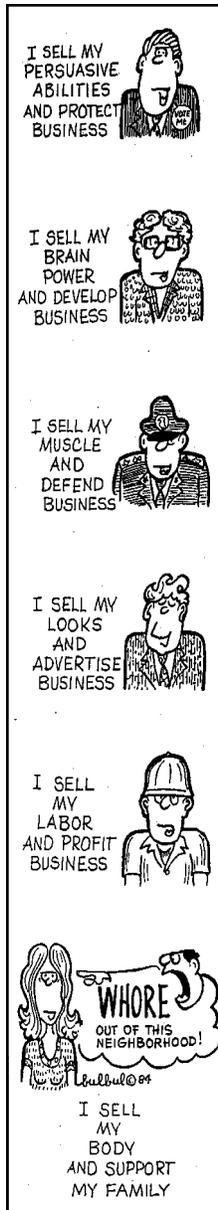
—*The Lancet*, Vol 344, Nov. 19, 1994³⁴²

In those parts of Africa with the highest incidence of HIV infection, its rapid spread is linked to the high prevalence of poverty-driven migrant labor. This migrant labor pattern derives from a polarized class system dating back to colonial times. But during the last decade foreign debt, recession, and SAPs have made the plight of the poor more extreme. These factors have pushed down real wages, slashed public services for the poor, and required peasant farmers to grow cash crops for export at increasingly low prices. These desperate conditions have forced vast numbers of destitute peasants (especially men) to periodically migrate to distant mining towns and cities, where those fortunate enough to find work are packed into dismal dormitories and paid starvation wages for thankless, grueling work.

Having left their wives and girlfriends behind in the villages, these itinerant workers seek other sexual outlet, often with female sex workers (many of whom come from equally destitute situations and have only their bodies to sell). When the men occasionally return to their women and families in the villages, they take their STDs and HIV infections with them. The result is a rampant spread of these diseases.

Region	1970	1990	2025
	(percent)		
Africa	23	32	54
Asia (excl. Japan)	20	29	54
Latin America	57	72	84
Europe	67	73	85
North America	74	75	85
World	37	43	61

Fig. 3-24 Share of Population Living in Urban Areas, by Region, 1970 and 1990, with Projections to 2025.³⁴³



In Latin America, as in Africa, extreme inequity also appears to contribute to the proliferation of HIV and AIDS. Three countries with the highest incidence of HIV infection—Brazil, Mexico, and most recently Honduras—also have a widening gap between rich and poor, mushrooming squatter settlements, desperately low wages, and high rates of unemployment, crime, street children, and prostitution. A growing number of sex workers are destitute children, boys as well as girls, some of them as young as 8 or 10 years old.

In Honduras—similar to the Philippines and elsewhere—an increase in HIV infection has occurred in the areas surrounding foreign (US) army bases, for obvious reasons. (Likewise, it is reported that HIV infection has escalated where UN peace-keeping forces have been stationed in Cambodia and elsewhere.) Wherever some people have a lot of money and others are destitute, HIV and AIDS seem to flourish. Sexual tourism in Thailand is a prime example.

Until the recent crash of the peso, Mexico was lauded for its modest economic growth in recent years, as one of the few success stories of structural adjustment. But since the early 1980s unemployment has soared and the purchasing power of working people's daily wages has dropped by more than 50%.

As in many countries subjected to liberalization and economic restructuring, the rapid spread of HIV in Mexico can be linked to a high rate of migrant labor that periodically separates men from their wives (see page 148). The North American Free Trade Agreement (NAFTA) has exacerbated the already dismal unemployment situation, compelling millions of *braceros* or "wetbacks" to illegally cross the border into the United States in search of work and decent wages. There they contract HIV and other STDs, and later take them back home to their wives and girlfriends. In this way, AIDS is likely to reach pandemic proportions in Mexico, just as it has in parts of Africa and elsewhere that harsh inequities cause massive migration of peasants into the mines and labor camps of the cities.³⁴⁴

What can be done to halt the spread of HIV/AIDS?

In the pernicious social conditions where HIV is spreading fastest, educating high risk individuals to use con-

doms may be better than nothing. But it is not enough. Only by correcting the inequitable social structures that allow the affluent to exploit the destitute, that force long separations between husbands and wives, and that create such hopelessness that people throw precaution to the wind, can the rapid spread of HIV be contained. To get at the root cause of the Third World HIV/AIDS epidemic would require, for a start, cancellation of foreign debt and reversal of poverty-increasing structural adjustment policies. In rural areas it would require encouraging production of local foods for domestic consumption rather than for export, and public assistance to help poor farmers stay on their land and with their families. In urban areas it would require fairer wages, low cost family housing, and strengthening of independent labor unions permitting workers to demand their rights and hold both government and employers accountable. And it would also require the empowerment and greater equality of women. In the long run, social justice will do more to slow the spread of HIV than current attempts to promote safe sex. Both are necessary. Unfortunately, however, health planners and technocrats have once again tried to solve what is fundamentally a social problem with a technological fix.

CONCLUSION TO PART 3

In this third part we have seen that levels of health are determined more by social, political, and economic factors than by medical breakthroughs or technological fixes. In the North, improvements in health came only after workers began to organize and demand their rights. More recently, in the South, it has become clear that selected technological interventions—be they ORS packets to combat dehydration, condoms to prevent AIDS, or contraceptives to combat overpopulation—at best will give very limited results...unless they are integrated into a comprehensive, equity-oriented, and empowering approach.

We have seen several examples of countries that have approached *good health at low cost* by following a course of development that places the basic needs of all people before the tunnel-visioned pursuit of economic growth for a few. But as promising as they are, the equity-oriented paths of development—even in a country as large and independent as China—have proved difficult to sustain in an international climate that increasingly places the demands of the global marketplace (i.e. the unregulated accumulation of wealth by the already wealthy) before the needs of the entire population.

There are, however, many examples of people working together to achieve local, short-term needs within a broader context of building a healthier, more equitable society. In the final part of this book we will look at some of these alternative approaches, their strengths and weaknesses, and what we can learn from them to move forward during these difficult times.