Population Control and Health Care in the Developing World

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Editor's Note: *In the last issue of the Journal, Dr. Tom Gates provided fascinating insights into the challenges of providing health care in Malawi, based on his work there for Partners in Health.*[1] *His experiences offered a unique perspective on global health from the front lines in a poor country, and anyone who hasn't read that article is urged to do so. His article did not have the space to address population control, though it is an essential aspect of the inter-dependent issues of health care and economic development, and I asked him to explore the topic separately in the following article.*

INTRODUCTION

I begin with an observation: over the past 25 years, whenever I talk to Americans about the challenges of medicine in Africa, overwhelmingly the first question I am asked is about "population control." By contrast, Africans are much more likely to ask why their children are still dying of malaria or their neighbors of tuberculosis, 60 years after effective treatments became widely available.

As always, it is important to understand the context of the question. For 400 years, Africa was *depopulated* by the slave trade; first by Europeans, then Americans (North and South) and lastly by Arabs. The Arab slave trade was not finally eradicated in Malawi by the British until the 1890s, only to be re-instituted in all but name during World War I, when nearly 200,000 Malawians were forcibly conscripted into the British colonial army (mostly as porters) in the fight against the Germans in Tanganyika. In the process they suffered horrific mortality rates from malnutrition and epidemic disease. Africans understandably remain sensitive to outsiders telling them they need to "control" their population; historically, they did not have much control.

THE POPULATION PROBLEM

Be that as it may, Malawi does have a looming demographic problem. The population is growing at 2.8% per year, which in 2014 was the sixth highest rate in the world. From 3.9 million at independence in 1964, the population has now grown to over 17 million—an increase of 400% in 50 years. (Interestingly, the population of the United States increased from 3.9 million in 1790, to 17 million in 1840: an almost identical rate of growth in the first 50 years of our independence; of course, the U.S. has a much larger land mass, and much of the increase was due to immigration.) Malawi's population is predicted to reach 23.4 million by 2030, and 32.2 million by 2050—sobering numbers for a country that already struggles to feed itself.[2] The median age is 16, and three quarters of the population is younger than 28 years.

Around the world and throughout history, the poorest countries have always had the highest fertility rates, so given Malawi's extreme poverty, this population growth is not surprising. The question of course is, which is the cause and which the effect? Are countries poor because of high population growth, or do they have high population growth because of poverty? Probably a little bit of both, but the consensus seems to be the latter is more important. By implication, the way to bring down rapid population growth is to promote economic development ("development is the best contraceptive"). But we seem to expect countries like Malawi to bring their rate of population growth down in the face of economic stagnation or even decline, which has never happened anywhere in history.

WHAT IS BEING DONE?

Attitudes are slowly changing. The total fertility rate* in Malawi was 6.7 in 1992, declining gradually to 5.7 by 2010, and then declining drastically to 4.4 in just five years, from 2010 to 2015.[3] Such a rapid rate of decline is unprecedented. Moreover, the fertility rate in urban areas (3.0) is substantially lower than in rural ones (4.8), though more than 80% of

* Fertility rate: live births per woman per lifetime.

the population still lives in rural areas.

According to the latest government survey, 58% of married, and 43% of unmarried women, use a modern method of birth control. Injectables are most popular, followed by implants and tubal ligation.[3] IUDs have proved less popular—but that is also true in the U.S.

Partners in Health (PIH) has a major commitment to women's health, especially addressing the high rate of maternal mortality, which is currently 634 per 100,000 live births (45 times higher than the U.S. rate of 14).[2] As an example, a year ago we opened a 24-bed "waiting home," where expectant mothers who live more than a two hour walk from the hospital are encouraged to stay for the last few weeks of pregnancy, to increase the proportion of births that take place in the hospital instead of the village.

All patients are counseled on birth control methods and are encouraged to accept the method of their choice. All methods available in the United States are available here, absolutely free of charge from the government, though with only one brand of oral contraceptive, as opposed to 30 or 40 in the U.S. It would not be an exaggeration to claim that lack of access to birth control for financial reasons is less likely here than in the U.S. — witness the political battle over mandated contraception coverage via Obamacare.

The basic problem is not lack of availability, though certainly there is room for improvement in logistics. Rather, in a rural subsistence agricultural economy, it still makes a certain amount of economic sense for families to have lots of children, however short-sighted that may be for the country as a whole. Remember, too, that in the context of high child mortality rates, it is not unusual to meet women who have had six or seven pregnancies, but have only a couple of living children. Many studies have shown that the single most important factor in decreasing population growth is *not* access to modern birth control methods, but opportunities for girls to get a secondary school education. Educated young women, with prospects for employment, have strong reasons to delay their first pregnancy, which in turn puts downward pressure on the fertility rate.

In regard to the role of church-related organizations (which Partner in Health is not), it should be noted that when I worked in Kenya in the early 1990s, I worked at a *mission* hospital, yet in two years I performed about 400 tubal ligations and uncounted contraceptive implants. These procedures were all heavily subsidized by the U.S. Agency for International Development (USAID), and a tubal ligation cost the client about $1. The Catholic mission hospital a few miles away had no qualms about referring their tubal ligations to us.

In my view, it is U.S. politics that has hopelessly complicated this issue. The prime factor is the so-called "Mexico City Policy," the on-again, off-again prohibition of USAID funds (or any other taxpayer money) going to any organization that even discusses abortion as an option, which was instituted under Reagan, rescinded by Clinton, re-instituted under G.W. Bush, rescinded by Obama, and now recently re-instituted in stronger form by President Trump. This should be a moot point here in Malawi, where virtually all abortion is illegal — though it is not uncommon for women to self-induce abortions by taking herbal medicines or even misoprostol.

CONCLUSIONS

So, yes, population growth is a concern. But as outsiders, forbearance is called for. It is not up to us to dictate how many children Africans choose to have, but rather to do whatever we can to create the conditions where Africans can freely make good choices, conditions that include reduced maternal and child mortality rates, more widely available economic and educational opportunities (especially for girls), and good access to family planning services. This is an issue that Malawians will have to solve, in their own time.

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