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Third World debt

What's the point of immunising children if we are then going to starve them?

Last year there was a net flow of $19 billion from the 40 poorest countries in the world to the richest. These low income countries, 30 of them in sub-Saharan Africa, received $16 billion in aid but paid $35 billion in debt repayments and interest. They defaulted on $12 billion, which has been added to their debt. The total debt now stands at $450 billion—nearly half of their combined gross national products. While struggling to feed their own people they are forced to grow cash crops for export, and all the time their debt to the developed world is growing. Extricating them from this debt trap is a global public health priority. Medical Action for Global Security (MedAct), an association of health professionals, held a conference last week to examine what health professionals should be doing.

The seeds of the debt crisis were sown in the early 1970s, when Western banks and governments had money to lend. Developing countries, with populations outgrowing their agricultural capacity, were keen to borrow, and vast sums were transferred with few checks or conditions attached.[1] Then came the oil crisis, the beginnings of world recession, climbing interest rates, and the collapse of commodity prices. With their economies closely tied to the West, developing countries had no protection when the international money markets hit bad times. Africa's terms of trade (the ratio of revenue from exports to costs of imports) fell by one third between 1980 and 1989, while over the same period the cost of servicing the debt rose from $4·8 billion to $9·4 billion.[2] Latin America, richer but deeper in debt, suffered similar reverses. Natural and manmade disasters—recurrent droughts, civil war, corruption, and political instability—have added to the developing world's economic woes.

Attempts by the International Monetary Fund (IMF) and the World Bank to solve the crisis have been largely unsuccessful. In health terms they may even have been disastrous. The so called "structural adjustment programmes" imposed on debtor nations placed earnings from exports above every other goal and included the privatisation of state owned industries and services, including health care. In its 1993 world development report the World Bank claims that the programmes have been responsible for continued improvement in health and reductions in mortality,[3] but the main aid agencies disagree.

According to Unicef, Christian Aid, Oxfam, and Save the Children, the absence of substantial increases in infant mortality has nothing to do with structural adjustment. Rather it suggests that better vaccination coverage, oral rehydration therapy, and community health initiatives have balanced out the effects of food shortage, economic stagnation, and AIDS.

The aid agencies report that the progress seen in many regions during the 1960s and '70s has slowed or stopped. Health indicators have in some cases gone into reverse. Worldwide, the number of underweight children has risen from 21 million in 1980 to 30 million in 1989.[4] While overall mortality among children in the developing world fell in the 1980s, seven countries recorded a rise in mortality among children aged under 5 years, which is widely accepted as a key indicator of development.[5] The decade also saw the re-emergence of some of the communicable diseases most closely linked to poor nutrition, housing, and sanitation.

Austerity measures aimed at cutting public spending have hit health and education most. User fees for health care and education—a central part of health policy in structural adjustment programmes—have reduced access. Among both boys and girls enrolment at primary schools in Africa fell by 7% between 1980 and 1990—a combination, says Unicef, of the rising cost of education and the need for children to contribute to the family's survival.[6]

The problem with many aid programmes, particularly structural adjustment programmes, is that they are either targeted wrongly or not targeted at all. The initial loans and the subsequent intervention had as their goal the insurance of proper financial returns. While spending on health was hit, military spending went unchecked. In 1985 the Stockholm International Peace Research Institute estimated that one fifth of Third World debt (excluding that of oil producing countries) could be attributed directly to arms purchases).[7]

In contrast, the world summit for children in 1990 set as its priority the meeting of basic needs—primary health care, primary education, housing, sanitation, and nutrition. Its goals included reducing mortality in children under 5 by a third (or to under 70/1000 live births, whichever is lower), providing basic education for all children, halving maternal mortality, and assuring universal access to clean water and sanitation.[8] One hundred and fifty countries have endorsed a plan for achieving these goals by 2000. Unicef estimates that the plan will cost an extra $25 billion, but only a small proportion of this need come from new aid money. Two thirds of the amount could come from reallocating resources within developing countries—for example, by reducing military spending and redirecting funds from tertiary to primary health care. Much of the remaining third could

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be generated by improving terms of trade along the lines proposed in the talks on General Agreement on Tariffs and Trade.

The United Nations Development Programme's *Human Development Report 1992* recommends that one fifth of overseas aid budgets should go towards meeting basic needs.[9] Most donors earmark about a tenth of their budgets for this, Britain earmarks 8·8%. Britain also lags behind the target for overseas aid of 0·7% of gross national product set by the United Nations for donor nations. Britain, at 0·3%, is not even half way there.

Of most immediate importance, however, is the removal of the millstone of debt from around the neck of developing countries. A meeting of the group of seven major industrialised countries (G7) in Toronto in 1988 agreed to write off 50% of debts, but the terms applied only to debts recently incurred by the poorest countries. In Trinidad in 1990 Britain proposed writing off up to 80% of debt, but other members of the group, including the United States, have yet to agree. Opposition parties in Britain are also proposing that debt repayments be limited to a maximum of 10% of a country's export revenue.

Public support for these measures is vital. The members of parliament attending last week's conference made it clear that little would be achieved unless concern for the plight of developing countries registered strongly in opinion polls at election time. Mobilising such concern during a recession is not easy. One approach is to show people that what happens in the Third World directly affects them.[10] Third World debt holds back world economic recovery, increases the spread of disease, feeds the international traffic in drugs, damages the environment, and increases political instability and civil war, thus adding to the global refugee crisis. It also indirectly adds to the desire for arms.[10] We need to recognise that security in the period after the cold war rests not in armaments but in the creation of political, economic, and social stability. Like the public health reforms of the Victorian age, action for the Third World can quite properly be justified by enlightened self interest.

The immediate role of health professionals is clearly to raise public awareness in whichever way they can. With greater public awareness might come pressure on the World Bank and the International Monetary Fund for greater accountability. The conference concluded that there should be an annual debate in parliament to examine the activities of these two agencies, which fall outside normal democratic control. They should have to justify how they spend the £20 ($30) that they receive from each of us every year.

Third World debt is a drain on health and must be addressed. In the words of Dr Dorothy Logie, a general practitioner and a member of MedAct, "What is the point of immunising children if we are then going to starve them?"

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Prostitution: would legalisation help?

Social and moral attitudes, rather than legal restraints, are central to the problem

It may be the oldest profession, but prostitution remains a thriving industry because it satisfies a demand. Although the buyer (more often male) wants to buy, the seller (more often female) is often obliged to sell sexual services because of limited economic opportunities. For some sellers this necessity is increased by a drug habit. Easy to define in theory, less so in practice, prostitution enjoys in Britain a paradoxical legal status whereby the actual transaction is legal while more peripheral aspects (including collaborating with others to provide a service and public promotion) are illegal.

Several problems exist for male and female sex workers, some due to and many exacerbated by illegality. Access to health care may be difficult, and sexually transmitted diseases have always been a risk, which HIV highlights. The risks of infection are increased by market forces, which make unsafe sex more lucrative, while the carrying of condoms is used as legal evidence of prostitution. Physical violence including rape is common, but police and legal services may be inaccessible or unsympathetic, rendering its reporting futile.

While some people cannot acknowledge that commercial sex is anything but a minority "deviant" demand, others recognise it as commonplace, with some people regarding it as a component of normal male sexual behaviour. Whatever the viewpoint, buyers from all backgrounds vastly outnumber sellers, yet if disclosure occurs the purchaser attracts sympathy for any repercussions while the provider, viewed as immoral and responsible for the prostitution, attracts censure. Thus prostitutes suffer stigmatisation and discrimination while working in inadequate conditions with poor remuneration and no employment rights or benefits.

So what would decriminalisation or legalisation of prostitution achieve? Theoretically, it should improve conditions for prostitutes in all circumstances by enabling them to work together in a more organised way, with more control over clients, services, and fees. Arguably, it would facilitate the provision of health care, while freedom to carry condoms would reduce the risk of sexually transmitted infections. The risk of physical assault would similarly be reduced by the freedom to negotiate openly with and to scrutinise potential customers without fear of legal penalties or harassment by police, who would instead provide protection from violent or sexual crimes.

But the reality would be different. Common throughout society, prostitution is particularly problematic at the lower end of the market, among women working in isolation on the streets and especially those with a drug habit. While prosecution might cease, the underlying poverty and social problems, including drug use, that led to prostitution would ensure its continuation. While the provision of health care might be improved, its inadequacy is a reflection not of

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