The great exterminator of children

Dorothy Logie

In April 1991 the Brazilian paediatrician Dr Lauro Monteiro visited Britain to raise funds for his work with street children. Eight million children, some as young as 4 or 5, sleep rough on the streets of Brazilian cities. Commonly separated from families who can no longer support them, they scavenge to eat, beg, and steal and fall victim to physical and sexual exploitation. In 1989 I visited Dr Monteiro's clinic in Rio de Janeiro and was impressed by the sensitive medical, psychological, and judicial care he offered these youngsters, who have lost trust in adults and are apprehensive of approaching any "authority" for help.

It was not only to raise funds, however, that Monteiro came to Britain. He was uneasy, even angry, at Amnesty International's campaign focusing attention on the murder of street children in Brazil.¹ Children whose only crime may be poverty are indeed being brutally killed by death squads: in 1990 450 of these killings were reported in Sao Paulo, Rio, and Recife. But for centuries homeless children have been brutally murdered or sold into slavery: in Bombay in 1976, 3000 homeless children were rounded up in Operation Beggar.²

Worldwide, tradespeople tend to be hostile to homeless people because their presence on the streets is bad for business. But why are there eight million children on the streets in Brazil? And why, Monteiro asks, is Amnesty International distracting attention from the real exterminator of Brazilian children—namely the burden of international debt? In 1991 Unicef reported that at least half a million children worldwide had died in the previous 12 months as a direct result of debt.³

Brazil is rich in natural resources and the eighth largest economy in the world. It is also the world's most indebted country. It has ample means to feed its 144 million people, yet in 1990 one third of Brazilian children suffered malnutrition and 350 000 died of preventable diseases. After decades of decline infant mortality has risen to 200 per 1000 in some areas. Diseases thought to have been eradicated are creeping back. Cholera is spreading along "seams of poverty" from Amazonas into the cities.

Brazilian governments have been notorious for mismanaging the economy, and the current debt is only one aspect of the country's social problems. Nevertheless, huge repayments (of \$27bn in 1989 on a gross foreign debt of \$114bn) have become an economic nightmare, and the harsh rescheduling conditions demanded by the World Bank and the International Monetary Fund are draining the country's lifeblood. Echoing former President Nyerere, of Tanzania, Monteiro asks, "Must we starve our children to pay our debts?"

Background to international debt crisis

The debt crisis erupted in 1982, when Mexico signalled its inability to pay and other countries did so soon afterwards. Many economists regarded this as no more than a temporary cash flow problem caused by the conjunction of high interest rates, world economic recession, and fall in Third World commodity prices. Instead, however, it has become a major obstacle to development. Country after country in the South has

A group of street children found shot dead in Rio de Janeiro, November 1991

found it impossible to achieve growth and repay debts which have suddenly become so much more expensive. The result has been a spiral of decline in living standards, with collapse of investment, deterioration of infrastructure, and rising poverty. In sub-Saharan Africa debt as a percentage of gross national product increased from 43% in 1985 to 97% in 1990.⁴

The poorest, most debt laden countries will have paid 31.3% of export earnings—their main source of foreign revenue—to the wealthier countries in 1991 as compared with 23.8% in 1990.⁵ The United Nations has estimated that Africa lost \$19bn in 1986 because of loss of purchasing power of its exports.⁶ Debt now stands at half the total national income of the South and is 60% higher than in 1986.⁷ Total debt has continued to mount throughout the past decade, though developing countries have paid back more than a trillion dollars in interest charges and principal. This is because many are continuing to borrow (from multi-lateral institutions like the World Bank) to pay off past loans or have had their repayment periods rescheduled to provide breathing space but at the expense of future hardship as the final amount owed increases and interest must still be paid.

Reverse flow of capital

In the early 1980s banks, realising that developing countries were bad creditors, stopped lending, which along with the collapse in commodity prices and rising interest rates caused a reverse flow of capital from south to north. Latin America's terms of trade (the cost of imports in relation to exports) deteriorated by 30% in the 1980s and Africa's by 40%.⁸

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Overseas aid to developing countries was £28.3bn in 1990. But countries receiving that aid have had to pay back £34.5bn in interest on their debts.⁹ This is the equivalent of every man, woman, and child in the developing world paying the industrialised north £17.40 a year.¹⁰

In 1990 repayment of the British debt from developing countries exceeded official and private flow of money to the South by £2493m. In addition, British aid overseas fell by two thirds of its 1979 value to the lowest ever 0.27% of gross national product. The United Kingdom is now 14th in the league table of donors (Christian Aid, personal communication).

Economic adjustment policies

Structural adjustments (austerity programmes) demanded by the International Monetary Fund in return for renegotiating debt deadlines have had a disastrous effect on health and education in the South, diverting resources from food, wages, and welfare to producing exports in order to service debt. The IMF's

Total external debt as a percentage of gross national product in low income economies 1989 (World Debt Tables)

approach is based on the premise that debtor countries have brought the crisis on themselves—or as one United States Treasury official said, “We have to keep their [debtors’] feet in the fire.”¹¹ An anti-inflationary austerity package reduces the amount of credit available, makes borrowing more expensive by increasing interest rates, cuts public spending, raises the cost of public services (for example, water and electricity), abolishes consumer subsidies and price controls (particularly on basic foodstuffs), and tries to hold back or reduce wages. “Earn more and spend less” is the basic message.

Medical consequences

When a poor country is asked to “tighten its belt” it may not have much excess to squeeze, except in health, education, and services. Rises in food prices have been dramatic, hitting the poor hardest. As government expenditure on food subsidies declines malnutrition worsens, young children suffering most.

In Chile in 1983 the amount of milk distributed in a supplementary programme was 31% lower than in 1982, and within months the nutritional status of the under 2s declined.¹² In 1985 the price of cooking oil, beans, and rice in Zambia, Egypt, and Sudan trebled, leading to serious food riots.¹³ In a 600 page report on IMF adjustment Unicef stated, “Malnutrition during the 1980s is increasing in many parts of the developing world. . . . Infant mortality has been rising in some areas—including Barbados, Brazil, Chile, Jamaica, Uruguay, and parts of the Philippines and Sri Lanka—after decades of decline, while the trend towards improvement has been halted in 21 countries.”¹⁴ Tanzania’s record during the 1960s and 1970s was exceptional: nearly all children attended primary school, and life expectancy had reached 60. But in 1986, with the IMF insisting on devaluation of the currency and the country devoting 60% of all exports to debt service, free schooling had stopped and the price of maize and rice rocketed.¹⁵

Diseases thought to have been eradicated have been creeping back. Yaws and yellow fever have reappeared in Ghana.¹⁶ Tuberculosis is now rife in Peru, having been almost eliminated.¹⁷ Medical fees were introduced in Zambia in 1987.¹⁸ And as pharmaceutical imports of \$400 000 in 1982 fell to \$20 000 in 1986 three quarters of Zambian health centres had run out of chloroquine. Deaths from malaria are rising rapidly.¹⁹ Patients in Lusaka needing an operation were asked to bring the necessary surgical gloves. In Zambia in 1986, 400 of the 1000 medical posts were left unfilled because there was no money for doctors’ salaries.²⁰ Teachers, nurses, and factory workers have been paid off in Senegal in massive cuts in public spending.²¹ Tourism has become the main means of debt service in Thailand, where the sex industry now employs more than a million girls, some very young,²² with all the dangers of aggressive spread of AIDS.

In the *State of the World’s Children (1989)* Unicef claims, “For almost 900 million people, approximately 1/3 of mankind, the march of human progress has now become a retreat. In many nations, development is being thrown into reverse. After decades of steady economic advance, large areas of the world are sliding back into poverty. Throughout Africa and much of Latin America, average incomes have fallen by 10%-25% in the 1980s. The average weight-for-age of young children, a vital indicator of normal growth, is falling. . . . In 37 poorest nations spending per head on health has been reduced by 50% and on education by 25% over the last few years.”²³

Women have greater demands made on their time and energy. If food subsidies are cut they still have the task of feeding the family. Any cutback in primary

health care (including family planning) causes untold misery and adds to overpopulation.

Ecological debt

The early emphasis of "adjustment" was to encourage large scale projects such as building dams and mining to service debts. Land was concentrated in the hands of a few to produce vast areas of crops for export. Rural land is still being usurped from peasant farmers and tropical forests cut down for hardwood in Brazil and Peru. Extensive wooded areas have been destroyed in Chile and Costa Rica.²³ This despoliation exhausts soil and causes erosion and drought. With mass immigration to the cities, 70% of Brazil's population is now urban. In the seething shanty towns families do not cope, which is why eight million children are abandoned to earn a living on the streets.

The situation today

Since the crisis broke in the early 1980s all the major charities have campaigned against repayment. The crisis is not a disaster for the banks, whose exposure to Third World debt is only 3% of their total assets (and who have already received over £1bn of public money in tax relief to cushion against non-repayment).^{23a} But it is a crisis for the poorest peoples of the world. Many question the legality of forcing them to pay for the folly of past (often illegal) governments. Much of what was borrowed lined the pockets of the rich or was transferred back to the North in "capital flight" or was squandered on ill advised schemes. For example, President Ferdinand Marcos, of the Philippines, devised a scheme in which a loan was made for a nuclear power station at Bataan with an interest repayment of \$335 000 a day. As the reactor was sited on an unstable earthquake fault it is perhaps fortunate that it never functioned. But five British banks lent £11.7m for the project.²⁴

Attempts at solving the crisis

There has recently been a modification of the hardline approach that a debt must be honoured. Several recent initiatives to ease the plight of the severely indebted countries have been proposed, though the interests of the commercial banks of the North still take priority. The 1989 Brady plan suggested swapping commercial debt for lower priced bonds which could then be bought by speculators from big business (debt-equity swaps) or even by the country involved itself. Because of the complexity of the deals the precise balance of benefits to debtors and creditors has varied from case to case, and so far only six countries have benefited.

The most important government to government proposal has been John Major's Trinidad Terms of September 1990. That plan (aimed only at low income debtors) will make a small dent in the burden of the very poorest countries, but it is a start. In December 1991 at a meeting of the Paris Club the United Kingdom agreed to cancel 50% of the debt to the very poorest countries over the next three years while others (America and Australia) agreed to provide long term rescheduling (Christian Aid, personal communication). As with all Paris Club agreements the debtor countries still have to implement a structural adjustment programme, and the agreement does not address debt owed to the World Bank. Now that the British government has offered relief a "comparable response" (requested by John Major) should be made by the commercial banks. The Trinidad Terms should be extended to include all heavily indebted countries, whether middle income or lower income.

Total external debt as percentage of gross national product in the world's 12 poorest of the low income economies in 1980 and 1989 (World Debt Tables)

PAID

During his visit to Scotland Dr Monteiro and I discussed setting up an international pressure group of doctors to plead with banks, governments, and the international community to look again at the morality of debt repayment and make human development a priority. We tentatively planned to call our organisation Physicians Against International Debt—PAID (for in many cases the original debt has been paid). It would be interesting to hear what others think. Perhaps an international medical symposium might air the subject? Not only can doctors influence society's thinking but they may also have the sort of bank balance that exerts leverage on banking opinion.

To many numerically illiterate doctors the language of international finance, adorned by rows of noughts and titillated by trillions, is couched in mystery, numbing us to inaction by its complexity. But we should be angry as we watch hard earned medical improvements in infant mortality and nutrition evaporate. As Tony Smith argued, "it makes little sense to improve the health of the world's children if we are then going to starve them."²⁵ The debt burden is a scandal which in numerical terms makes the international slave trade of the nineteenth century look like petty crime.

Conclusion

During the last week of February this year every member of parliament received an egg timer from Christian Aid to remind him or her that time is running out; that the flow of resources from south to north must be reversed. For ultimately, developing countries will find their own survival techniques—whether in the growing of illegal drugs for lucrative Western markets, or the swelling of cities breeding disease and crime, or social unrest encouraging guerrilla groups like Shining Path in Peru, or the destruction of the world's ecology—and the impact will affect us all. If action is not taken soon it will be our crisis, too, whether we like it or not.

I thank Dr Lauro Monteiro Filho, President of ABRAPIA (Brazilian Multiprofessional Association of Protection to Childhood and Adolescence), Rua Pinheiro Machado, 39,

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Current Issues in Cancer

Testicular cancer and related neoplasms

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This is the fourth in a series of articles examining recent developments in cancer.

TABLE I—Incidence of four most common cancers in men aged 15-34

Site	No of cancers/year*
Testis	485
Hodgkin's disease	255
Malignant brain tumours	155
Leukaemia	146

*Office of Population Censuses and Surveys cancer statistics registrations, England and Wales, 1985.

TABLE II—Incidence of testicular cancer in England and Wales

Year	No of cases*	Rate/100 000 population
1970	660	2.7
1975	762	3.2
1980	843	3.5
1985	922	3.8

*Office of Population Censuses and Surveys cancer statistics registrations.

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This review is primarily concerned with germ cell tumours of the testis (seminoma and teratoma), which are by far the most common testicular cancers in adults. Comparable neoplasms may, however, develop in the ovary or at extragonadal sites, particularly the mediastinum in men and the pineal area in both sexes. Primary retroperitoneal tumours probably do not occur; in such cases an occult testicular primary tumour is present.

Germ cell tumours of the testis are comparatively rare, comprising about 1% of cancers in men; however, they are by far the commonest cause of cancer in young men (table I) and their incidence has increased rapidly in the Western world,¹ as has the incidence of ovarian germ cell malignancy.

During the past 15 years management of these tumours has become highly sophisticated, and patients in whom prognosis was hopeless only 15 years ago are now commonly cured. These advances are largely due to chemotherapy, particularly with cisplatin and its derivatives.² The production of the tumour markers α fetoprotein and human chorionic gonadotrophin by these cancers is of particular importance, and they have served as a model in the search for similar markers in other tumour types.

Though most men with a germ cell tumour present with an obvious testicular mass, this is not always the case. Indeed a diagnosis of metastatic germ cell tumour needs to be excluded in any young man presenting with metastatic cancer in whom no obvious primary site is present (fig 1). This diagnosis can usually be effectively excluded by measurement of tumour markers, together with testicular ultrasonography and a review of the diagnostic biopsy specimen. No patient with a putative germ cell tumour, however ill at presentation, should be considered beyond cure. Most such patients are now managed by specialist units.

Epidemiology

In England and Wales 900-1000 new cases of testicular germ cell tumours are seen each year (representing a life time risk of about 1 in 500). There has been a remarkable 300% increase in incidence in men aged 25-29 during this century, and the numbers continue to rise (table II). The main risk factors are a history of unilateral or bilateral testicular maldescent

FIG 1—Computed tomogram of large cystic retroperitoneal mass which was the presenting feature in 33 year old man. No testicular primary tumour was palpable. Concentrations of tumour markers were greatly raised (α fetoprotein 30 300 U/l, chorionic gonadotrophin 780 U/l; normal <10). Ultrasonography showed a tumour in the right testis

(recorded in about 10% of cases of testicular cancer) or a strong family history. It is not known why testicular cancer is increasing in incidence. At present public health measures include encouraging early identification of cancers by public education and correction of maldescent (although the impact of this on the future incidence of cancer is unknown).

Pathogenesis

Testicular germ cell tumours are often histologically intimately related to areas of in situ germ cell carcinoma, and these lesions are thought to precede germ cell cancer in a high proportion of cases.³ Testicular biopsy has shown carcinoma in situ in a proportion of patients with cryptorchidism or gonadal dysgenesis and in the contralateral testis of patients with a germ cell tumour. The risk of subsequent germ cell tumour in patients with carcinoma in situ may be as high as 50%.⁴ These histological lesions can, however, be eradicated with radiotherapy.