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Values, Development and Demography

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Introduction

There is an intricate reciprocal relationship between values, development and demography (and the components of population growth). In effect, values impact on development that in turn affects trends in fertility, mortality and migration. On the other hand, development also impacts on values. It should be noted that Africa, which is the least developed continent, experiences the highest fertility and mortality rates, while its migration patterns and trends are determined by the respective countries' and global development trends. Within the respective countries, there are pockets of development such as the urban settings, educated and high income groups of people; these differentially distributed development factors are in turn highly causal for the differentials in fertility, mortality and migration of people within and between countries.

This chapter will briefly trace the changes in development and the demography of the world, paying special attention to the African continent and the Sub-Saharan region in particular. Data from Zimbabwe and Zambia are used as specific examples of the relationship between demographic phenomena and development. An effort is made to show data on the changes in fertility and mortality over the past two and half decades. Subsequently, a discussion of factors underlying the observed trends is provided. Given the limited space, factors underlying fertility are covered in greater detail compared to the brief discussion on factors underlying mortality and migration respectively. The discussion on underlying factors to demography will highlight the interaction between values, development and demography.

Global Levels of Development and Demographic Characteristics

As noted earlier, the world is characterised by differential developmental levels that qualify respective countries to be classified as either developed or less developed. Two indices of development, the proportion of the population that resides in urban areas and gross national product (GNP) per capita are used as proxies for development. Two mortality indices, infant mortality rate and life expectancy, and total fertility rate are the demographic aspects that are compared between and within regions. The composite rate of population growth is also used. These indices, covering the period 1981- 2005 are shown in Table 6.1. World indices and those for developed and less developed regions are covered. Indices for respective aspects within Africa, for Zimbabwe and to a lesser extent, Zambia, are also shown.

There is, of course, a marked difference in GNP per capita between the developed and less developed nations; with per capita GNP in the developed nations being about ten times higher than in the less developed nations. The rate of increase of the GNP is also higher in the developed nations compared to the less developed nations. For instance, while GNP per capita for the developed nations ranged from US$8,657 in 1981 to US$19,480 in 2000, it ranged from a meagre US$728 to US$1,260 for less developed nations. The gross national product (GNP) per capita for the developed nations was US$26,320 in 2005 compared to only US$4450 for less developed regions. On the other hand, GNP per capita for the African region falls below the average of less developed nations; and the GNP per capita declined over the two decades as it ranged between US$783-670. Within Africa, the Southern African region fares better than other regions. GNP per capita for Southern Africa ranged between US$2,349 in 1981 to US$3,100 in 2000; as compared to a meagre US$305 to US$260 for Eastern Africa. Consistent with the trend in the less developed countries, Zimbabwe's GNP per capita declined from US$630 in 1981 to US$620 in 2000.

The developed regions of the world are also more urbanised than the less developed regions, albeit with increasing urbanisation over time in less developed regions. For instance, while the proportion residing in urban areas ranged between 70 per cent in 1981 to 76 per cent in 2005 in the developed nations, such proportions ranged from 29 per cent to 41 per cent in the less developed nations. It should be noted that the rate of increase of urbanisation is higher in the less developed compared to the more developed nations. Urbanisation is not the most accurate indicator of development as it differs significantly between the developed and the developing nations and within these categories; and we only use it as a proxy for an admittedly complex dynamic.

As alluded to earlier, the developed nations have more positive general demographic indices than the less developed nations. The developed nations

experience better health than less the developed nations. The infant mortality rate reduced from 19 to 6 deaths for 1,000 live births between 1981 and 2000 for the developed regions. Infant mortality for the less developed nations reduced from 93 to 59, while that for the Africa region reduced from 120 to 88 over the same period. It should be further noted that while the infant mortality rate ranged between 97 and 46 deaths per 1000 births in 1981 and 2000 respectively for Southern Africa, it ranged from 111 to 90 for Eastern Africa. Consistently, life expectancy is higher in the developed compared to the less developed nations. It ranged from 73 to 76 years between 1981 and 2005 respectively, for the former compared to 58 and 65 years respectively for less developed nations. This compares with only 50 and 52 years, respectively for the African continent. While life expectancy for Southern Africa ranged between 60 and 50 years for the same period, it ranged between 46 and 48 years for the Eastern African region and declined from 54 to 41 years respectively for Zimbabwe.

The less developed regions experience higher fertility than the more developed regions. While the total fertility rate ranged between 1.9 and 1.6 children between 1981 and 2005 in the developed regions of the world, it ranged between 4.5 and 3.0 children respectively, for the less developed nations; and between 6.5 and 5.1 children for Africa. Fertility rate ranged from 5.2 to 2.9 children for the Southern African region, and from 6.6 to 5.7 children respectively for Eastern Africa. Zimbabwe's fertility ranged between 6.7 and 3.8 children, respectively. In Zambia, fertility declined 7.1 in 1980 to 6.3 in 1990, and then 4.9 in 2000. Estimates based on the Zimbabwe Demographic and Health Survey has shown a similar downward trend in fertility. This showed a decline from 6.5 births in 1992 to 6.1 in 1996 and 5.9 in 2001 to 2002.

The high fertility rates in the less developed nations coupled with declining, albeit high mortality rates give rise to high rates of population growth. While the rate of natural increase ranged between .6 and .1 between 1981 and 2000 in the developed nations, this compares 2.1 and 1.5 respectively for the less developed nations. The African region experienced rates of increase of between 3.0 and 2.3 per cent, with the Southern African region experiencing a decline in the rate from 2.6 to .7 per cent compared to 3.1 to 2.5 per cent for the East African region. What is it in development, or the lack of it, that explains the differentials in the demography of the world?

Table 6.1: Development and Demographic Indices for the World

Socio-demographic Data 1980-2005

	1981	1985	1990	1995	2000	2005
World						
Population (millions)	4677	4845	5321	5702	6067	6477
Rate of Natural Increase (%)	1.8	1.7	1.8	1.5	1.4	1.2
IMR (per 1000)	84	81	73	62	57	54
TFR (per woman)	3.9	3.7	3.5	3.1	2.9	2.7
Life Expectancy	62	62	64	66	66	67
Urban Population (%)	39	41	41	43	45	47
GNP per capita (USD)	2754	2760	3470	4500	4890	8540
Developed Regions						
Population (millions)	1158	1174	1214	1169	1184	1211
Rate of Natural Increase (%)	0.6	0.6	0.5	0.2	1.7	0.1
IMR (per 1000)	19	18	16	10	8	6
TFR (per woman)	1.9	2	2	1.6	1.5	1.6
Life Expectancy	73	73	74	74	75	76
Urban Population (%)	70	72	73	74	75	76
GNP per capita (USD)	8657	9380	15830	17270	19480	26320
Less Developed Regions						
Population (millions)	3519	3671	4107	4533	4883	5266
Rate of Natural Increase (%)	2.1	2	2.4	1.9	1.7	1.5
IMR (per 1000)	93	90	81	67	63	59
TFR (per woman)	4.5	4.2	4	3.5	3.2	3
Life Expectancy	58	58	61	65	64	65
Urban Population (%)	29	31	32	35	38	41
GNP per capita (USD)	728	700	710	1030	1260	4450

Africa						
Population (millions)	513	551	661	720	800	906
Rate of Natural Increase (%)	3	2.9	2.9	2.8	2.4	2.3
IMR (per 1000)	120	110	109	90	88	88
TFR (per woman)	6.5	6.3	6.2	5.8	5.3	5.1
Life Expectancy	50	50	52	56	52	52
Urban Population (%)	27	31	31	31	33	36
GNP per capita (USD)	783	750	600	660	670	2300
Northern Africa						
Population (millions)	120	128	144	162	173	194
Rate of Natural Increase (%)	3.1	2.9	2.8	2.4	2	2
IMR (per 1000)	109	97	87	63	51	45
TFR (per woman)	6.4	6	5.2	4.4	3.6	3.3
Life Expectancy	55	56	59	65	64	68
Urban Population (%)	42	42	41	45	46	47
GNP per capita (USD)	1165	1190	1110	1040	1200	4050
Western Africa						
Population (millions)	155	166	206	199	234	264
Rate of Natural Increase (%)	3.1	3	3	3.1	2.8	2.5
IMR (per 1000)	139	118	119	86	89	105
TFR (per woman)	6.8	6.4	6.6	6.4	5.9	5.9
Life Expectancy	47	48	48	55	51	47
Urban Population (%)	22	29	30	23	35	40
GNP per capita (USD)	681	580	340	370	340	1200
Eastern Africa						
Population (millions)	146	159	199	226	246	281
Rate of Natural Increase (%)	3.1	3.1	3	3	2.4	2.5
IMR (per 1000)	111	109	116	106	102	90
TFR (per woman)	6.6	6.8	6.7	6.4	6	5.7

Life Expectancy	48	49	5	52	46	47
Urban Population (%)	14	17	18	21	20	24
GNP per capita (USD)	305	300	230	210	260	1020
Middle Africa						
Population (millions)	58	62	68	83	96	112
Rate of Natural Increase (%)	2.7	2.7	3	2.9	3	2.8
IMR (per 1000)	121	119	118	107	106	98
TFR (per woman)	6	6.1	6.1	6.3	6.6	6.3
Life Expectancy	46	48	50	51	49	48
Urban Population (%)	30	34	37	33	32	35
GNP per capita (USD)	483	420	420	-	320	1240
Southern Africa						
Population (millions)	34	37	45	50	50	54
Rate of Natural Increase (%)	2.6	2.2	2.7	2.3	1.3	0.7
IMR (per 1000)	97	92	61	49	51	46
TFR (per woman)	5.2	5.2	4.7	4.2	3.1	2.9
Life Expectancy	60	53	62	67	54	50
Urban Population (%)	46	52	53	59	42	50
GNP per capita (USD)	2349	2280	2150	2720	3100	10360
Zimbabwe						
Population (millions)	8.0	8.6	9.7	11.3	11.3	13.0
Rate of Natural Increase (%)	3.4	3.5	3.2	2.7	1.0	1.1
IMR (per 1000)	74	70	72	53	80	62
TFR (per woman)	6.7	6.6	5.8	4.4	4.0	3.8
Life Expectancy	54	56	58	54	40	41
Urban Population (%)	20	24	25	27	32.0	34
GNP per capita (USD)	630	740	660	540	620	590

(PRB, 1981, 1985, 1990, 1995, 2000c)

Demography and Development

As noted earlier, there is reciprocal relationship between development and population. The simple causalities are often argued as follows. First, for a country to develop economically, it is necessary that there be investment. Investment is only possible in a situation where the country is able to save, *ceteris paribus*. In situations where there is a high rate of population increase as was the situation in most less developed nations during the past twenty-five years, saving and investment become minimal if not impossible; and this impacts negatively on development. The minimal savings are largely a result of higher consumption patterns necessitated by large proportions of dependants. For instance, the proportion of the population less than fourteen years averaged about 35 per cent in the less developed nations during the period under discussion. This compares to an average of 20 per cent in developed nations, and about 43 per cent in Africa. On the other hand, development impacts on demographic characteristics especially because it changes values underlying the demographic determinants.

The ensuing section covers the relationship between development and components of population growth in Africa. The bulk of the discussion is on development, values and fertility in Sub-Saharan Africa (SSA). Brief discussion will be on mortality and migration for two reasons. First, human beings value mortality to the extent that all population policies are unidirectional with regard to mortality. They are aimed at reducing mortality and increasing longevity. Second, even when there is high population growth, a country cannot ask its people to emigrate in order to reduce population pressure, for country of residence is an unalienable human right. Thus, fertility remains the component of growth most amenable to intervention with minimal negative impact, if any, on people's rights. Yet policies that are insensitive to respective people's norms and values regarding fertility have had minimal impact on such fertility. Hence, a discussion of the relationship between demography, values and population can best be started within a context of fertility and its determinants.

Development, Values and Fertility in Sub-Saharan Africa

Pre-transitional Fertility Regimes

The Sub-Saharan African (SSA) region has experienced very high fertility levels for decades amidst sustained fertility declines in the developed world. However, it is clear that fertility decline is now underway in SSA (Table 6.1). What explains the sustained high fertility levels in pre-transitional (integration in the world economy and relative democratisation of political society are two important dimensions of the transition) SSA, and what has changed in the mix of such interacting variables that has ushered in fertility decline in the region? In answering these two

questions, this discussion focuses on factors underlying high fertility levels and subsequently the fertility decline, highlighting the interplay between development, values and fertility.

It must be noted that pre-transitional Africa has been characterised by a mosaic of strongly contrasting levels of fertility and a commensurate variety of socio-cultural practices whose underlying values are indeed variable (Mhloyi 1988). Pre-transitional fertility regimes are largely governed by supply variables to the extent that a shift from a natural to a controlled fertility regime is often paralleled by a shift not only in the relative importance of supply vis-à-vis demand variables, but also a change in the relative importance of the supply variables (1988). The most important supply variable in transitional societies is contraception which is intended to regulate fertility in order for couples to realise their desired number of children (demand for children).

In this chapter, fertility is perceived as a function of proximate determinants or supply variables which are, among others, duration of marriage, primary and secondary sterility, birth intervals, breastfeeding, pregnancy wastage and infant mortality in pre-transitional societies. In addition to these variables, a proximate determinant which typifies transitional societies is contraception. In turn, these variables are affected by background or development factors. The development variables include, among others, education, urbanisation, public health, employment, income, media or information. These variables have a reciprocal relationship with values. What happens as countries move from a pre-transitional to a transitional fertility regime?

In pre-transitional, SSA high value is placed on fertility to the extent that fertility supply variables are the dominant determinants underlying such fertility. In SSA, fertility has had, and continues to have, an economic and psycho-social value which is commensurate with the level of development in respective communities. In pre-transitional subsistence and agrarian societies, children are perceived as assets since they provide labour along with their mothers whose productivity in the fields is perceived only as a necessary support for their most important role: reproduction (Boserup 1970; Kamuzora 1987; Mhloyi 1987). In these communities, fertility is the essence of femininity, while infertility is generally perceived as a curse from the gods (Mhloyi 1987). As children were perceived to offer economic security to their mothers, such mothers also accrued status with increased childbirth.

Generally, women in pre-transitional Africa were not educated nor employed, hence their consequent low status. With colonisation, came pockets of development in urban areas. In Southern Africa, these pockets necessitated the splitting of African families as men were expected to migrate to urban areas for work while women remained in their rural homes. At that time, it was worthwhile to educate the boy-child who had to be prepared for urban employment. The girl-child was not expected to migrate to urban areas, for such was associated with prostitution.

Note that the education of the boy-child was also linked to the utility of children who are also perceived as old-age security especially for mothers (Robertson 1984; van de Walle 1987). As noted by the Caldwells (Caldwell and Caldwell 1987:51) '[t]he African knows from personal experience that high fertility does not carry economic penalties'. Instead, numerous children are economic assets since they provide labour from childhood through adulthood; they provide old-age security and prestige to their parents. Granted that children are so valued within high mortality contexts, high fertility is valued because it assures parents of some surviving children.

High fertility also has a cultural value attached to it. As maintained by van de Walle (1987), in the mind-set of the traditional man, in his world of hunting, sowing and reaping, fertility is the first value: fertility of the fields, of domestic and wild animals, indeed fertility of the woman. Children are valued for the extension of the family line; boys retain and sustain the father's name. Note that within this context, the family comprises the couple and the next of kin, the woman is only connected to this kin group via her fertility. As noted by Fortes (1978), a woman does not gain adult status fully until she is a mother and not just a wife. Her future depends not on old pension, but on having sons who win her the respect of her husband and mother-in-law.

Transitional Fertility Regimes

The discussion on transitional fertility regions will draw heavily from the Zimbabwean and Zambian cases assuming that the values discussed above for SSA also pertain to these two countries which are also undergoing fertility transition with a total fertility rate which declined from over 7 children prior 1980, to 6.7 in 1981 down to 3.8 in 2005 in Zimbabwe. What has changed in the proximate determinants, indeed, the values and background factors underlying fertility?

In order to understand those factors that facilitated the decline, and their relationship to values, it is important to discuss the developmental stages that Zimbabwe has gone through in broad terms. It is argued that Zimbabwe has gone through five developmental stages: hunting and gathering, sedentary pre-colonial rural, colonial rural/urban, post-colonial rural/urban and the distant modern semi-developed stages.

In the first stage, division of labour was based more on convenience and support between sexes, and not necessarily on subordination. A large number of children was an asset. At that stage, fertility is perceived to have been low since it was necessary for the population to move from place to place in search of the means of survival.

In the second stage, the sedentary stage, predominance of the patriarchy took shape as women's contribution through fertility and food production on land which belonged to the patriarchy was perceived to enhance women's major role

of child bearing. Fertility was then high, albeit not recorded. The colonial stage, which is the third stage, saw men getting more educated and urbanised with the bulk of the women remaining in the rural areas as de facto heads of households. Children were an economic asset to such mothers who depended on the assistance of their children in the cultivation of the land, the herding of animals and the building of the necessary infrastructure needed for the running of homes. Children were a source of economic, social and physical security. Fertility increased in this stage up to over 7 children per woman. The role of Christian missions in changing the valuation of types of work and thus gender relationships, should not be underestimated (Comaroff and Comaroff 1992:113-114).

The fourth stage, the post-colonial era which started in 1980, saw the government of Zimbabwe making concerted efforts to reverse the sex imbalance in education and employment. Government endeavoured to provide education to all citizens regardless of sex with the hope of enhancing marketability in the common modern labour market. More women got education and training in a number of areas such as nursing and teaching. Legislation stipulating equal pay for equal jobs were stipulated while a number of women were also appointed in positions of power, a situation which not only accrued women another source of income as they were also contributing to household incomes, but served as role models for the girl-child. More and more women were now living with their husbands in the urban areas. Within the urban context, women's decision-making powers increased. On the other hand, children became more expensive as there was need to pay for housing, food and clothing. During this period, fertility declined to 6.5 in 1984. However, urban women were further ahead in the transition with lower levels of fertility than their rural counterparts. Rural fertility declined for different reasons; education increasingly became necessary for children to be marketable in the modern labour sector hence maintaining their role of providing old-age security. Although such children were still helping with their manual labour, some parents found it necessary to reduce their fertility to the educable number of children. This need increased as the economic situation in Zimbabwe deteriorated and the cost of both children's education and health was transferred from the state to parents. Thus, fertility declined because of development and the lack of it; it became a crisis-driven fertility transition.

Zimbabwe is currently experiencing all the five stages. There are still semi-sedentary, hunting and gathering groups such as the Tembomvura of the Zambezi valley (Marindo-Ranganai 1995). These women are experiencing high fertility, approximately seven children. The bulk of Zimbabwean women still live in rural agrarian communities where children remain economic assets for a number of reasons: they provide labour to their mothers, but most importantly, they provide old-age security to their parents. Education and training for children is essential if such children will manage to provide the needed security; yet such education and

training are increasingly becoming expensive. Such couples reduce their fertility to the educable number of children. In this situation, it is the lack of development that is driving fertility downwards. Note that the high cost of children is worse in urban compared to rural areas; hence, urban women have declining but lower fertility than their rural counterparts. Both groups are, however, reducing their fertility to lower levels than could have been achieved if the economic situation or development was sustaining. But the urban, thus more developed, couples are further ahead in the fertility transition. Both groups are managing to effectively achieve their desired number of children because of yet another developmental factor, availability of contraception.

A small proportion of women can be described as living in the fifth stage, the modern developed stage in which they are educated, employed and holding positions of power in work places. Such women have status not only in society, but also in the extended families within which they are daughters-in-law. Such status affords them the opportunity of having small families with minimal or any reprisals from in-laws – a reversal of a cultural value because of development. It is important to highlight at this juncture that these women are a "squeezed generation"; they feel obligated to help their parents while at the same time do not like to depend on their children for their old-age security. Such women are investing for themselves for the future through life insurances and other investments. At the same time, they are also investing heavily in their children, not for parent's old age security per se, but in order to make sure their children will be able to support them in the future. Fertility for this group of women is declining because the cost of children is high as they send their children to expensive schools. These parents also have competing needs and tastes that are incompatible with high fertility. Such tastes are ushered in by development that is thus eroding pro-natalistic values.

One can summarize this brief exposition by noting that the interplay of development and values has culminated in the observed fertility levels, hence demographic transition in Zimbabwe. First, the lack of development in pre-transitional Zimbabwe supported high levels of fertility since children were an economic asset with minimal economic costs. In addition, couples had not been exposed to the whole notion of family planning and family limitation of the nature necessitating substantial fertility decline. Family planning during the colonial era was only perceived as a colonial gimmick to reduce the African population. Second, the ushering in of development in the form of increased urbanisation and education altered values regarding production and reproduction. Yet the high value placed on sons as the inheritors of their fathers negatively impacted on the education and employment of women. "High producers" were those people who were educated and working in the modern labour market. They were valued

in society for their ability to produce incomes that could purchase goods and services unavailable to the agrarian communities. Within the urban settings, the cost of children also increased, people were also exposed to new goods and services commensurate with modernisation. Such modernisation not only eroded the value of children, but it also redefined the status of women. Fertility and income-generation complemented to define high status for women. Such development shifted the tastes away from children towards consumer goods. At the same time it ushered in family planning services while legitimising the whole notion of family planning. Today, even the least developed couples are exposed to their successful low fertility urban counterparts and desire to achieve such success, albeit at modest levels. The role model family has commensurately shifted from a high fertility to a low fertility one. High fertility increasingly gets associated with backwardness; it is development that changes values which in turn determines population.

A cursory assessment of the Zambian situation also shows that fertility levels and trends are influenced by developmental variables. For instance, education has persistently shown a depressant impact on fertility since 1980. In all census years, women with no education had half a statistical child more than those with tertiary education. Furthermore, between 1980 and 2000, women with no education, primary, and secondary education experienced increases in the TFR (Total Fertility Rate). In contrast, those with tertiary education experienced a slight decline in fertility. Similar findings were observed on the basis of Zambia Demographic and Health Survey findings. These, for example, show that women who have some secondary education experienced a steady decline in fertility, with the fertility rate for such women dropping buy one birth over the period from 1992 to 2001/2002.

Table 6.2: Total Fertility Rate by Educational Background: Zambia Census Year

Education	1980	1990	2000
No education	6.1	7.6	7.4
Primary	6.9	7.4	7.4
Secondary	4.7	5.9	6.4
Tertiary	3.9	3.2	3.5

(CSO, 2003a: 105)

Development, Values and Mortality

As noted earlier, people, regardless of level of development, value life to the extent that policies and programmes on mortality are often aimed at reducing morbidity and mortality. However, development has a significant impact on the achievement of health. It impacts on factors underlying morbidity and mortality; hence the differential mortality levels between developed and less developed nations. A discussion on factors underlying the modern rise in world population will assist in showing the relationship between development, values and mortality.

Factors Underlying Massive Mortality Decline

Although there are at least three schools of thought on factors underlying the decline in mortality, hence modern rise in population since 1650 – which include the medical (Razzell 1974), public health (Griffith 1967) and nutrition (McKeown 1976) – it is clear that all these factors are developmental. It is often argued that mortality decline was underlined by a host of factors that include: improved agriculture that necessitated the production of food and the consequent reduction in malnutrition. It is argued that industrialisation reduced mortality through the production of useful goods and services such as iron ploughs, steam engine, soap and other things. In turn, the production of soap facilitated the improvement of personal hygiene. Public health in the form of improved water supply and sewage disposal, and the reduction of water and airborne diseases all conspired to reduce mortality. The discovery of asepsis and anti-sepsis by John Lister facilitated the killing of disease-causing agents. This was complimented by the discovery of immunology that necessitated immunisation against killer diseases such as smallpox by Jenner, chicken pox by Koch and diphtheria by Behring and Roux. The discovery of drugs against syphilis by Ellick also enhanced health. Transport facilitated the transportation of all these discoveries, including that of food to the rest of the developed regions. As people's nutrition improved, as they got used to certain disease causing agents, people became more resistant to diseases, while the virulence of certain diseases also reduced. In addition to these discoveries was a change in attitude towards workers that led to social reforms that improved working conditions while prohibiting child labour.

Note that all these factors are a consequence of the overall development within contexts where life was, and continues to be valued. Mortality in the developing nations started to decline fairly substantially in the 1950s. In SSA the decline was necessitated largely by the importation of medical technology such as the wonder drugs. As colonialists built cities, they imported the public health knowledge and measures that they had enjoyed in their homes into the urban areas which became islands of development. Tertiary care was facilitated at central hospitals. However, substantial public health measures such as public sanitation, safe water and personal hygiene could not be implemented especially in the rural

areas where the bulk of people reside. Agriculture has also not improved to the levels of the developed nations; to the extent that malnutrition remains the most important underlying cause of infant and child deaths especially in SSA. As one can note, mortality declined to the extent that life expectancy increased to as high as 60 years in some countries in SSA; mortality levels of the developed nations will be achieved in Africa once there is significant developmental gains. What underlies the increase in mortality in SSA in a context of declining mortality in the developed world?

The increase in mortality in SSA since the mid-1980s is a consequence of high levels of HIV and AIDS. Lack of development enhances the spread and impact of HIV in SSA. First, little knowledge regarding the aetiology of disease makes it difficult for people of SSA to even appreciate HIV as the cause of the increasing mortality so far observed. Within SSA there are many social practices that enhance the spread of HIV. Such practices include, among others, polygamy, levirate, widow cleansing ceremonies, virginity testing by fathers-in-law, betrothal of young girls to older males and ceremonial and social sharing of sexual partners. Perennial poverty not only exposes a population to more disease, but also necessitates commercial sex work, and the moral/spiritual poverty that enhances the demand for such commercial sex work characterises the SSA region. For all these reasons, the entire sexually active population in SSA is at risk of HIV infection, unlike in the developed nations where high-risk groups could be clearly identified. This poverty, or lack of development, makes HIV a death sentence for most of the people who get infected by the virus, especially because most people cannot afford the anti-retroviral drugs now commonly used in the developed world to delay the progression of HIV to AIDS. One can simply argue that people die in their thousands from AIDS in Africa not because they do not value life. To the contrary, SS Africans value life; however, the lack of development does not enable the African man and woman to preserve their lives!

Development, Values and Migration

Introduction

Most theories of migration maintain that people migrate from areas of less development, and therefore less opportunities, to areas of development and opportunities (Lee 1968). In SAA such migration is dominated by the rural-urban type. Consistent with this argument is the argument that people are attracted by education and employment opportunities and a more comfortable life-style, the so-called pull factors, while they are pushed away from the rural areas by lack of such amenities, the push factors. This argument holds for migration within and between countries. The ensuing discussion intends to support these assertions drawing heavily from the Zimbabwean and Zambian experiences.

The Zimbabwean Experience

Data from Zimbabwe (Table 6.3) shows that Zimbabwe's net migration was negative since 1980. During the 1980-1984 period, there was a mass exodus of the white population from Zimbabwe. Indeed, this was largely politically precipitated. In fact, the white emigration was somewhat counterbalanced by the immigration of black Zimbabweans who had been in the Diaspora, having run away from the war. The massive emigration fairly stabilised from the late 1980s to the end of the 1990s. From 1998, emigration started to increase from about 1,375 emigrants and peaked in 2005 that recorded about 10,986 emigrates. We should note that the current emigration is paralleled by the deterioration of the economic situation and hence the lack of development. Zimbabwe has lost large numbers of both professionals and non-professionals alike to other countries where they go in search for better employment opportunities. These opportunities are being sought in the developed nations such as Britain, Australia, New Zealand and the United States of America.

During the 1992-2002 period, a significant proportion of the internal migration was between rural and urban areas within Zimbabwe. For instance, while net migration for the two largest cities, Harare and Bulawayo, respectively, was about 25 per cent and 50 per cent respectively, these rates had declined to 23 per cent and 28 per cent respectively (CSO 1994; CSO, 2004). During this same period, the bulk of the rural areas had a negative net migration. Thus, both short and long-distance migration are dependent on developmental situations, while the actual migration process is also facilitated by development which is facilitating travelling for long distances.

Table 6.3: Migration in Zimbabwe 1980-2005

Year	Immigrants	Emigrants	Net Migration
1980	6407	17240	-10833
1981	7794	20534	-12740
1982	7715	17942	-10227
1983	6944	19067	-12123
1984	5567	16979	-11412
1985	5471	6918	-1447
1986	4897	3787	1110
1987	3925	5330	-1405
1988	2915	4305	-1390
1989	3342	4565	-1223
1990	2964	4224	-1260
1991	3583	4031	-448
1992	3171	2620	551
1993	3461	3056	405
1994	2921	3474	-553
1995	2901	3282	-381
1996	3286	1629	1657
1997	2483	1821	662
1998	1286	2661	-1375
1999	3152	3860	-708
2000	1747	5531	-3784
2001	752	6739	-5987
2002	966	8524	-7558
2003	643	8950	-8307
2004	987	12110	-11123
2005	643	11629	-10986

The Zambian Experience

Historical Oatterns of Migration

Early migratory trends were spurred on by policies pursued by the British Colonial Office and its agent, the British South Africa Company. These policies were all designed to encourage labour migration, first to the mines of South Africa and later to Northern Rhodesia's own Copperbelt. Among these policies were those that prevented alternatives to wage labour, which included outlawing traditional subsistence systems and cash cropping, and enforcing hut and poll taxes (Chipungu 1992; Seleti 1992; Vail 1983).

Colonialism established a system by which migrant labourers were temporary town dwellers, in town solely for employment, while maintaining their real home in the village. Residence and housing were restricted to specific areas of town, and for men only. Women's employment in town was banned until the late 1950s and licences for business were given to Africans only in the Native Territories (Seleti 1992). In the late 1950s, however, restrictions on travel, work and housing were eased and employment opportunities for women became more readily available (Schuster and Van Pelt 1993; Schuster 1979). By the time of independence in 1964, all such restrictions were lifted, and people could flow to and from town, and more importantly, find better and more permanent employment, as well as establish long-term households there.

Yet, despite the potential for decreasing links with the rural family that more freedom of movement and longer residence in town might encourage, the pattern of circulatory migration persisted into the 1970s (Chilivumbo 1985; Ohadike 1981). Using data from the 1980s, Ogura (1991) suggests that while circular migration might have decreased during recent years in Zambia, town migrants still ultimately return to their home villages upon retirement, and thus maintain some kind of link with home communities. Rural-to-urban migration is necessitated by the search for education and jobs, from areas of little development to areas of greater development.

Contemporary Patterns of Migration

Post-independence migratory flows between 1963 and 1980 followed the normal "gravity" pattern whereby the nearest attractions were preferred. It was from the less developed rural areas to the more developed urban areas.

An analysis of migratory patterns between 1980 and 2000 shows the pattern decreasing the importance of rural-urban migration and the emergence of urban-rural and urban-urban migration. Overall, the picture that emerges shows that urban-rural migration is taking dominance over rural-urban migration. The economic recession has made migration to the Copperbelt, Central, and Lusaka

less attractive than it was before independence. The economic recession has been more pronounced in the mining industry whilst the more diversified economy of Lusaka still exerts an influence in attracting migrants.

It is clear that migration is influenced by development patterns as shown in Table 6.4 below that compares net migration, poverty, levels and income. This shows that between 1980 and 2000, the more impoverished provinces like Northern, North-Western, Eastern, Luapula and Western provinces experienced significant losses, whilst richer and more developed provinces like Lusaka and the Copperbelt had net gains in population.

Table 6.4: Relationship between Migration and Development Indicators in Zambia

	Per capita Income (US$)	**Overall**	**1980**	**1990**	**2000**
			Poverty		
Zambia	347.4	73			
Residence					
Rural		83			
Urban		56			
Province					
Central	271.6	77.0	12.4	13.6	12.8
Copperbelt	414.5	65.0	22.2	7.0	-6.1
Eastern	311.8	80.0	-26.9	-14.0	-5.7
Luapula	243.1	81.0	-15.1	-10.2	-3.4
Lusaka	588.6	52.0	33.1	27.8	21.2
Northern	265.7	81.0	-23.8	-14.2	-6.9
North –Western	263.7	76.0	-21.1	-13.6	-5.2
Southern	362.8	76.0	-3.3	-4.2	-5.8
Western	210.2	89.0	-13.8	-11.3	-6.3

p103 p. 4 (ZDHR, 2004 estimates)

(CSO, 2003a:4, ZDHS, 2007i:103)

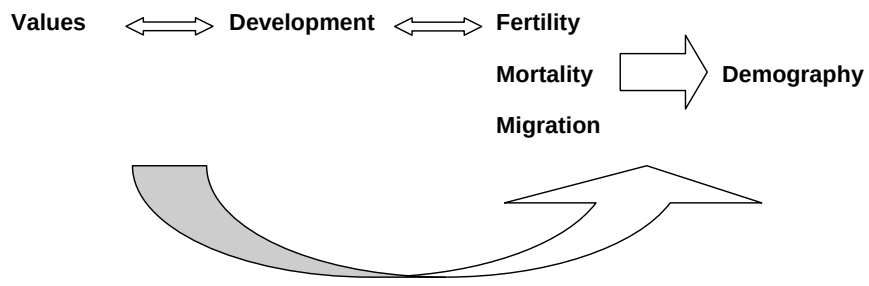
The patterns of migration in Zambia and Zimbabwe, therefore, are broadly similar as economic and political change and legal and social restrictions determine most of the dynamics. However, it is interesting that the connection to a cultural and social setting in a rural context retains some purchase as can be seen in the circulatory migration patterns – even if the circulation is co-determined by economic factors.

Conclusion

The demography of any nation is affected by three components of population growth: fertility, mortality and migration. In turn, these components of growth take place within socio-economic and cultural nexi with variable values, hence differential demographic characteristics between and within countries. The values regarding reproduction, mortality and migration are affected by development, yet values also affect development. And demography impacts upon development: it is an interplay of reciprocal relationships as shown in Figure 6.1 below.

Yet, this simple causality that underlies most of the argumentation above only works on an aggregate level and the explanation is a rational choice-based model of a complex reality in which new meaning develops over time and with many variations. The fact that it does seem to play out in the terms that were suggested at the beginning does not mean that a closer reading of the material and the data from other methodologies will not enhance our understanding of the dynamics and the mechanisms of change. We still cannot conclude decisively what the direction of causalities is. To answer that question, a qualitative analysis is needed and, even then, such an analysis will be dependent on theoretical points of departure.

Figure 6.1: Interplay of Reciprocal Relationships between Demography and Development



The intricate relationship between values, development and demography also emphasizes the need for holistic intervention programmes if changes, especially, in values, development and demography are to be effected. For instance, efforts to reduce the rates of population growth, especially in Africa where children were highly valued, through the provision of family planning did not yield results. However, as developmental factors changed, such undermined the value of children, thereby rendering contraception logical. And if mortality is to be significantly reduced in Africa, it is necessary to tackle poverty thereby enhancing development, the driver to good health. It is imperative to repeat the cry by developing nations in the 1970s when family planning was being pushed into the region: "Development is the best pill". With development, the exodus of professionals from the poor countries of Africa to the developed nations will abate; the high levels of fertility will reduce, while the high levels of morbidity and mortality will be the story of the past. Such changes will be the bedrock of increased development and human welfare in Africa. The value system will change commensurately.