POPULATION CHANGE IN SOUTHERN AFRICA IN THE 1990's

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This paper focusses on population growth in Southern Africa, and on the countries where growth rates can be expected to fall in the 1990s, notably the Republic of South Africa, Botswana, and Zimbabwe. These are contrasted with a ring of countries to the North, where growth rates can be expected to remain high, at above 3% per annum.

Fordham (1970: 19) writing about Africa in the 1960s, considered that when the problems of political cohesion had been overcome :

" .. size becomes an advantage rather than a hinderance. For except in a few overcrowded areas like Rwanda, Burundi or parts of Kenya and Nigeria there is room to expand and develop: room for the population to grow (as it is beginning to grow) and be absorbed; room to contain a growing and much needed labour force: room to experiment with new agricultural techniques to produce the food for the new generation as well as the food for today; above all there will be room to live .... space will be one of Africa's greatest assets for a long time to come. " In 1989 Bryceson (1989:427) stated that " Sub- Saharan Africa is land abundant relative to Asia and Latin America. Although most of the population lives in rural areas (roughly 80%) population densities are low. "

However Sai (1988 : 267) points to a change in attitudes:
" Until very recently many would have said that Africa was a vast continent, sparsely populated and where over-population was not a problem. What is needed , they would have said , is economic and social development, not population programmes. Now, however, perceptions are changing...."

THE COMPONENTS OF GROWTH

The discussion looks at the population growth rate and its components: fertility, mortality and international migration. It must be remembered that the rate of natural increase (the difference between the birthrates and the death rates, expressed as a percentage) will be the same as the growth rate if there is no international migration. The main emphasis is on fertility, with family planning as the key determinant. Major falls in mortality have either been attained or are difficult to predict, while international

migration is seen as the most unpredictable of the three components.

Fertility

Africa is typified by high rates of population growth due to high fertility and falling mortality. Indeed when writers claim that a particular African country has " one of the highest population growth rates in the world " they may obscure the fact that a number of other African countries. have simlar growth rates. The World Bank (1988: 276-7) anticipates falling fertility in a number of countries ranging from Malawi with a per capita income of US $ 160 through to South Africa whose per capita income was ten times greater. This can be contrasted with the following statement by Caldwell and Caldwell (1987 : 434):

" Fertility in sub- Saharan Africa will fall ... But in this century there will be no declines like those of Asia, and fertility will probably remain above even the seemingly cautious World Bank standard projection. That projection shows the Crude Birth Rate for the entire region falling from the current level of 47 per thousand population to around 40 in the year 2000. We feel that it might not fall much below 45 in the absence of a radical change in government attitudes toward family planning programs and the population of sub- Saharan Africa might indeed climb to well over 750 million instead of the 696 forecast by the United Nations (1986, p.45) or the 730 million forecast by the World Bank (1986, pp 13-16). "

Data from those African countries that participated in the World Fertility Survey between 1977 and 1982 had shown low contraceptive use amongst married women (5% on average) and desire for large families on, on average, eight children (Way et al. 1987). However marked increases in contraceptive use have been recorded amongst married women in several countries, including Zimbabwe and Botswana, which are discussed in more detail below.

Mortality

Falling mortality has made a substantial contribution to the rise in growth rates, but the possibility exists that famine and the AIDS epidemic will cause mortality to rise. In recent years many African countries have experienced adverse economic conditions, yet this does not necessarily result in worsening mortality. For instance Sanders and Davies (1988: 723) have written about Zimbabwe in the 1980s that:

" Despite a prolonged drought, economic recession and the imposition of economic stabilisation measures, there is evidence of sharp improvement in infant and child

mortality ". Before Independence in 1980 the Infant Mortality Rate was around 120, falling to around 83 in 1982 (Sanders and Davies, 1988: 729) In contrast, adverse economic conditions related to political destabilisation or natural disasters must effect mortality, although changes may not be reflected in the statistics.

Vaughan (1987: 16) discusses the view that because of international relief efforts, better communications, and the commercialisation of the agriculture, famine no longer acts as a' Malthusian check. Yet she finds it hard to accept evidence for the 'conquest of famine ' when millions are starving in Africa. " Nowhere in Africa , it seems , if you are starving can you be sure that relief will come your way, and this is as true for the wealthiest country ".

A new influence on the mortality situation is AIDS, the Acquired Immune Deficiency Syndrome, but how will this affect mortaltiy ? WHO estimates, cited in the Southern Africam Economist in April 1989 are that over a million Africans are already infected with the HIV virus. The costs of AIDS programmes of education and treatment will be a " further drain of affordable resources for African nations " (Southern African Economist, 1989 : 53--54). However one view is that AIDS will have only a minimal impact on population growth. One factor is that death may occur more than a decade after contracting the virus, another is that AIDS is prevalent in countries which already have quite high mortality, so that if AIDS doesnt kill you, something else must.

International Migration

International movements, including labour migration, are often influenced by political factors and are therefore highly volatile. Examples are the substantial numbers of refugees who fled from Angola and Mozambique to neighouring countries in recent years. Conversely perhaps 100,000 refugees have returned to Namibia this year when the nation gained its Independence. According to United Nations (1989) estimates 8% of South A frica's population is foreign- born, compared with 5% for Swaziland, 4% for Zambia, and 0.3% for Mozambique. According to Gouveia (1990), " close to one million while immigrant South African possess or have access foreign passports. The stability of this large group wiil have serious implications for a peaceful transition to a new social order ".

THE REPUBLIC OF SOUTH AFRICA

The Republic of South Africa is treated first, partly because of its size and economic strength and partly because as an employer of migrant labour its policies have had an impact on the population dynamics of neighbouring states. SOUTHSCAN (1989: 354) cited population figures for the whole of South Africa, including the ten homelands, for June 1989 : the total was 30.1 million, with Africans numbering 21.2 million, Whites just under 5 million, Coloureds 3.2 million, and Indians 950,000. The population was estimated to be growing at 2 percent per annum. The 1987 report of the Department of National Health gave an optimum population based on South Africa's economic resources of 80 million which could be achieved if the Total Fertiity Rate fell to 2.1 by the year 2010. (Cooper et al. 1989: 149- 150).

In 1980 the population density for South Africa was 24 persons per square Kilometre. However the White areas with a 1980 population of just over 18 million, covered 1,064,000 out of the total area of 1,235, 000 square Kilometres. This gave a density of 24 in the White areas, compared with 66 in the reserves which contained 11.3 million persons with an area of around 171,000 square kilometres. In the Republic of South Africa the population density of the KwaNdebele reserve was 214, and in the Qwa Qwa reserve 329 (Wilson and Ramphele, 1989: 37).

Because of the inequalities between the Whites, Indians, Coloureds, and Blacks, they must be considered separately. Indeed two key statistics given by the World Bank (1988: 237)- a life expectancy of birth of 61 years and a Total Fertility Rate of 4.5 births per woman - are really rather uniformative.

White fertility has fallen to below the replacement level, but immigration has contributed to the population of whites growing by 2.1 % in the period 1960-1970, compared with 2.6% for Indians and Africans, and 3.0% for Coloureds. Africans constituted 71% of South Africa's population in 1975, but this was projected to rise to 78% by the end of the century (Brown, 1987: 256-7). The rates given in the 1987 annual report of the Department of National Health and Development imply a greater proportion of Africans in the population, for the African growth rate was 2.8% whereas the rate of increase had fallen to 0.8% for Whites and 1.9% for both Indians and Coloureds. (Cooper et al., 1989: 149).

Mauldin and Segal (1988: 344) give an estimate of contraceptive prevalence for 1976 between 37% and 50%.which woulod mean that in the 1970s South Africa was far in advance of other sub- Saharan African countries. Soaring unemployment among the growing black labour force was a

factor leading to the establishment of a national family planning programme in 1974, which although officially non-discriminatory, in practice/ targetted the African, particularly the urban blacks. Spending on family planning services increased thirteenfold in the first ten years of the programme. (Brown, 1987: 266- 7). The number of women protected by modern contraceptive methods rose from 437,000 to 1,200,000 in 1983. The contraceptive prevalence target of 50% by 1980 was achieved, with the Total Fertility Rate falling from 6.6 in 1960 to 5.2 in 1980 for Africans and from 6.5 to 3.3 for Coloureds. Thereafter the programme seems to have stalled and the Science Committee of the President's Council considered further reductions in fertility would require improved living standards for the poor and lower mortality. (Brown 1987: 270). Ex- nuptial fertility is believed to be very high in parts of South Africa: for example Murray (1987: 104) asserts that 60% of the African township of Soweto were out of wedlock.

ZIMBABWE

In 1965 the Rhodesian whites had announced a unilateral declaration of independence. By the end of the 1970s the country was ' destabilised ' . About one in seven of the African population had left their homes because of the conflict and agriculture, health and education had been severely damaged. (Kay, 1987:1107)In the light of this, the achievements in health and education after Independence were quite remarkable, with rising proportions of government expenditure devoted to these services between 1980 and 1987 (World Bank: 1989: 264). During the same period the Infant Mortality Rate is estimated to have fallen from 82 deaths per 1,000 live births to 74. (World Bank, 1989: 272).

Estimates of fertility have fluctuated over time, with a 1984 survey estimate of a Total Fertility Rate of 6.7 per women providing no hint of a fertility decline. However, the 1988 Demographic and Health Survey indicated a recent fall to 5.5, and a rise in the current use of modern methods of contraception from 27% in 1984. to 36% in 1988. (Zimbabwe, 1989: 30-31 and Table 4.15). thus although the World Bank (1989: 269) shows a population rate of 3.7 % for the period 1980-7, the average is expected to be 3.0% from 1987-2000.

BOTSWANA

The National Development Plan 1985- 91 (Botsana, no date: 8-9) gives a population growth rate of 3.4% per annum, with the population doubling every 20 years, attibutable to high fertility, and declining mortality and emigration. Attention is drawn to the high proportion of children and young people in the population, and to the high proportion (25 %) of males aged 20-40 years working abroad in 1981. The Plan (page 68) significantly indicates that paid

employment can cater for only a minority of new entrants to the labour force.

The 1988 Demographic and Health Survey 1988 showed a decline in the Total Fertility Rate from 7.1 in 1981 to 5.0 in 1988, contraceptive prevalence of 33% and an Infant Mortality Rate of 37 per 1000 (Botswana, 1989). However, the declines in fertility and infant mortality have been met with some scepticism, and may have been affected by the prolonged drought.

ANGOLA AND MOZAMBIQUE

According to Curtis (1988:6-7), the population of Angola in 1988 was about 8.5 million, with population growth of about 2.8%, and expected to reach 13 million by the year 2000. This rapid growth was achieved in spite of infant mortality of around 200 per thousand live births and HIGH ' under five ' mortality. Because of destabalisation, access to health centres had fallen to below 30% of the population, and in Malanje Province about half of the health centres and health posts had been destroyed.

Using unpublished 1983 census results Sousa Colaco (1986) showed that in the Angola's Luanda, which contained about 12% of the country's population,, the average parity of a woman aged 40-49 was around 6.9 while the Total Fertility Rate was 6.9. However in 1982 child spacing programs were implemented. Family planning had been accepted after considerable public debate to minimize infant and maternal mortality and " sensibilisation " had gradually begun in hopitals. (Angola, 1985)

UNICEF estimates of infant and child mortality for Mozambique and Angola in 1986 are the same with an Infant Mortality Rate of 200 per 1000 live births and Under 5 mortality rates, calculated from fragmentary data of between 325 and 375 per 1000 births. In comparison Under 5 mortality was 132 in Zambia, 96 in Botswana, and 270 in Malawi. As in Angola, health posts and centres had been attacked, and more than half had been destroyed or forced to close since 1982. (Green et al., 1989: 12- 13).

ZAMBIA

. The United National Independence Party (UNIP) has been the ruling party since Independence in 1964, with President Kenneth Kaunda as party leader and chief executive. Under the independence constitution, executive power was placed

with the President, who used his position to initiate policy. In the 1960s President Kaunda was able to initiate major economic reforms, apparently without Cabinet involvement, and to extend his control within the party. (Gertzel et al.,1984: 13).

A Key statement was made by President Kaunda, in his opening address to the National Conference on Zambia's Population Policy in May, 1989. This included the following:

". for the first decade and a half after independence , we in Zambia did not view the high rate of population growth as a developmental problem .. Things have, however changed considerably both nationality- wise and interantionally. We in the leadership accordingly had to reappraise our perceptions of the role of population in our national developmental efforts. Such a reppraisal led us to believe that our planning and plan implementation processes should not only try to accomodate the increased demands for goods and services brought about by increase in the size and growth rate of our population , but should also aim at influencing those aspects of our socio-cultural life that have kept high our levels of reproduction and thus of population growth '.

The Economic Review 1986 and Annual Plan 1987 (Zambia 1987: 68) notes that " in the previous national development plans demographic factors were barely treated". However " the Party and the Government had decided that population factors should from part of the national development planning process " and consequently a Chapter on the demographic situation appeared for the first time in the Fourth National Development Plan. In 1985/6 a Population and Development Unit was established within the National Commission for Development Planning. In 1990 the NCDP published " Zambia's Population Policy ". It was noted that the population growth rate had risen from 2.6 % per annum in the 1960s to 3.7 % in the 1985- 1990 period. This was " among the highest rates of population growth in the world and implies an 18- year doubling time of the population ". (Zambia, 1990 :3). The Population Policy targets for the yedar were the reduction of the growth rates to 3.4% , the Total Fertility Rate to 4, and the infant mortality rate to 65, and to " make family planning services accessible and affordable by at least 30 per cent of all adults in need of such services by the year 2000 '. (Zambia, 1990: 21- 22).

Significantly, in making the demographic projections for the period 1985- 2000 the Central Statistical Office (Zambia 1985) assumed that fertility would remain constant, with a TFR of around 7 per woman. On the assuption that mortality

would continue to fall, the 1980 census population was projected to rise from 5.7 million to between 1190.5 and 11788.5 by the year 2000. In both the 1969 and 1980 census' Western Province and North Western had lower fertility than the rest of the county, and higher levels of childlessness (Zambia 1985: 52-3).

The assumption that mortality will continue to decline may be unrealistic. According to the the National Commision for Development Planning Commission (Zambia 1987: 73) life expectancy has increased because of free medical services , but the health system is now facing severe problems due to rapid population growth and severe economic problems. In 1986 there wsere only 358 doctors compared with 945 established posts. (Zambia 1987: 337)

Use of contraception in 1977 was believed to be negligible.(Mauldin and Segal, 1988 : 345). Family planning service statistics issued by the Planned Parenthood Association of Zambia (PPAZ) also give some support to the assumption of constant and high fertility, even though their figures only clients attending PPAZ and Ministry of Health clinics. The number of acceptors using modern contraception was 114, 538 in 1986 and 162, 028 in 1987 of which 61,646 were new acceptors. (PPAZ, 1988). This represented a considerable improvement on the 48,857 accptors in 1980.

Using results from the 1988 Contraceptive Prevalence Survey, Banda (1989: 40-41) noted that while 60% of women had heard of at least one method of contraception, only 12% had used at least one method. Of the women who had never used contraception, just under half had positive intentions of using a family planning method in the future.

Urban bias has been a feature of the Zambian economy for decades. In 1968 a Zambian urban worker's income was more than six times greater than that of a typical village family, and this led President Kaunda to warn of the dangers of ' two nations within one '. (Gertzel et al.1984: 7). Until the early 1980s Zambia's health services focussed on urban hopitals and it has been hard to allocate resources for the development of primary health care since its inception in 1981. (Zambia, 1987: 343). Nurses were distributed in favour of urban areas.(Zambia 1987: 338) The staff shortages for family health nurses in rural areas was aggravated by a lack of accomodation, particularly in Western, North- Western , Northern and Luapula Provinces. Other constraints include a lack of incentives for rural staff, transport, and delys in amending the regulations to permit nurses and midwives to prescribe contraceptives and insert IUDs. (Zambia 1987: 83).

Doctors are highly concentrated in the urbanized Provinces, so that in 1983 there was one doctor per 7,604 overall, but at the provincial level the ratio ranged from 1: 3217 in Lusaka to 1: 22,375 in Northern Province. In Northern Province 43% of the population lived more than 12 Km away from a health facility compared with a national average of 27%.(Zambia:1987: 342). Within Lusaka facilities are are evenly distributed: for example in a pilot survey of clinic clients in 1984, no did not include women in squatter areas since no clinics were located in squatter areas. (Munachonga, 1989: 4). Family planning services have tended to be used by the urban elite, partly because in the past voluntary services have been an urban phenomena (Munachonga 1989 : 7).

MALAWI

In the intercensal period 1977- 1987 Malawi's growth rate was 3.7 percent, implying that the 1987 population of almost eight million would double in less than 20 years. Admittedly the rate of growth had been forced up by an influx of refugees from Mozambique, but even so the rate of natural increase was 3.2 percent .The population density had increased from 22 persons per square kilometre to 85 in 1987. (Mbale, 1989). According to Vaughan (1987: 60) overpopulation had became a new concern in the Southern Province, in which Blantyre district was situated, as early as 1931.

In 1982 modern child spacing services had been integrated into the Maternal and Child Health Programme of the Ministry of Health in September,1982. (Krugmann- Randolf, 1989).

Interest in population was increasingly evident in the second half of the 1980s, even though the Statement of Development Policies 1987- 1996 gives only limited attention to the population dynamics and interactions. Indeed on its first page its statement that ' Total population in 1987 is estimated at just over 7 million ..... ' was, in retrospect, incorrect. Consequent upon a World Bank Population Review in 1986, a population unit was set up in the Department of Economic Planning and Development. (Zimalirana, 1989). In 1988 a UNFPA Country Adviser was appointed.

SWAZILAND

Swaziland has a small population of 706,137 at the census of July 1st, 1986, but is described as having one of the

highest living standards of sub- saharan Africa. About 60% of the population are Christians, while the Catholic church had an estimated 37,000 adherents in 1983.(Africa South of the Sahara, 1987: 973, 978, 983).

A 1988 Family Health Survey showed that women aged 45-49 reported an average of 5.4 children, with the urban average of 4.5 slightly more than one child higher than the rural average of 5.6. The Total Fertility Rate from the Survey is 5.0, but reporting problems are believed to have affected this estimate, (Swaziland 1989: 15) which will probably be below that of the forthcoming estimates based on the 1986 Census. Knowledge of modern contractive methods was quite extensive, although clearly higher in urban than in rural areas. (Swaziland 1989 : Table 5). Current use of contracepetion was reported by 16.6% of women, and 19.8% of ever married women (1836 cases) and unmarried women with children (1416 cases). The corresponding use of modern methods was 13.9% and 17.1 %, but reponses from males sugget that condom use may have been under-reported. (Swaziland 1989 : Tables 7-9). As can be seen from the sample numbers, many mothers are unmarried, and, as in Botswana, changes in family formation mayy influence fertility levels.

LESOTHO

Lesotho is distinguished because females are more likely to be educated that males. In 1965 the enrolment ratio for primary education was 74% for males and 102% for females. By 1986 these figures had risen to 114% for males and 127% for feamles. (World Bank, 1989 : Table 32). By this standard Lesotho should be one of those African countries where Caldwell's (!982 : Chapter 10) theory about the attainment of mass education being associated with the onset of the fertility decline can be put to the test. Other features are also relevant to Caldwell's writings. Landlessness is increasing, and the country is predominantly Christian with
education admininstered by the main missions.

Lesotho has, by African standards, quite low fertility with a Total Fertility Rate in 1976 between 5 and 6 births per woman (Lesotho 1981: Table 3.4). Contributory factors include childlessness and the absence of males who are working in South Africa. In the mid-1970s these comprised about 22% of the de jure male population, although a quarter of these migrants visit home at least twice a year. (Lesotho 1981 : 3.8)

In the 1980-5 Development Plan the Government explicitly stated that the current population growth rate of 2.3% was

too high. Howeever although the Government was aware of the consequences of high fertility it was ' also aware of the sensitive nature of fertility issues due to a complex of cultural and religious factors ' and accordingly the major policy objective was childspacing to improve family well-being. (Lesotho, 1988: 18)

In 1988 there were 460 nurses in Lesotho, but a half of these (232) were in Maseru District. Thus the ratio of nurses per 1,000 population ranged from 1: 1123 in Maseru to 1:8522 in the mountainous Mokhotlong. Maternal and child health services were stated to cover the whole country and to be satisfactorily used by rural communities while 64% of families were within one hour walking distance from a health facility. (Lesotho, 1988 : 93-95).

With so many of the men absent in South Africa, it must be presumed that many wives are exposed to the risk of pregnancy. Unpublished figures from the Health Statistics Unit for show that family planning attendances totalled 61,258 in 1988.

In 1987, 51% of attendances were for the pill and 29% injectables. Assuming that there were around 370,000 females aged 15-49 in 1987 (See Lesotho 1981: 6.7) , that clients for the major methods would need to attend four times to obtain a years supply, perhaps 4% of women were attending family planning clinics.

Family planning service statistics are collected by Health Service Area, and by dividing 1988 attendance figures to the 1989 population estimates of the Ministry of Health,. it can be seen that in the lowlands women are clearly more likely to attend a clinic than in the foothills or mountainous areas.

POLICIES AND PROSPECTS

Demographic papares often end with a plea for more data and more research, so it is pleasing to note how gaps in odemographic knowledge have been filled in the 1980s. The main lacunae are indicators for Mozambique, Angola, Namibia and for black South Africans.

Sai (1988: 269) showed that of 24 African countries, 13 felt that fertility was too high in the 1980s , and that most of these governments supported family planning in the 1970s for demographic rather than for health reasons. Of the countries discussed above, Zimbabwe and Botswana thought that fertility was too high, as did Lesotho, and all

three supported family planning for demographic reasons. Zambia thought its fertility to be satisfactory, and supported family planning for health reasons. Angola, Mozambique, and South Africa were excluded from the Table. In 1984, using the scores of family planning effort developed by Mauldin and Lapham, Sai (1988 : 274) classed African family planning programmes for 24 African countries were all classed as ' Very Weak ' ' or ' Weak ' while Zimbabwe which was ' Moderate '.

In at least two countries, Malawi and Lesotho, the objective is to reduce the population growth rate, but family planning is not stated to be one of the instruments of the change. Instead child spacing is supported for non-demographic reasons. Yet as shown above family planning has made progress in Botswana and Zimbabwe, which has begun to influence fertility levels. However policy changes in Malawi and Zambia are unlikely to have any significant effect on fertility levels in the 1990s.

In many of the countries under dicussion there are severe economic and logistical problems to the provsion of family planning services. These may be related to low population density, transport difficulties or staff shortges. It could be argued that these constraints should also prevent improvements in mortality, but in practice it seems easier to conduct an immunization campaign than to make family planning supplies readily available. Improvements in mortality may occur together with a decline in traditional methods of birth spacing, combining to keep growth rates at high levels.

Political change can affect international migration and national growth rates. The end of destablization can mean the return of refugees, e.g. from Malawi to Mozambique. Conversely there may be new flows of refugees from new areas in the 1990s. Labour migration to South Africa is on the decline, which adds to the growth rates of the sending countries as the numbers of returning absentees rise.

Overall it appears as if rapid population growth will be a significant factor in the political economy of the region, even if fertility declines have begun. Zambia's Population Policy draws attention to the population momentum for " the size of the population is certain to continue to increasing for many years to come even if fertility levels were to decline considerably ...Since the number of young persons, who are the future parents, is already so large. " (Zambia, 1990: 8-9). This means that all governments in the region will need to cope with a gowing demand for school places and employment opportunities.

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