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Negotiating Culture: Poverty, Inequality and Population

Sustainable development decreases poverty and inequality and promotes socio-economic inclusion for all groups. Unequal distribution of the products of economic growth increases both the extent and the depth of poverty. Poverty and inequality limit access to resources and opportunities. In this reality, cultural components such as family relationships, patterns of human activity, coping strategies and prescribed and unsanctioned behaviours are important and consistent features. Poor health and low levels of education make it more difficult to translate additional income into improved well-being, preventing people from establishing or reaching personal goals.¹

Some 750 million people face socio-economic discrimination or disadvantage because of their cultural identities.² Policies may deliberately exclude them or, by limiting access to services and funding, may expose them to a life of poverty. Minorities subject to discrimination and disadvantage are more likely to be poor. The poor are less healthy than the better-off, use health services less, are less likely to avoid unhealthy practices or adopt healthy ones and are disadvantaged in other areas that determine health status.³ Life expectancies are short and maternal mortality and morbidity are high. Poor women in particular are bound by aspects of tradition and culture detrimental to their well-being.

Recent analyses emphasize that relationships of inequality sustain the structures and processes that keep people in poverty. Economic and political analysis must be placed within cultural contexts, examining not only the types of choices made but the local conditions and external dynamics within which they are made. This is a requirement to substantiate and improve the resulting policy advice.

◀ *A family business in Kathmandu, Nepal. In many cultures, doing other people's laundry is typically a job for the poor.*

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Cultural Contexts of Population Issues, Poverty and Inequality

High fertility increases poverty by slowing economic growth and by skewing the distribution of consumption against the poor. Reducing fertility – by reducing mortality, increasing education and improving access to services, especially reproductive health and family planning – counters both of these effects.⁴ The Programme of Action of the International Conference on Population and Development (ICPD) is the basis for achieving population and development objectives within a framework of human rights and gender equality. Goals include universal access to reproductive health care, universal education and the empowerment of women and gender equality as decisive factors needed to facilitate development and reduce poverty. These goals have been incorporated in the Millennium Development Goals (MDGs).

Conditions of poverty and inequality, including women's unequal rights to household assets and decision-making, the burden of care that HIV and AIDS impose on women, and girls' and women's exposure to gender-based violence (including women who are refugees or victims of trafficking) make it more difficult to promote reproductive rights and health.

Population issues at the community, family and individual levels come down to decisions about the number of children to have and when to have them; decisions about health care and health-related behaviour; investments in children (often dependent on the gender of the child and anticipated future returns to the family); and decisions about whether and when to move in search of a better livelihood. All of these decisions are made within specific cultural contexts.

Culture and Fertility Issues

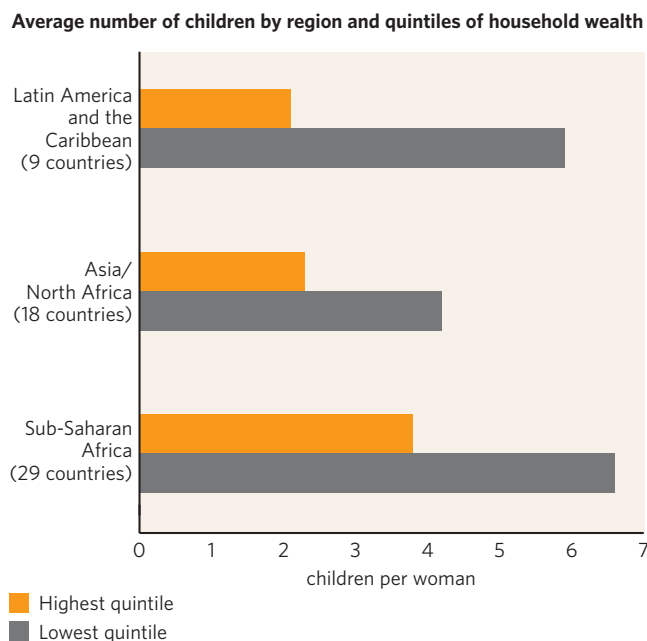
One of the most fundamental decisions a couple makes is whether, when and how many children to have. In the past, rigid societal and cultural constraints shaped child-bearing behaviour; under-five mortality was high; and very high fertility was necessary for society's survival. This requirement became ossified in strict behavioural norms favouring numerous and closely spaced births. This remains true in situations where health care is poor, the cost of childrearing is relatively low and stable, children's

labour is an important economic asset for the family and there are no economic opportunities beyond subsistence farming. In these conditions, families reason that children can contribute to household welfare through child labour, agricultural work, domestic work and support for parents in old age. Where under-five mortality is high, higher fertility increases the likelihood that the desired number of children will survive.

Development redefines the value of children. More children survive, and their labour is no longer an important source of income for the family; on the contrary, parents wish to invest in their family's health and education. Cultural norms adapt, aided by increased exposure to reproductive health information and services.

Globally, the average number of children a woman has is 2.6; the number in developed countries is 1.6 and in less developed countries, 2.8. Income quintiles within countries also reflect fertility differentials. In each of the 48 countries where such data were gathered, women from the lower-income quintiles had consistently higher fertility than those in the highest-income quintiles (Figure 2). In sub-Saharan Africa and Latin America and the Caribbean,

Figure 2: Fertility differences between the rich and the poor



Source: Gwatkin, D.; Rutstein, S.; Johnson, K.; Suliman, E.; Wagstaff, A. and Amouzou, A. 2007. *Socio-Economic Differences in Health, Nutrition and Population Within Developing Countries: An Overview. Country Reports on HNP and Poverty.* Washington, D.C.: The World Bank.

poorer women had at least two children more than women in the higher-income quintiles. Women in the lower-income quintiles are also less likely to be using any method of contraception, even though they say they do not want any more children or that they do not want another one soon (Figure 3).

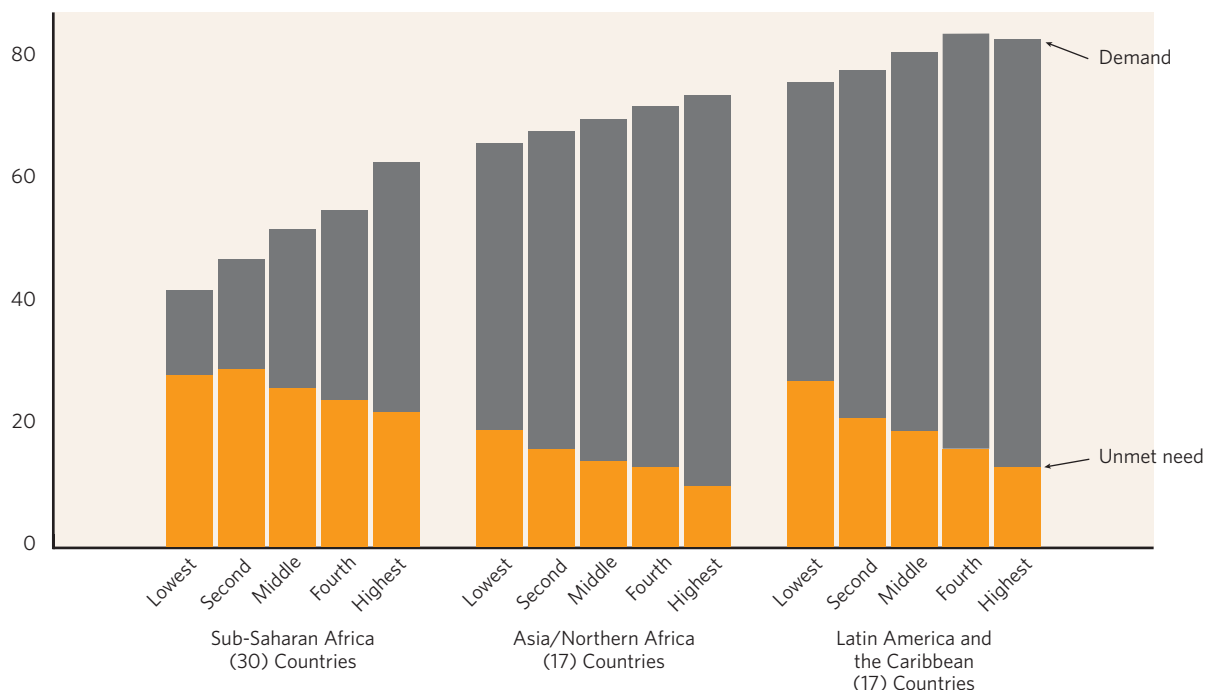
In every developing region of the world, the proportion of reproductive-age women who say they do not want another child (or do not want one soon) is higher among the wealthier quintiles than among those in the lower quintiles. The difference is particularly marked in Africa. Among women in the wealthier quintiles the proportion not using any method of contraception is lower than the corresponding proportion among poorer women. In other words, it is often maintained that poorer women have lower demand for contraception – they are more likely to want more children. Among those with demand, a higher proportion have an unmet need – they are less likely to have access to contraception. As smaller families become the norm, a larger share of observed fertility differences between rich and poor results from differences in access and use of contraception. The rich in poor countries have

both higher demand and greater ability to satisfy it. The poor desire larger families, in part because of residual cultural norms and in part because their circumstances have changed less. They do not get the signals about the changes in mortality levels and the returns on investments in education available to their wealthier compatriots.⁵

There are many reasons why women say they do not want any more children yet are still not using contraception. They may not have knowledge of family planning or access to it; but increased exposure to information and access to family planning services alone does not eliminate unmet need. Where cultural constraints have been taken into account, however, programmes to promote family planning have been more successful. One example is the rapid increase in contraceptive use among couples in the Islamic Republic of Iran and the ensuing decline in fertility rates. In 1989, the national family planning programme gained the support of high-ranking religious leaders who promoted smaller families in their weekly sermons as a social responsibility.⁶

While poorer women tend to have greater unmet need for family planning, there are instances where contracep-

Figure 3: Mean level of unmet need and total demand for family planning, by region and quintiles of household wealth



Source: Westoff, C.F. 2006. *New Estimates of Unmet Need and the Demand for Family Planning*. DHS Comparative Reports No. 14. Calverton, Maryland: Macro International Inc.

Note: Unweighted averages based on the most recent available survey for each country.

tive use has increased in the absence of economic development. In Bangladesh, for example, government commitment and intensive work by non-governmental organizations in securing local political and community-based support have led to increases in contraceptive use by low-income, illiterate women.⁷

Women with some information but little money, for example, in some poor, urban areas, may make decisions that they believe suit their circumstances but which might seem to be irrational and unhealthy. Rates of surgical contraception, especially among the poor, are very high. Ethnographic fieldwork revealed very high rates among low-income women in urban Brazil. Apparently this is a strategy to cope with increasing poverty rather than fertility regulation as such; apart from the pill, surgical contraception is the only method available.

Wealthier women, on the other hand, have access to a variety of methods through private clinics.⁸

Poverty and Health Care Delivery

Maternal mortality rates (MMR) mirror the huge discrepancies between the haves and the have-nots both within society and between countries:

- Poor women are far more likely to die as a result of pregnancy or childbirth.
- Poor families and individuals have less money and tend to live further away from health care facilities.
- Tackling maternal death and disability will reduce poverty.
- Investing in maternal health improves overall health service delivery. Maternal health indicators are used to gauge health system performance in terms of access, gender equity and institutional efficiency.⁹

Table 1: Estimates of MMR number of maternal deaths, lifetime risk, and range of uncertainty by United Nations MDG regions, 2005

Region	MMR (maternal deaths per 100,000 live births)*	Number of maternal deaths*	Lifetime risk of maternal death*: 1 in:	Range of uncertainty on MMR estimates	
				Lower estimate	Upper estimate
WORLD TOTAL	400	536,000	92	220	650
Developed regions**	9	960	7,300	8	17
Countries of the Commonwealth States (CIS)***	51	1,800	1,200	28	140
Developing Regions	450	533,000	75	240	730
Africa	820	276,000	26	410	1,400
Northern Africa****	160	5,700	210	85	290
Sub-Saharan Africa	900	270,000	22	450	1,500
Asia	330	241,000	120	190	520
Eastern Asia	50	9,200	1,200	31	80
South Asia	490	188,000	61	290	750
South-Eastern Asia	300	35,000	130	160	550
Western Asia	160	8,300	170	62	340
Latin America and the Caribbean	130	15,000	290	81	230
Oceania	430	890	62	120	1,200

Source: WHO, UNICEF, UNFPA and The World Bank. 2007. *Maternal Mortality in 2005*. Geneva: WHO.

* The MMR and lifetime risk have been rounded according to the following scheme: < 100, no rounding; 100-999, rounded to nearest 10; and >1,000, rounded to nearest 100. The numbers of maternal deaths have been rounded as follows: < 1,000, rounded to nearest 10, 1,000-9,999, rounded to nearest 100; and >10,000, rounded to nearest 1,000.

** Includes Albania, Australia, Austria, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Serbia and Montenegro (Serbia and Montenegro became separate independent entities in 2006), Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, the United Kingdom, and the United States of America.

*** The CIS countries are Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, the Republic of Moldova, the Russian Federation and Ukraine.

**** Excludes Sudan, which is included in sub-Saharan Africa.

Culture and Issues Related to Reproductive Health

In October 2007, the 62nd General Assembly of the United Nations approved a new target on universal access to reproductive health (following the recommendation of the 2005 World Summit). The indicators for measuring progress towards the target include providing access to family planning to reduce unintended pregnancies and to space intended pregnancies; addressing pregnancies of adolescents; and providing antenatal care to address health risks to mothers and children. Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. The impact of reproductive health initiatives is to make motherhood safer by (1) improving access to family planning in order to reduce unintended pregnancies and achieve preferred spacing between intended pregnancies; (2) achieving skilled care for all births; and (3) providing timely obstetric care for all women who develop complications during childbirth.

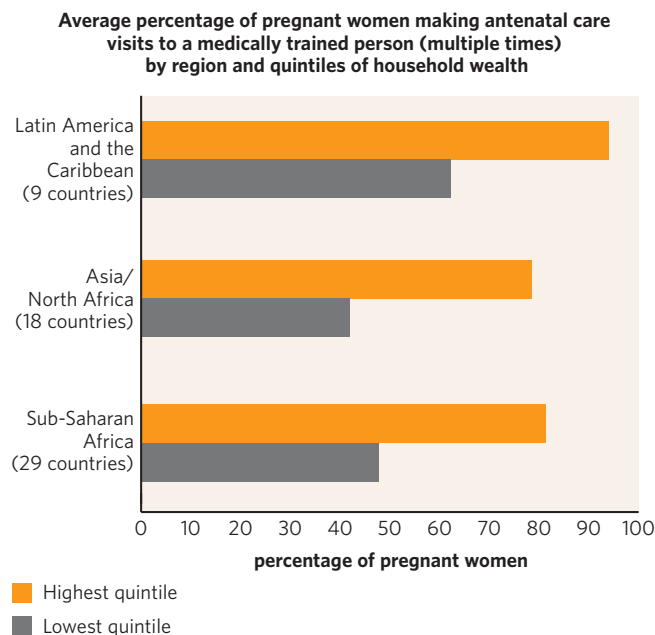
SAFE MOTHERHOOD

Skilled care for all births, together with a range of interventions before, during and after pregnancy, is one of

the keys to maternal health. Skilled birth attendants are accredited health professionals – midwives, doctors or nurses – with the skills to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-natal period; to identify and manage complications in women and newborns; and to make referrals to appropriate emergency and obstetric care.¹⁰ This definition excludes traditional birth attendants, trained or not. Antenatal care and delivery by a skilled birth attendant are more easily accessible and available to the better-off. In Africa, just 46.5 per cent of women have skilled birth attendants, in Asia, 65.4 per cent and in Latin America and the Caribbean, 88.5 per cent.¹¹ Data from 48 developing countries indicate that the proportion of women receiving antenatal care and the proportion of women giving birth with the assistance of a skilled birth attendant were consistently higher among high-income quintiles than the lowest quintiles (Figures 4 and 5). In sub-Saharan Africa, South Asia and South-Eastern Asia, the proportion of women giving birth with the assistance of a skilled birth attendant is more than twice as high among the wealthy than among poorer women.

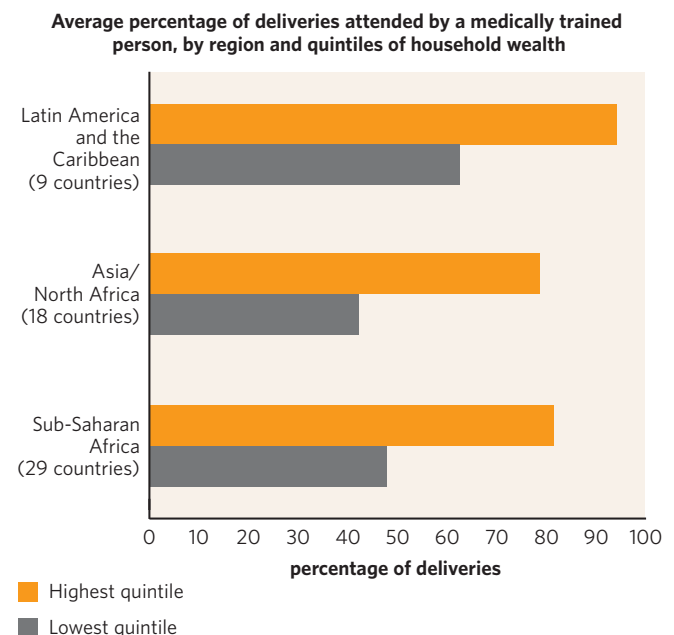
Most women who use traditional birth attendants do not have access to trained birth attendants. But many

Figure 4: Availability of antenatal care



Source: Gwatkin, D. et. al. 2007. *Socio-economic differences in health, nutrition and population within developing countries*, Washington, D.C.: World Bank.

Figure 5: Births with skilled attendants



Source: WHO, 2007. "Proportion of Birth Attended by a Skilled Attendant—2007 Updates" *WHO Factsheet*. Geneva: World Health Organization.

22 LOCAL RESIDENCE DETERMINES THE EFFECTIVENESS OF AUXILIARY NURSE MIDWIVES

Research by Action Research and Training for Health (ARTH) in rural Rajasthan, India, revealed a correlation between the place of residence of the Auxiliary Nurse Midwives (ANMs) and their effectiveness. The majority (62 per cent) of the ANMs did not live in the villages where they worked because of poor living conditions, threats to their personal security and other factors. They found little demand for their services. The study concludes that improving the living and working conditions of the ANMs, and their own empowerment within the system, is essential for better maternal and child health care. Addressing the needs of first-line health care providers such as ANMs ensures good communication and trust, which in turn determine the quality of care. It also ensures their long-term participation and the sustainability of the programme.

Source: Action Research and Training for Health (ARTH). 2003. *Nurse Midwives for Maternal Health*. <http://www.arth.in/publications.html>, accessed June 2008.

choose traditional birth attendants because they assist in more than labour and the delivery of a child. They provide a variety of services ranging from physical care to advice on contraception, reproductive ailments and cures – before and after the birth. They are socially and emotionally connected to their clients, and are selected for the care and kindness they show, apart from their skill in birthing. These considerations should be part of the training of skilled birth attendants. For example, auxiliary nurse midwives who did not live in the communities they served found little demand for their services.

Gaining the confidence of women in rural households is the main reason the Government of Ethiopia has initiated a plan to train 2,800 women to become rural health extension workers. The plan, initiated in 2003, is “designed to improve the health status of families, with their full participation, using local technologies and the community’s skill and wisdom”.¹² Effective emergency obstetric care backup and referral can spark even faster reduction in maternal mortality.

Addressing the concerns of those opposed to information and services calls for advocacy and sensitive negotiation.

Knowing the opposition and understanding its views can be the key to successful negotiations on sensitive issues such as adolescent information and service needs, and decision-making on fertility. Developing a different advocacy strategy for each stakeholder is often the most effective way to achieve consensus. For example, in Guatemala, advocacy, consultations and the involvement of as many actors as possible secured enactment of the Social Development Law in 2001.

In Iran, an initiative known as the “Women’s Project” is mobilizing support for quality reproductive health services and the promotion of women’s rights by providing research-based evidence, mounting public awareness campaigns and involving grass-roots communities. It builds capacity among institutions and organizations working in the social sector, and supports activities to empower women, including income-generating schemes. Prompted by a more open environment, religious leaders, community leaders and

23 GUATEMALA: FINDING COMMON GROUND AND BUILDING ON IT

The Social Development Law of 2001 was made possible by broad political support for reducing one of the highest maternal mortality ratios in Latin America — 270 deaths per 100,000 live births. It adopts specific policies in the areas of population, reproductive health, family planning and sexuality education.

The Government and a number of stakeholders developed an elaborate advocacy strategy well in advance, including traditional supporters, potential allies within the Catholic and Evangelical churches and business leaders. There was broad consensus on the need to reduce maternal and infant mortality, which became the starting point for negotiations and the centrepiece of the new law.

Strategic partnerships helped gain support and reduce the influence of opposition groups. Articles on population and reproductive health ran in newspapers and magazines, and debates were aired on television and radio. UNFPA facilitated the process, supporting the government institutions and civil society organizations which assumed authorship and accountability for the new law.

Source: UNFPA. 2004. *Culture Matters: Working with Communities and Faith-based Organizations: Case Studies from Country Programmes*. New York: UNFPA.



▲ *Washing clothes in Madagascar. Without piped water, poor people have no choice but to use the same source for all their water needs – drinking, washing and sewage disposal.*

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parliamentarians are now discussing protective legislation and other measures.

HIV AND AIDS

HIV and AIDS illustrate the contribution of economic inequalities in spreading infectious disease. HIV and AIDS cuts across social classes, but people who live in conditions of poverty are more vulnerable to infections, including HIV, and less likely to be treated. Loss of income and medical costs may drive a family into a new spiral of poverty. Caring for people living with HIV and AIDS increases the burden of women's unpaid workload and reduces their options for earning income. They may feel forced into high-risk work such as the sex industry. Caring for a growing number of orphans puts additional strain on the elderly and older siblings. This keeps children, especially girls, out of school, magnifying the intergenerational transmission of poverty and reducing potential economic growth.

There is no cure for AIDS and none is on the horizon; prevention remains critical for efforts to halt the epidemic.

Prevention efforts are taking hold in a number of countries. The downward trend in the number of new HIV infections in Côte d'Ivoire, Kenya, Zimbabwe, Cambodia, Myanmar and Thailand may be the result of scaled-up prevention.¹³ Traditional leaders, indigenous and community elders, as well as faith-based organizations can be an important resource in the struggle to eliminate the spread of HIV, in countering stigma and in helping those affected and infected cope with economic and social hardship.

Migration, Immigrants and Cultural Diversity

MIGRATION, CULTURES AND CHOICE

In 2005, international migrants numbered 191 million, of whom nearly half were female.¹⁴ Migration has been a mixed experience for both source and host communities and countries, and for migrants themselves. Migrants tend to fill the economic niches left by the local labour force, and migrants without qualifications or skills may find themselves in low-paid, unpleasant and often dangerous jobs. On the other hand, many migrants and

24 COMMUNITIES FIGHT AIDS

The HIV and AIDS Regional Programme in the Arab States (HARPAS), sponsored by the United Nations Development Programme (UNDP), has worked, since it was founded in 2002, towards “breaking the silence” around HIV and AIDS. HARPAS is committed to creating social conditions that would encourage the transformational leadership needed to keep prevalence rates low in the region and prevent the spread of the disease. This is particularly daunting in contexts where culture imposes a strong taboo on any public discussion of sexuality-related issues. HARPAS identified and brought together the economic, sociocultural and political agents of change — religious leaders, businessmen, women’s NGOs, legislators and media, among others — in the Arab region’s first HIV and AIDS networks. The view of HARPAS is that a successful response to HIV and AIDS needs the true involvement of the whole community, complementing and supporting each other as one force. Religious leaders are a vital influence in the Arab community, whose impact cannot be neglected. “They have legitimacy, a durable presence and, even more than that, they help shape the social values and norms of people and are well-positioned to influence public attitudes and national policies related to HIV and AIDS.”

Source: UNDP and HARPAS. Forthcoming, *AIDS in the Arab Cultures*. <http://hapras.org/products.asp>, accessed June 2008.

their families have found opportunities for earning, investment, education and professional experience. Remittances to family members have helped reduce household poverty levels and contributed to economic growth. The figures have reached at least \$251 billion annually.¹⁵ According to one study, a one per cent increase in the share of remittances in a country’s GDP leads to a 0.4 per cent decline in poverty.¹⁶

Remittances are much more than an economic phenomenon; they demonstrate how cultures — shared understandings and responses concerning family and communal responsibilities and obligations — can provide economic security for families.

Over time, migration encourages cultural shifts, as some migrants broaden their identities, attach less significance to some of the belief systems and norms within their old communities, and perhaps begin to contest some of them. Migrants transmit change through contact

from abroad and by returning home with new ways of thinking and making sense of reality. Individuals can be influential — rock stars and football players, political dissidents and successful entrepreneurs send powerful cultural messages. Migration stimulates cultural shifts in host countries as well, as people absorb new ideas and approaches from other countries. Through routes such as these, cultures encompass different approaches to issues, including human rights and gender equality. Much depends on the character of these wider contexts, and on individual migrants’ experience in host societies and in their home countries.

Some migrants enrich their world view by exposure to different cultures; others remain focused on the discrimination and hostility they face. Economic perceptions, such as migrants’ poverty or wealth, competition for jobs with the local population or economic dependence, may bolster social barriers and deepen misunderstanding. Host populations sometimes hold migrants responsible for a variety of economic and social ills, whether poverty in South Africa or social disruption in Italy.

Host countries’ migration policies can promote integration, strategies to manage diversity and cross-cultural learning. Civil society can assist by dispelling myths and quelling rumours, providing migrants with knowledge of and access to certain services, and engaging their participation in integration processes. Source countries have to contend with losing not only skills but key family and community members even while they may gain overseas cultural interlocutors. Social and economic policies have to protect the families of migrants and the interests of workers going overseas, especially women.

Trafficking is the dark underside of migration, damaging communities of origin and destination as well as the individuals concerned. Opening national borders and international markets has increased legal flows of capital, goods and labour across borders, but it has also globalized organized crime. Improved information technologies and transportation allow transnational syndicates to operate easily. Those who fall into the hands of traffickers are drawn by the chance of a better life or forced by friends or relatives. They may be duped by false promises, or simply sold. Increasingly restrictive immigration policies in Europe and North America are driving more and more



▲ *Eight-year-old Hajira at the door of a battery recycling workshop in Bangladesh. She works with her mother and looks after the younger children, too.*
© Shehzad Noorani/Getty Images

would-be migrants into the hands of traffickers. Trafficked women find themselves forced into prostitution, sex tourism or commercial marriages, or into unpaid or poorly paid domestic, agricultural or sweatshop labour.¹⁷

INTERNAL MIGRATION

Migration from rural areas as well as natural increase are responsible for the rapid increase in urban population in recent decades. Both migrants and the non-migrant urban poor are greatly disadvantaged. Compared to other poor urban residents, the reproductive health care needs of migrants may have more to do with their insecurity in respect to employment, livelihood and social networks than with medical or health services as such.¹⁸ Although repro-

ductive health-care services may be easier to reach in urban areas than in rural areas, many urban migrants cannot afford to use them. Urban migrants' lack of social contacts also works against their access to and use of emergency obstetric and gynaecological care in hospitals. Poor migrant women in Rajasthan, for example, return to their homes in the village to give birth,¹⁹ even though emergency obstetric and gynaecological care, child immunization and postnatal care are likely to be less accessible than in the city.

CONTEXTS AND COMPLEXITIES

Lifestyles and expectations are rapidly changing. As geographical and social mobility increases, relationships and the extent of shared experience among family members and communities also change. Changes in social and economic opportunities are altering people's expectations and desires for their families. The accumulating impact of social change is creating the conditions whereby cultural shifts take place.

As cultures impact on the context within which policies take place, the various elements that make up culture are also transformed. Cultural meanings, norms and practices are, therefore, not immutable. They shift and change as individuals and groups acquire new information, gain capabilities and are exposed to different contexts. Throughout, cultural sensitivity remains a key ingredient for policies that seek to deal with the challenges of migration and urbanization – wherever those intersect with gender relations and human rights dynamics.