

KEY ISSUE 3

Why Does Population Growth Vary among Regions?

- The Demographic Transition
- Malthus on Overpopulation
- Population Futures

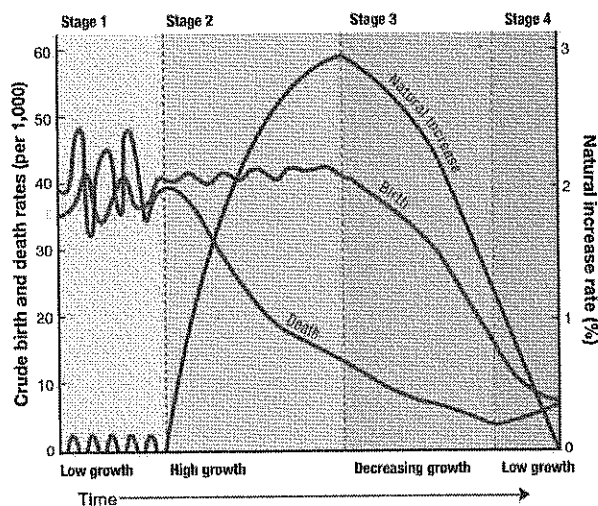
Learning Outcome 2.3.1

Describe the four stages of the demographic transition.

All countries have experienced some changes in NIR, CBR, and CDR, but at different times and at different rates. Why does global growth matter? In view of the current size of Earth's population and the NIR, will there soon be too many of us?

The Demographic Transition

The **demographic transition** is a process of change in a society's population from high crude birth and death rates and low rate of natural increase to a condition of low crude birth and death rates, low rate of natural increase, and higher total population. The process consists of four stages, and every country is in one of them (Figure 2-17).



▲ FIGURE 2-17 DEMOGRAPHIC TRANSITION MODEL The demographic transition model consists of four stages.

STAGE 1: LOW GROWTH

Very high birth and death rates produce virtually no long-term natural increase.

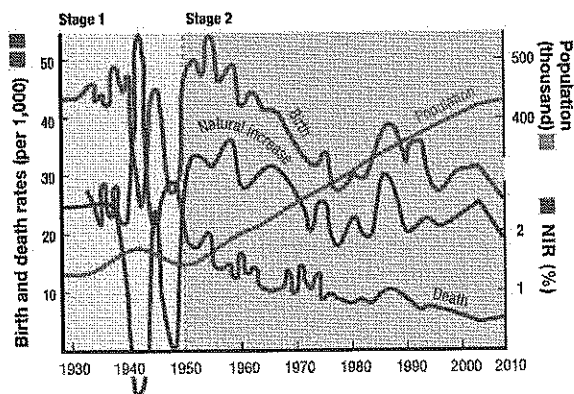
Most of human history was spent in stage 1 of the demographic transition, but today no country remains in stage 1. Every nation has moved on to at least stage 2 of the demographic transition, and, with that transition, has experienced profound changes in population. For most of this period, people depended on hunting and gathering for food (see Chapter 10). When food was easily obtained, a region's population increased, but it declined when people were unable to locate enough animals or vegetation nearby.

STAGE 2: HIGH GROWTH

Rapidly declining death rates and very high birth rates produce very high natural increase.

Europe and North America entered stage 2 of the demographic transition after 1750, as a result of the **Industrial Revolution**, which began in the United Kingdom in the late eighteenth century and diffused to the European continent and North America (including the United States) during the nineteenth century. The Industrial Revolution was a conjunction of major improvements in manufacturing goods and delivering them to market (see Chapter 11). The result of this transformation was an unprecedented level of wealth, some of which was used to make communities healthier places to live.

Stage 2 of the demographic transition did not diffuse to Africa, Asia, and Latin America until around 1950 (Figure 2-18), and it made that transition for a different reason than in Europe and North America 200 years earlier. The late-twentieth-century push of developing countries into stage 2 was caused by the **medical revolution**. Medical technology invented in Europe and North America has diffused to developing countries. Improved medical practices have eliminated many of the traditional causes of death in developing countries and enabled more people to experience longer and healthier lives.



▲ FIGURE 2-18 STAGE 2: CAPE VERDE Cape Verde entered stage 2 of the demographic transition in approximately 1950, as indicated by the large gap between birth and death rates since then.

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STAGE 3: DECREASING GROWTH

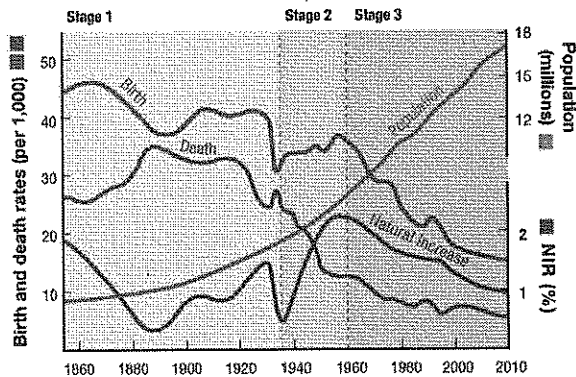
Birth rates rapidly decline, death rates continue to decline, and natural increase rates begin to moderate.

A country moves from stage 2 to stage 3 of the demographic transition when the CBR begins to drop sharply. The CDR continues to fall in stage 3 but at a much slower rate than in stage 2. The population continues to grow because the CBR is still greater than the CDR. But the rate of natural increase is more modest in countries in stage 3 than in those in stage 2 because the gap between the CBR and the CDR narrows.

A society enters stage 3 when people have fewer children. The decision to have fewer children is partly a delayed reaction to a decline in mortality.

Economic changes in stage 3 societies also induce people to have fewer offspring. People in stage 3 societies are more likely to live in cities than in the countryside and to work in offices, shops, or factories rather than on farms. Farmers often consider a large family to be an asset because children can do some of the chores. Urban homes are relatively small and may not have space to accommodate large families.

Most countries in Europe and North America (including the United States) moved from stage 2 to stage 3 of the demographic transition during the first half of the twentieth century. The movement took place during the second half of the twentieth century in many countries of Asia and Latin America, including Chile (Figure 2-19).



▲ FIGURE 2-19 **STAGE 3: CHILE** Chile entered stage 2 of the demographic transition in the 1930s, when death rates declined sharply, and stage 3 in the 1960s, when birth rates declined sharply.

STAGE 4: LOW GROWTH

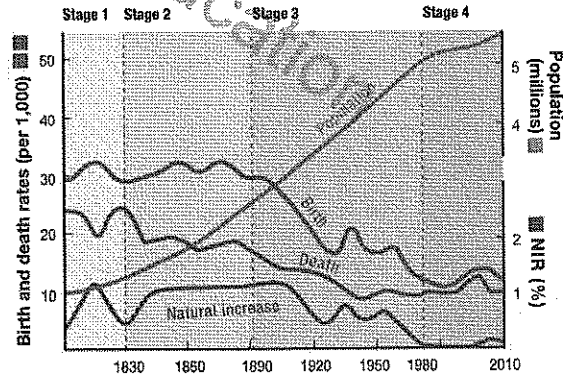
Very low birth and death rates produce virtually no long-term natural increase and possibly a decrease.

A country reaches stage 4 of the demographic transition when the CBR declines to the point where it equals the CDR and the NIR approaches zero. This condition is called zero population growth (ZPG), a term often applied to stage 4 countries.

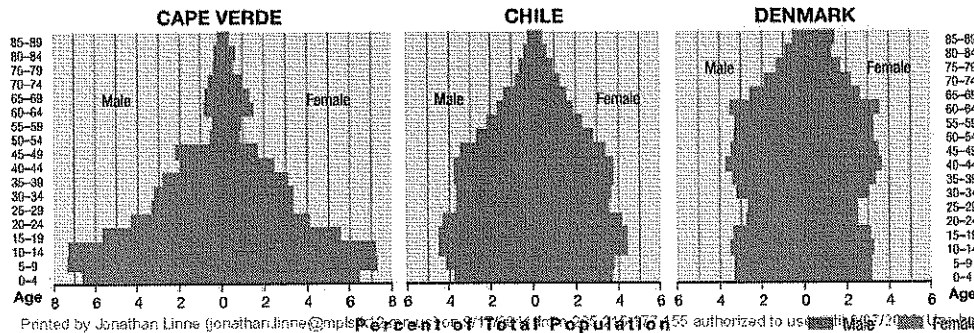
ZPG may occur when the CBR is still slightly higher than the CDR because some females die before reaching childbearing years, and the number of females in their childbearing years can vary. To account for these discrepancies, demographers more precisely define ZPG as the TFR that results in a lack of change in the total population over a long term. A TFR of approximately 2.1 produces ZPG.

Social customs again explain the movement to stage 4. Increasingly, women in stage 4 societies enter the labor force rather than remain at home as full-time homemakers. People who have access to a wider variety of birth-control methods are more likely to use some of them.

Denmark, like most other European countries, has reached stage 4 of the demographic transition (Figure 2-20). Denmark's population pyramid shows the impact of the demographic transition. Instead of a classic pyramid shape, Denmark has a column, demonstrating that the percentages of young and elderly people are nearly the same (Figure 2-21).



▲ FIGURE 2-20 **STAGE 4: DENMARK** Denmark has been in stage 4 of the demographic transition and has experienced virtually no change in total population since the 1970s.



▲ FIGURE 2-21 **POPULATION PYRAMIDS** As a country moves through the demographic transition, the shape of the pyramid flattens. (left) Cape Verde's pyramid has a broad base, as is typical of a stage 2 country. (center) Chile's graph still resembles a pyramid. (right) Denmark's pyramid is flat, an indication of the aging of the population.

DECLINING BIRTH RATES

Learning Outcome 2.3.2

Summarize two approaches to reducing birth rates.

The CBR has declined rapidly since 1990, from 27 to 20 in the world as a whole and from 31 to 22 in developing countries (Figure 2-22). Two strategies have been successful in reducing birth rates:

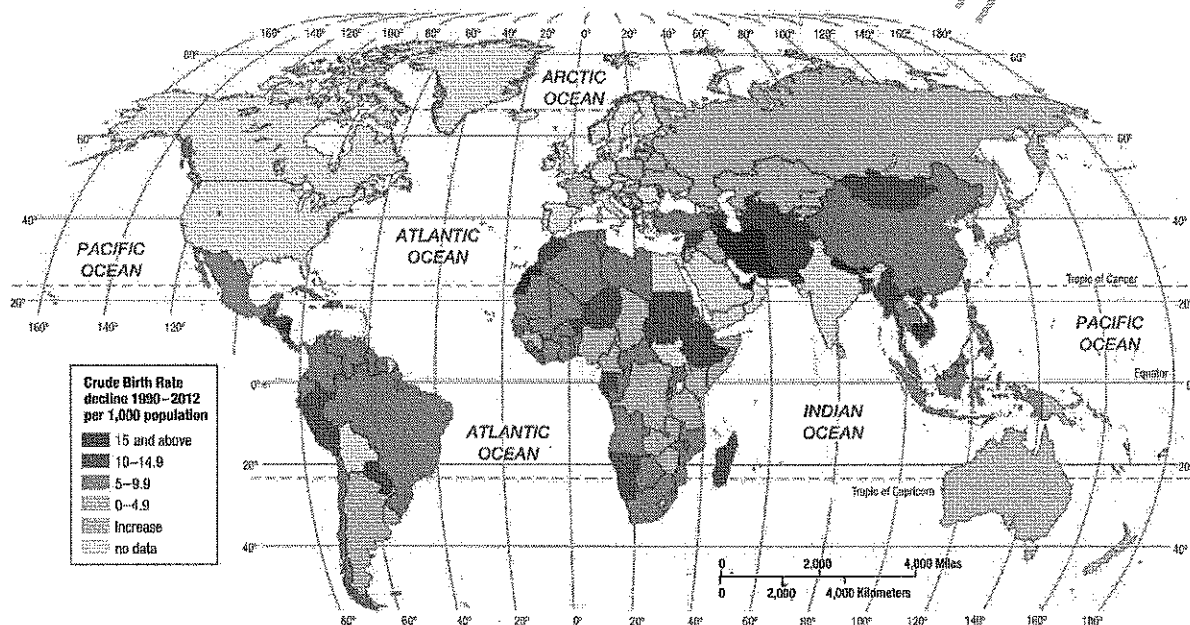
1. **Lowering birth rates through education and health care.** One approach to lowering birth rates emphasizes the importance of improving local economic conditions (Figure 2-23). A wealthier community has more money to spend on education and health-care programs that promote lower birth rates. According to this approach:
 - With more women able to attend school and to remain in school longer, they would be more likely to learn employment skills and gain more economic control over their lives.
 - With better education, women would better understand their reproductive rights, make more informed reproductive choices, and select more effective methods of contraception.
 - With improved health-care programs, IMRs would decline through such programs as improved prenatal care, counseling about sexually transmitted diseases, and child immunization.
 - With the survival of more infants ensured, women would be more likely to choose to make more

effective use of contraceptives to limit the number of children.

2. **Lowering birth rates through contraception.** The other approach to lowering birth rates emphasizes the importance of rapidly diffusing modern contraceptive methods (Figure 2-24). Economic development may promote lower birth rates in the long run, but the world cannot wait around for that alternative to take effect. Putting resources into family-planning programs can reduce birth rates much more rapidly. In developing countries, demand for contraceptive devices is greater than the available supply. Therefore, the most effective way to increase their use is to distribute more of them cheaply and quickly. According to this approach, contraceptives are the best method for lowering the birth rate.

Bangladesh is an example of a country that has had little improvement in the wealth and literacy of its people, but 56 percent of the women in the country used contraceptives in 2011 compared to 6 percent three decades earlier. Similar growth in the use of contraceptives has occurred in other developing countries, including Colombia, Morocco, and Thailand. Rapid growth in the acceptance of family planning is evidence that in the modern world, ideas can diffuse rapidly, even to places where people have limited access to education and modern communications.

The percentage of women using contraceptives is especially low in sub-Saharan Africa, so the alternative of distributing contraceptives could have an especially strong impact there. Fewer than one-fourth of women in sub-Saharan Africa employ contraceptives, compared to more



▲ FIGURE 2-22 CBR CHANGE 1990–2012 The crude birth rate has declined in all but a handful of countries. Declines have been most rapid in Latin America and South and Southwest Asia.

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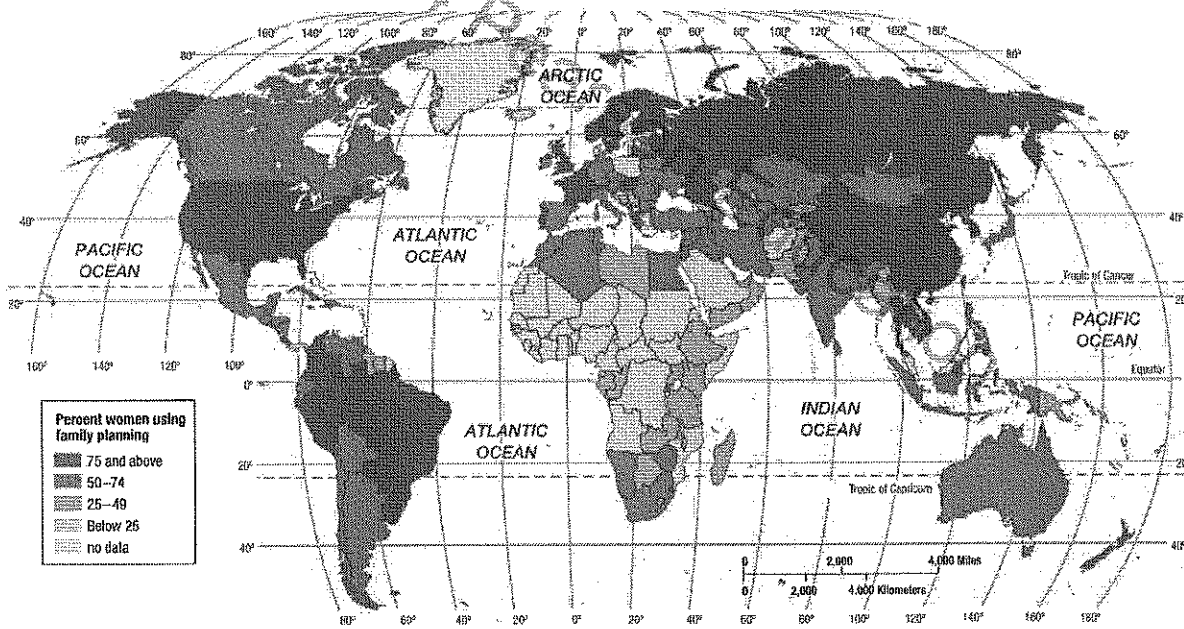
▲ FIGURE 2-23 PROMOTING FEWER CHILDREN Women talk about birth control at a health clinic in Kampong Cham, Cambodia.

than two-thirds in Asia and three-fourths in Latin America (Figure 2-25).

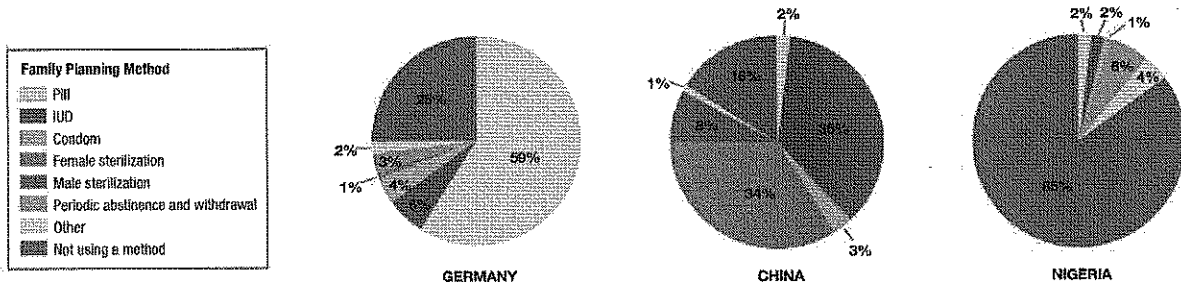
Regardless of which alternative is more successful, many oppose birth-control programs for religious and political reasons. Adherents of several religions, including Roman Catholics, fundamentalist Protestants, Muslims, and Hindus, have religious convictions that prevent them from using some or all birth-control methods. In the United States opposition is strong to terminating pregnancy by abortion, and the U.S. government has at times withheld aid to countries and family-planning organizations that advise abortion, even when such advice is only a small part of the overall aid program.

Pause and Reflect 2.3.2

Why have countries in Northern Europe had little if any decline in CBR since 1990?



▲ FIGURE 2-24 WOMEN USING FAMILY PLANNING More than two-thirds of couples in developed countries use a family-planning method. Family-planning varies widely in developing countries. China reports the world's highest rate of family planning; the lowest rates are in sub-Saharan Africa.



▲ FIGURE 2-25 FAMILY PLANNING METHODS The principal family-planning methods in developed countries like Germany are condoms and birth-control pills. The principal methods in China are intrauterine devices (IUDs) and female sterilization. People in sub-Saharan African countries such as Nigeria make minimal use of family planning.

Malthus on Overpopulation

Learning Outcome 2.3.3

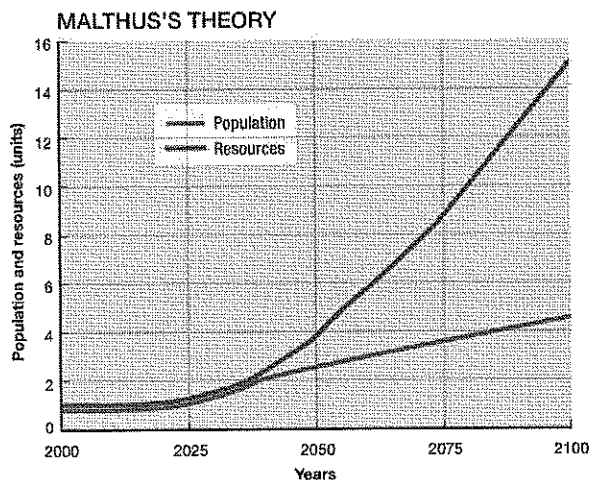
Summarize Malthus's argument about the relationship between population and resources.

English economist Thomas Malthus (1766–1834) was one of the first to argue that the world's rate of population increase was far outstripping the development of food supplies. In *An Essay on the Principle of Population*, published in 1798, Malthus claimed that the population was growing much more rapidly than Earth's food supply because population increased geometrically, whereas food supply increased arithmetically (Figure 2-26).

According to Malthus, these growth rates would produce the following relationships between people and food in the future:

| | |
|---------------------|-----------------------------|
| Today: | 1 person, 1 unit of food |
| 25 years from now: | 2 persons, 2 units of food |
| 50 years from now: | 4 persons, 3 units of food |
| 75 years from now: | 8 persons, 4 units of food |
| 100 years from now: | 16 persons, 5 units of food |

Malthus stated made these conclusions several decades after England had become the first country to enter stage 2 of the demographic transition, in association with the Industrial Revolution. He concluded that population growth would press against available resources in every country unless "moral restraint" produced lower CBRs or unless disease, famine, war, or other disasters produced higher CDRs.



▲ FIGURE 2-26 MALTHUS'S THEORY Malthus expected population to grow more rapidly than food supply. The graph shows that if in 2000, the population of a place were 1 unit (such as 1 billion people) and the amount of resources were 1 unit (such as 1 billion tons of grain), then according to Malthus's theory, in 2100 the place would have around 15 billion people and 5 billion tons of grain.

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Pause and Reflect 2.3.3

Calculate the units of population and food that Malthus predicted would exist in 200 years.

CONTEMPORARY NEO-MALTHUSIANS

Malthus's views remain influential today. Contemporary geographers and other analysts are taking another look at Malthus's theory because of Earth's unprecedented rate of natural increase during the twentieth century. Neo-Malthusians argue that two characteristics of recent population growth make Malthus's thesis even more frightening than when it was first written more than 200 years ago:

- In Malthus's time only a few relatively wealthy countries had entered stage 2 of the demographic transition, characterized by rapid population increase. Malthus failed to anticipate that relatively poor countries would have the most rapid population growth because of transfer of medical technology (but not wealth) from developed countries. As a result, the gap between population growth and resources is wider in some countries than even Malthus anticipated.
- World population growth is outstripping a wide variety of resources, not just food production. Neo-Malthusians paint a frightening picture of a world in which billions of people are engaged in a desperate search for food, water, and energy.

MALTHUS'S CRITICS

Malthus's theory has been severely criticized from a variety of perspectives. Criticism has been leveled at both the population growth and resource depletion sides of Malthus's equation.

RESOURCE DEPLETION. Many geographers consider Malthusian beliefs unrealistically pessimistic because they are based on a belief that the world's supply of resources is fixed rather than expanding.

POPULATION GROWTH. Critics disagree with Malthus's theory that population growth is a problem. To the contrary, a larger population could stimulate economic growth and, therefore, production of more food. A large population of consumers can generate a greater demand for goods, which results in more jobs. More people mean more brains to invent good ideas for improving life.

Marxists maintain that no cause-and-effect relationship exists between population growth and economic development. Poverty, hunger, and other social welfare problems associated with lack of economic development are a result of unjust social and economic institutions, not population growth. They argue that the world possesses sufficient resources to eliminate global hunger and poverty, if only these resources are shared equally.

MALTHUS'S THEORY AND REALITY

On a global scale, conditions during the past half-century have not supported Malthus's theory. Even though the human population has grown at its most rapid rate ever, world food production has consistently grown at a faster rate than the NIR since 1950. Malthus was fairly close to the mark on food production but much too pessimistic on population growth.

Overall food production has increased during the last half-century somewhat more rapidly than Malthus predicted. In India, for example, rice production has followed Malthus's expectations fairly closely, but wheat production has increased twice as fast as Malthus expected (Figure 2-27). Better growing techniques, higher-yielding seeds, and cultivation of more land have contributed to the expansion in the food supply (see Chapter 10). Many people in the world cannot afford to buy food or do not have access to sources of food, but these are problems of distribution of wealth rather than insufficient global production of food, as Malthus theorized.

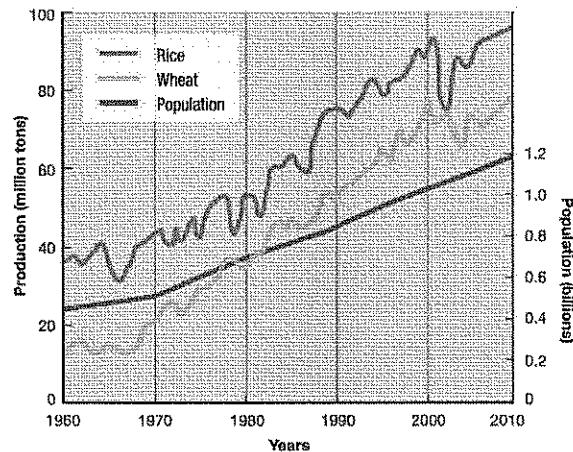
It is on the population side of the equation that Malthus has proved to be inaccurate. His model expected population to quadruple during a half-century, but even in India—a country known for relatively rapid growth (see the next section)—population has increased more slowly than food supply.

However, neo-Malthusians point out that production of both wheat and rice has slowed in India in recent years, as shown in Figure 2-27. Without new breakthroughs in food production, India will not be able to keep food supply ahead of population growth.

JAPAN'S DECLINING POPULATION

Japan is an example of a country that faces the prospect of population decline in future, from 127 million in 2010 to 95 million in 2050, according to the Japanese government. With population decline will come a dramatic shift in the country's population structure (Figure 2-28). By 2050, the Japanese pyramid is expected to be reversed from that of 1950. Instead of a very high percentage of children, Japan will have a very high percentage of elderly people.

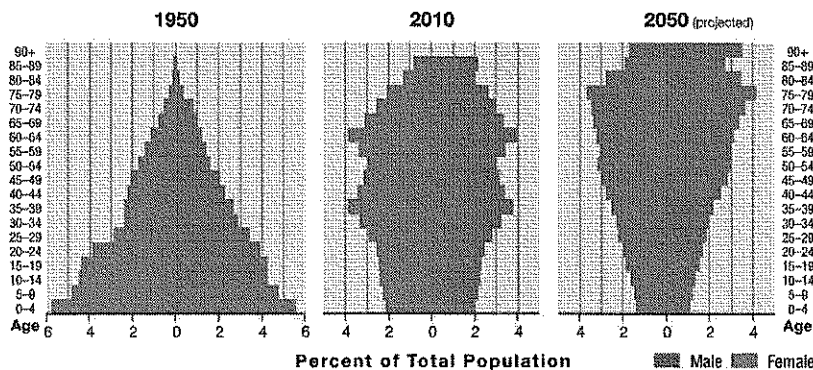
INDIA'S RECENT EXPERIENCE



▲ FIGURE 2-27 POPULATION AND FOOD PRODUCTION IN INDIA
Production of wheat and rice has increased more rapidly than has population.

In the United States, the population is expected to continue to grow through immigration rather than through natural increase (see Chapter 3), but Japan discourages immigration. Japanese society, having placed a high value on social conformity for thousands of years, does not welcome outsiders from other cultural traditions.

With few immigrants, Japan faces a severe shortage of workers. Japan is addressing the labor force shortage primarily by encouraging more Japanese people to work, especially older people and women. Programs make it more attractive for older people to continue working, to receive more health-care services at home instead of in hospitals, and to borrow against the value of their homes to pay for health care. In the long run, more women in the labor force may translate into an even lower birth rate and therefore an even lower NIR in the future. Rather than combine work with child rearing, Japanese women are expected to make a stark choice: either marry and raise children or remain single and work.



◀ FIGURE 2-28 JAPAN'S CHANGING POPULATION PYRAMIDS
Japan's population pyramid has shifted from a broad base in 1950 to a rectangular shape. In the future, the bottom of the pyramid is expected to contract and the top to expand.

Population Futures

Learning Outcome 2.3.4

Summarize the possible stage 5 of the demographic transition.

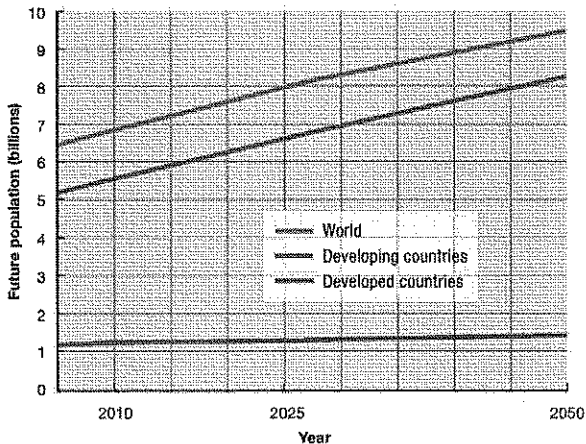
NIR is forecast to be much slower in the twenty-first century than in the twentieth, but world population will continue to grow. The Population Reference Bureau forecasts that world population will increase from 7 billion in 2011 to 9.5 billion in 2050 (Figure 2-29). Around 97 percent of this increase is forecast to be in developing countries, whereas many developed countries may move into a possible stage 5 of the demographic transition.

Future population depends primarily on fertility. The United Nations forecasts that if the current TFR of 2.5 remains unchanged, world population would reach 12 billion in 2050. On the other hand, if TFR declines in the next few years to 1.5, world population would actually decline to 8 billion in 2050.

DEMOGRAPHIC TRANSITION POSSIBLE STAGE 5: DECLINE

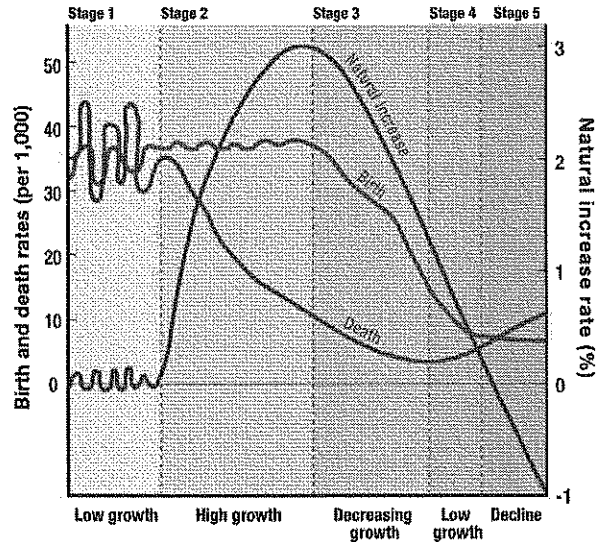
A country that has passed through the four stages of the demographic transition has in some ways completed a cycle—from little or no natural increase in stage 1 to little or no natural increase in stage 4. Two crucial demographic differences underlie this process:

- The total population of the country is much higher in stage 4 than in stage 1.
- At the beginning of the demographic transition, the CBRs and CDRs are high—35 to 40 per 1,000—whereas at the end of the process the rates are very low, approximately 10 per 1,000.



▲ FIGURE 2-29 FUTURE POPULATION GROWTH Nearly all of the world's population growth is forecast to be in developing countries.

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▲ FIGURE 2-30 POSSIBLE DEMOGRAPHIC TRANSITION STAGE 5 Stage 5 of the demographic transition would be characterized by a negative NIR, because the CDR would be greater than the CBR.

The four-stage demographic transition is characterized by two big breaks with the past. The first break—the sudden drop in the death rate that comes from technological innovation—has been accomplished everywhere. The second break—the sudden drop in the birth rate that comes from changing social customs—has yet to be achieved in many countries.

Meanwhile, a possible stage 5 of the demographic transition is predicted by demographers for some developed countries. Stage 5 would be characterized by a very low CBR, an increasing CDR, and therefore a negative NIR (Figure 2-31). After several decades of very low birth rates, a stage 5 country would have relatively few young women aging into child-bearing years. As the smaller pool of women each chooses to have fewer children, birth rates would continue to fall even more than in stage 4.

The world's future population will definitely be older. The elderly support ratio is the number of working-age people (ages 15 to 64) divided by the number of persons 65 and older (Figure 2-30). A small number means that relatively few workers must contribute to pensions, health care, and other support that older people need. With more elderly people than children, a stage 5 country would experience an increased CDR because of high mortality among the relatively large number of elderly people.

Several European countries, notably Russia and other former Communist countries, already have negative NIRs. Russia's high CDR and low CBR are a legacy of a half-century of Communist rule. The low CBR may stem from a long tradition of strong family-planning programs and a deep-seated pessimism about having children in an uncertain world. The high CDR may be a legacy of inadequate pollution controls and inaccurate reporting by the Communists.

CHINA AND INDIA

The world's two most populous countries, China and India, will heavily influence future prospects for global overpopulation. These two countries—together encompassing more than one-third of the world's population—have adopted different family-planning programs. As a result of less effective policies, India adds 12 million more people each year than does China. Current projections show that India could surpass China as the world's most populous country around 2030.

INDIA'S POPULATION POLICIES. India, like most countries in Africa, Asia, and Latin America, remained in stage 1 of the demographic transition until the late 1940s. During the first half of the twentieth century, the Indian population increased modestly—less than 1 percent per year—and even decreased in some years because of malaria, famines, plagues, and cholera epidemics.

Immediately after gaining independence from England in 1947, India saw a sharp decline in death rate (to 20 per 1,000 in 1951), whereas the CBR remained relatively high (about 40). Consequently, the NIR jumped to 2 percent per year. In response to this rapid growth, India became the first country to embark on a national family-planning program, in 1952. The government has established clinics and has provided information about alternative methods of birth control. Birth-control devices have been distributed free or at subsidized prices. Abortions, legalized in 1972, have been performed at a rate of several million per year. All together, the government spends several hundred million dollars annually on various family-planning programs.

India's most controversial family-planning program was the establishment of camps in 1971 to perform sterilizations—surgical procedures in which people were made incapable of reproduction. A sterilized person was entitled to a payment, which has been adjusted several times but generally has been equivalent to the average monthly income in India. At the height of the program, in 1976, 8.3 million sterilizations were performed during a 6-month period, mostly on women.

The birth-control drive declined in India after 1976. Widespread opposition to the sterilization program grew in the country because people feared that they would be forcibly sterilized. The prime minister, Indira Gandhi, was defeated in 1977, and the new government emphasized the voluntary nature of birth-control programs. The term *family planning*, which the Indian people associated with the forced sterilization policy, was replaced by the term *family welfare* to indicate that compulsory birth-control programs had been terminated. Although Mrs. Gandhi served again as prime minister from 1980 until she was assassinated in 1984, she did not emphasize family planning during that time because of the opposition during her previous administration.

In the past several decades, government-sponsored family-planning programs in India have emphasized

education, including advertisements on national radio and television networks and information distributed through local health centers. Given the cultural diversity of the Indian people, the national campaign has had only limited success. The dominant form of birth control continues to be sterilization of women, in many cases after the women have already borne several children.

CHINA'S POPULATION POLICIES. In contrast to India, China has made substantial progress in reducing its rate of growth. Since 2000, China has actually had a lower CBR than the United States.

The core of the Chinese government's family-planning program has been the One Child Policy, adopted in 1980. Under the One Child Policy, a couple needs a permit to have a child. Couples receive financial subsidies, a long maternity leave, better housing, and (in rural areas) more land if they agree to have just one child. The government prohibits marriage for men until they are age 22 and women until they are 20. To further discourage births, people receive free contraceptives, abortions, and sterilizations. Rules are enforced by a government agency, the State Family Planning Commission.

As China moves toward a market economy in the twenty-first century and as Chinese families become wealthier, the harsh rules in the One Child Policy have been relaxed, especially in urban areas. Clinics provide counseling on a wider range of family-planning options. Instead of fines, Chinese couples wishing a second child pay a "family-planning fee" to cover the cost to the government of supporting the additional person. Fears that relaxing the One Child Policy would produce a large increase in the birth rate have been unfounded.

Pause and Reflect 2.3.4

Why might China's One Child Policy result in many more male than female children?

CHECK-IN: KEY ISSUE 3

Why Does Population Growth Vary Among Regions?

- ✓ The demographic transition has four stages characterized by varying rates of births, deaths, and natural increase.
- ✓ The CBR has declined since 1990 in all but a handful of countries.
- ✓ Malthus believed that population would outstrip resources, but critics argue that that hasn't been the case in the world as a whole.

KEY ISSUE 4

Why Do Some Regions Face Health Threats?

- Epidemiologic Transition
- Infectious Diseases
- Health Care

Learning Outcome 2.4.1

Summarize the four stages of the epidemiologic transition.

As world NIR slows and the threat of overpopulation recedes, at least at a worldwide scale, geographers increasingly turn their attention to the health of the record number of people who are alive. Medical researchers have identified an **epidemiologic transition** that focuses on distinctive health threats in each stage of the demographic transition. Epidemiologists rely heavily on geographic concepts such as scale and connection because measures to control and prevent an epidemic derive from understanding its distinctive distribution and method of diffusion.

Epidemiologic Transition

The term *epidemiologic transition* comes from **epidemiology**, which is the branch of medical science concerned with the incidence, distribution, and control of diseases that are prevalent among a population at a special time and are produced by some special causes not generally present in the affected locality. The concept was originally formulated by epidemiologist Abdel Omran in 1971.

STAGE 1: PESTILENCE AND FAMINE (HIGH CDR)

In stage 1 of the epidemiologic transition, infectious and parasitic diseases were principal causes of human deaths, along with accidents and attacks by animals and other humans. Malthus called these causes of deaths “natural checks” on the growth of the human population in stage 1 of the demographic transition.

History's most violent stage 1 epidemic was the Black Plague (bubonic plague), which was probably transmitted to humans by fleas from migrating infected rats:

- The Black Plague originated among Tatars in present-day Kyrgyzstan.
- It diffused to present-day Ukraine when the Tatar army attacked an Italian trading post on the Black Sea.

- Italians fleeing the trading post carried the infected rats on ships west to the major coastal cities of Southeastern Europe in 1347.
- The plague diffused from the coast to inland towns and then to rural areas.
- It reached Western Europe in 1348 and Northern Europe in 1349.

About 25 million Europeans—at least one-half of the continent's population—died between 1347 and 1350. Five other epidemics in the late fourteenth century added to the toll in Europe. In China, 13 million died from the plague in 1380.

The plague wiped out entire villages and families, leaving farms with no workers and estates with no heirs. Churches were left without priests and parishioners, schools without teachers and students. Ships drifted aimlessly at sea after entire crews succumbed to the plague.

STAGE 2: RECEDING PANDEMICS (RAPIDLY DECLINING CDR)

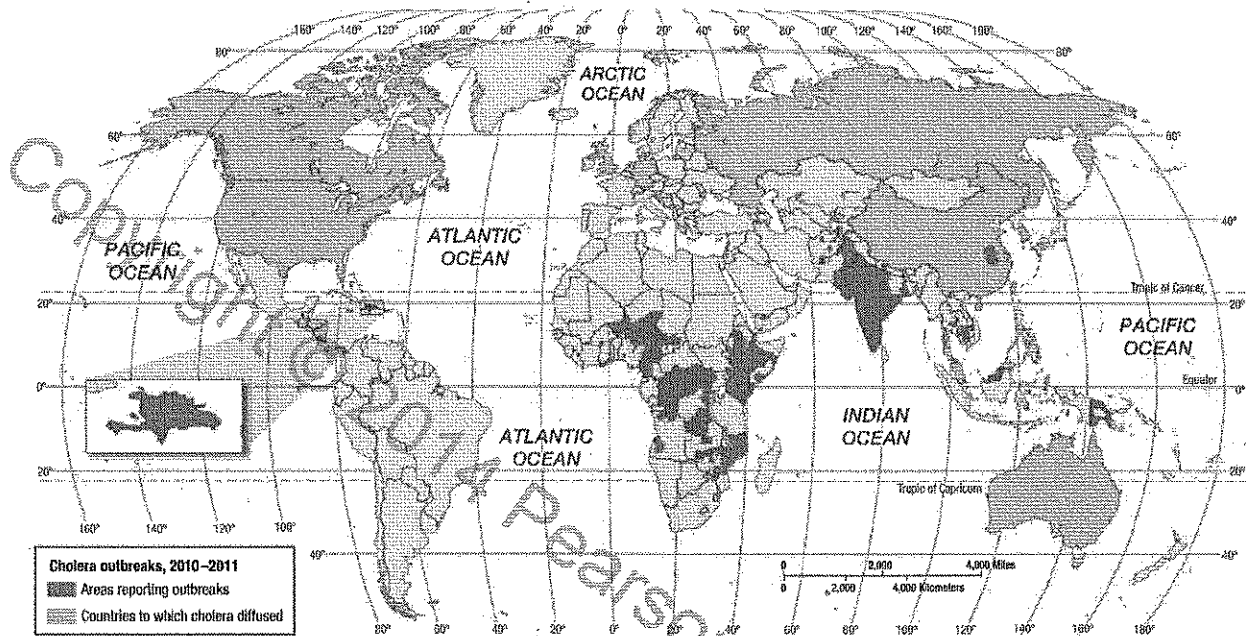
Stage 2 of the epidemiologic transition has been called the *stage of receding pandemics*. A **pandemic** is disease that occurs over a wide geographic area and affects a very high proportion of the population. Improved sanitation, nutrition, and medicine during the Industrial Revolution reduced the spread of infectious diseases. Death rates did not decline immediately and universally during the early years of the Industrial Revolution. Poor people crowded into rapidly growing industrial cities had especially high death rates. Cholera—uncommon in rural areas—became an especially virulent epidemic in urban areas during the Industrial Revolution.

Construction of water and sewer systems had eradicated cholera by the late nineteenth century. However, cholera persists in several developing regions in stage 2 of the demographic transition, especially sub-Saharan Africa and South and Southeast Asia, where many people lack access to clean drinking water (Figure 2-31). Cholera has also been found on Hispaniola, the island shared by Haiti and the Dominican Republic, especially in the wake of an earthquake in 2010 that killed 200,000 and displaced 1 million.

A computer-based Geographic Information System was invented in the twentieth century, but the idea of overlaying maps to understand human and natural patterns is much older. A century before the invention of computers, GIS helped to explain and battle stage 2 pandemics.

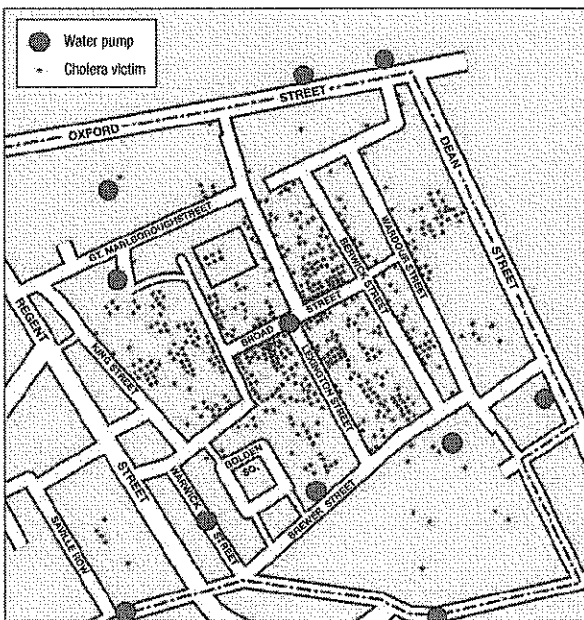
Dr. John Snow (1813–1858) was a British physician, not a geographer. To fight one of the worst nineteenth century pandemics, cholera, Snow created a hand-made GIS in 1854. On a map of London's Soho neighborhood, Snow overlaid two other maps, one showing the addresses of cholera victims and the other the location of water pumps—which for the poor residents of Soho were the principal source of water for drinking, cleaning, and cooking (Figure 2-30).

The overlay maps showed that cholera victims were not distributed uniformly through Soho. Dr. Snow showed that



▲ FIGURE 2-31 CHOLERA Countries reporting cholera in recent years are found primarily in sub-Saharan Africa and South Asia.

a large percentage of cholera victims were clustered around one pump, on Broad Street. Tests at the Broad Street pump subsequently proved that the water there was contaminated. Further investigation revealed that contaminated



▲ FIGURE 2-32 SIR JOHN SNOW'S CHOLERA MAP In 1854, Dr. John Snow mapped the distribution of cholera victims and water pumps to prove that the cause of the infection was contamination of the pump near the corner of Broad and Lexington streets.

sewage was getting into the water supply near the pump. Although no longer operative, the contaminated pump still stands in London and can be seen in the photo on page 42.

Before Dr. Snow's geographic analysis, many believed that epidemic victims were being punished for sinful behavior and that most victims were poor because poverty was considered a sin. Now we understand that cholera affects the poor because they are more likely to have to use contaminated water.

STAGE 3: DEGENERATIVE DISEASES (MODERATELY DECLINING CDR)

Stage 3 of the epidemiologic transition, the stage of degenerative and human-created diseases, is characterized by a decrease in deaths from infectious diseases and an increase in chronic disorders associated with aging. The two especially important chronic disorders in stage 3 are cardiovascular diseases, such as heart attacks, and various forms of cancer. The global pattern of cancer is the opposite of that for stage 2 diseases; sub-Saharan Africa and South Asia have the lowest incidence of cancer, primarily because of the relatively low life expectancy in those regions.

Pause and Reflect 2.4.1

In what climate zone are most of the countries that have experienced cholera recently?

STAGE 4: DELAYED DEGENERATIVE DISEASES (LOW BUT INCREASING CDR)

Learning Outcome 2.4.2

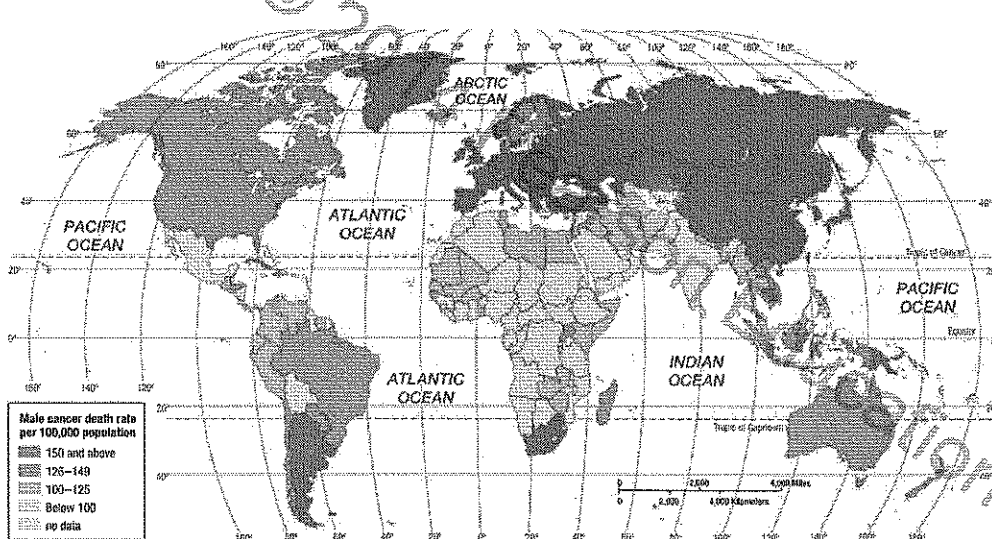
Summarize the reasons for Stage 4 and a possible stage 5 of the epidemiologic transition.

Omran's epidemiologic transition was extended by S. Jay Olshansky and Brian Ault to stage 4, the stage of delayed degenerative diseases. The major degenerative causes of death—cardiovascular diseases and cancers (Figure 2-33)—linger, but the life expectancy of older people is extended

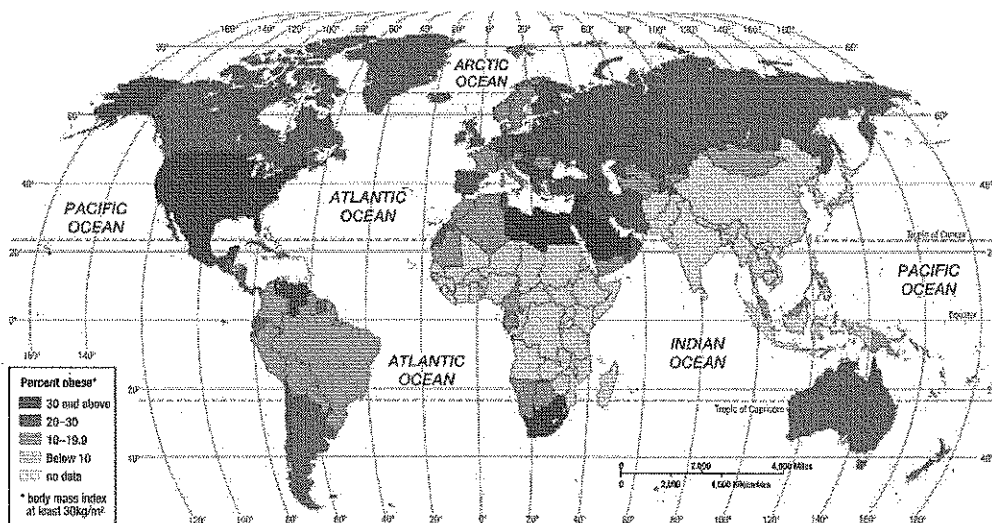
through medical advances. Through medicine, cancers spread more slowly or are removed altogether. Operations such as bypasses repair deficiencies in the cardiovascular system. Also improving health are behavior changes such as better diet, reduced use of tobacco and alcohol, and exercise. On the other hand, consumption of non-nutritious food and sedentary behavior have resulted in an increase in obesity in stage 4 countries (Figure 2-34).

Pause and Reflect 2.4.2

Have you had a parent or grandparent whose lifespan was extended by modern medical advances?



▲ FIGURE 2-33 MALE CANCER Cancer is an example of a cause of death for men that is higher in developed countries than in developing ones.



▲ FIGURE 2-34 OBESITY Obesity is a health problem in the United States and in Southwest Asia.

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Infectious Diseases

Recall that in the possible stage 5 of the demographic transition, CDR rises because more of the population is elderly. Some medical analysts argue that the world is moving into stage 5 of the epidemiologic transition, brought about by a reemergence of infectious and parasitic diseases. Infectious diseases thought to have been eradicated or controlled have returned, and new ones have emerged. A consequence of stage 5 would be higher CDRs. Other epidemiologists dismiss recent trends as a temporary setback in a long process of controlling infectious diseases.

In a possible stage 5, infectious diseases thought to have been eradicated or controlled return, and new ones emerge. Three reasons help to explain the possible emergence of a stage 5 of the epidemiologic transition: evolution, poverty, and increased connections.

REASON FOR POSSIBLE STAGE 5: EVOLUTION

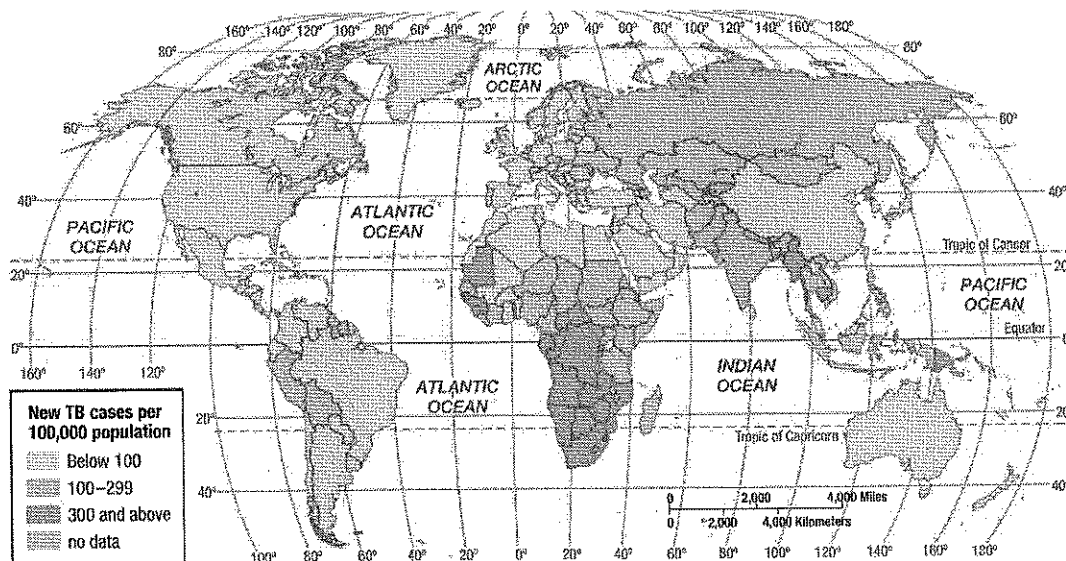
Infectious disease microbes have continuously evolved and changed in response to environmental pressures by developing resistance to drugs and insecticides. Antibiotics and genetic engineering contribute to the emergence of new strains of viruses and bacteria.

Malaria was nearly eradicated in the mid-twentieth century by spraying DDT in areas infested with the mosquito that carried the parasite. For example, new malaria cases in Sri Lanka fell from 1 million in 1955 to 18 in 1963. The disease returned after 1963, however, and now causes more than 1 million deaths worldwide annually. A major reason was the evolution of DDT-resistant mosquitoes.

REASON FOR POSSIBLE STAGE 5: POVERTY

Infectious diseases are more prevalent in poor areas than other places because unsanitary conditions may persist, and most people can't afford the drugs needed for treatment. Tuberculosis (TB) is an example of an infectious disease that has been largely controlled in developed countries but remains a major cause of death in developing countries (Figure 2-35). An airborne disease that is often called "consumption" and that damages the lungs, TB spreads principally through coughing and sneezing. TB was one of the principal causes of death among the urban poor in the nineteenth century during the Industrial Revolution.

The death rate from TB declined in the United States from 200 per 100,000 in 1900 to 60 in 1940 and 4 today. However, in developing countries, the TB rate is more than 10 times higher than in developed countries, and nearly 2 million people worldwide die from it annually. TB is more prevalent in poor areas because the long, expensive treatment poses a significant economic burden. Patients stop taking the drugs before the treatment cycle is completed.



▲ FIGURE 2-35 TUBERCULOSIS (TB) CASES Death from tuberculosis is a good indicator of a country's ability to invest in health care, because treating the disease is expensive.

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REASON FOR POSSIBLE STAGE 5: INCREASED CONNECTIONS

Learning Outcome 2.4.3

Describe the diffusion of AIDS.

Several dozen "new" pandemics, such as H1N1 (swine) flu and severe acute respiratory syndrome (SARS), have emerged over the past three decades and have spread through the process of relocation diffusion, discussed in Chapter 1. Motor vehicles allow rural residents to have greater connections with urban areas and for urban residents to easily reach rural areas. Airplanes allow residents of one country to easily connect with people in other countries. As they travel, people carry diseases with them and are exposed to the diseases of others.

The most lethal pandemic in recent years has been AIDS (acquired immunodeficiency syndrome). Worldwide, 30 million people died of AIDS from the beginning of the epidemic through 2010, and 34 million were living with HIV (human immunodeficiency virus, the cause

of AIDS). The impact of AIDS has been felt most strongly in sub-Saharan Africa, home to 23 million of the world's 34 million HIV-positive people (Figure 2-36).

AIDS diffused from sub-Saharan Africa through relocation diffusion, both by Africans and by visitors to Africa returning to their home countries. AIDS entered the United States during the early 1980s through New York, California, and Florida (Figure 2-37). Not by coincidence, the three leading U.S. airports for international arrivals are in these three states (Figure 2-38). Though AIDS diffused to every state during the 1980s, these three states, plus Texas (a major port of entry by motor vehicle), accounted for half of the country's new AIDS cases in the peak year of 1993.

The number of new AIDS cases dropped rapidly in the United States during the 1990s and in sub-Saharan Africa in the 2000s. The decline resulted from the rapid diffusion of preventive methods and medicines such as AZT. The rapid spread of these innovations is an example of expansion diffusion rather than relocation diffusion.

Pause and Reflect 2.4.3

Have other pandemic diseases diffused rapidly in recent years?

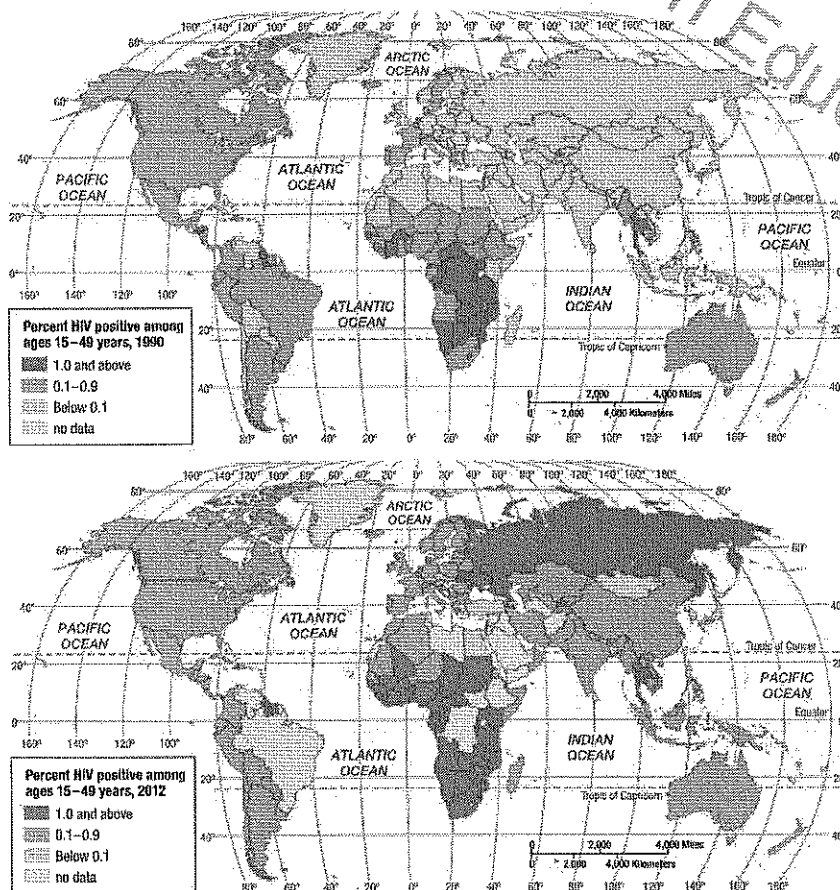
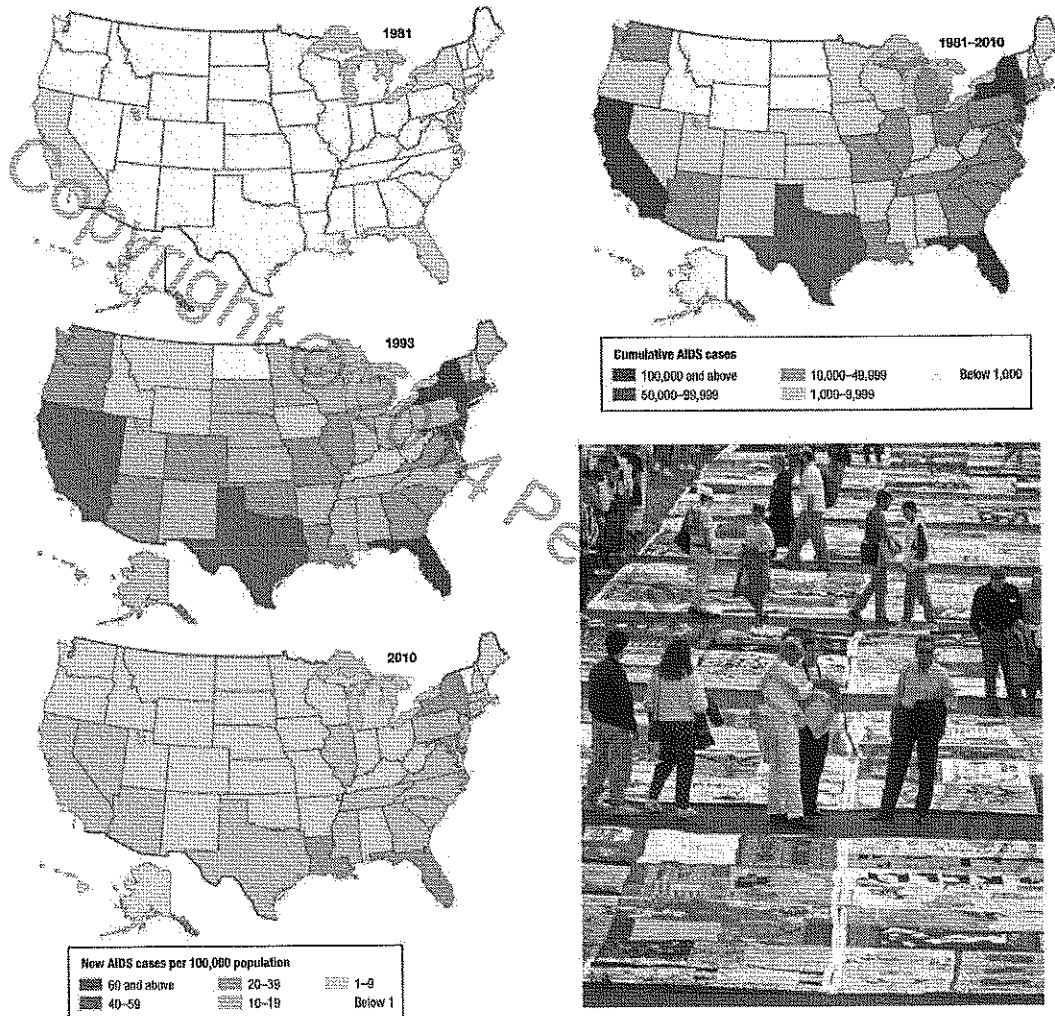
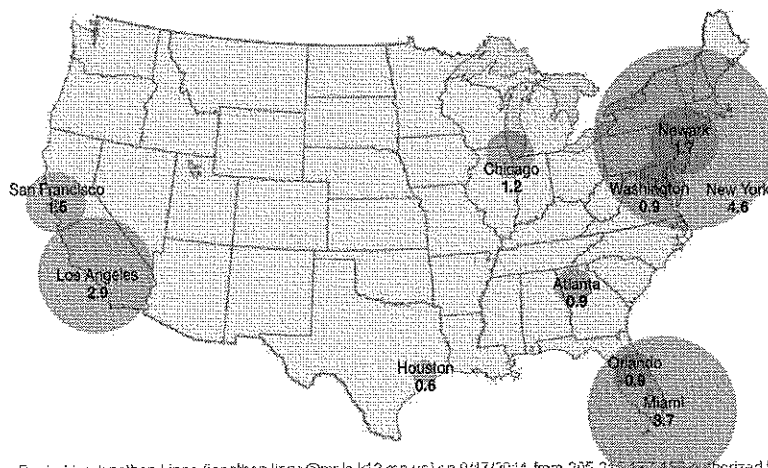


FIGURE 2-36 DIFFUSION OF HIV/AIDS The highest rates of HIV infection are in sub-Saharan Africa and Russia.



▲ FIGURE 2-37 DIFFUSION OF HIV/AIDS IN THE UNITED STATES AIDS diffused from states with relatively high immigration rates, such as California, Florida, and New York. The AIDS Memorial Quilt was assembled as a memorial to people who have died of AIDS.



◀ FIGURE 2-38 INTERNATIONAL PASSENGER ARRIVALS AT U.S. AIRPORTS 2011 Because AIDS arrived in the United States primarily through air travelers, the pattern of diffusion of AIDS in Figure 2-37 closely matches the distribution of international air passenger arrivals.

Health Care

Learning Outcome 2.4.4

Understand reasons for variations in health between developed and developing countries.

Health conditions vary around the world. Countries possess different resources to care for people who are sick.

INDICATORS OF HEALTH

Two important indicators of health in a country are the infant mortality rate and life expectancy. The **infant mortality rate (IMR)** is the annual number of deaths of infants under one year of age, compared with total live births (Figure 2-39). As is the case with the CBR and CDR, the IMR is usually expressed as the number of deaths among infants per 1,000 births rather than as a percentage (per 100). In general, the IMR reflects a country's

health-care system. Lower IMRs are found in countries with well-trained doctors and nurses, modern hospitals, and large supplies of medicine.

The global distribution of IMRs follows the pattern that by now has become familiar. The IMR is 5 in developed countries and 80 in sub-Saharan Africa, meaning that 1 in 12 babies die there before reaching their first birthday. Life expectancy at birth measures the average number of years a newborn infant can expect to live at current mortality levels (Figure 2-40). Like most of the mortality and fertility rates discussed thus far, life expectancy is most favorable in the wealthy countries of Europe and least favorable in the poor countries of sub-Saharan Africa. Babies born today can expect to live to nearly 80 in Europe but only to less than 60 in sub-Saharan Africa.

Pause and Reflect 2.4.4

Why do men have lower life expectancies than women in most countries?

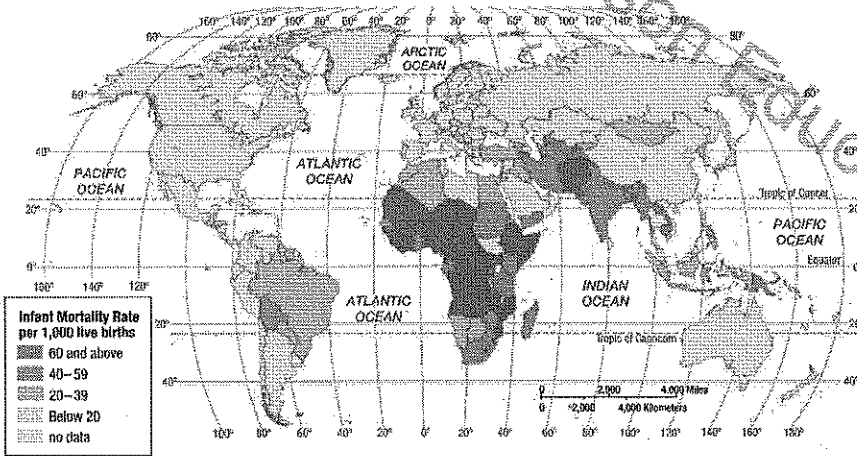


FIGURE 2-39 INFANT MORTALITY RATE (IMR) The highest IMRs are in sub-Saharan Africa, and the lowest are in Europe and South Pacific.

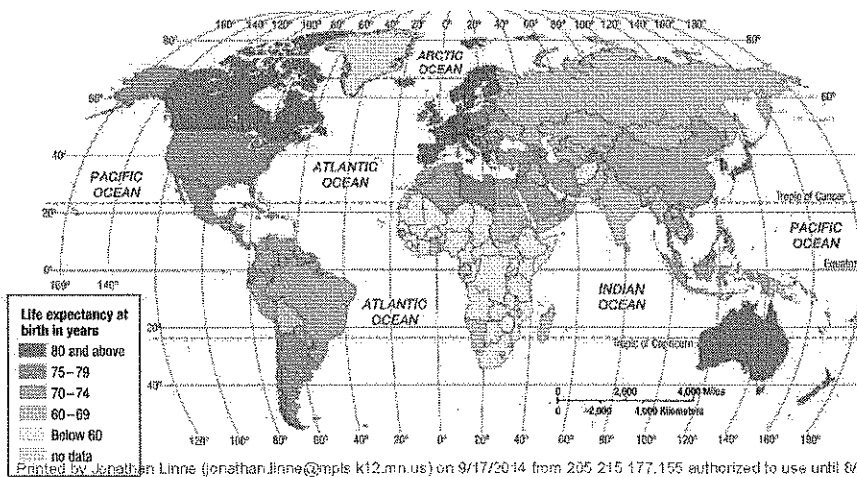


FIGURE 2-40 LIFE EXPECTANCY AT BIRTH As with IMRs, the highest life expectancies are in sub-Saharan Africa, and the lowest are in Europe and South Pacific.

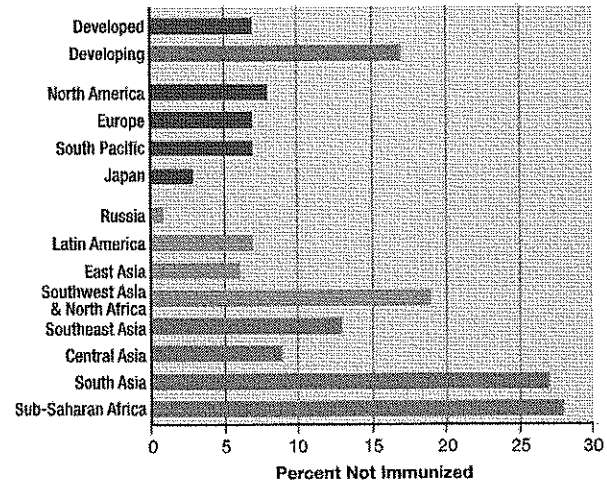
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PROVISION OF HEALTH CARE

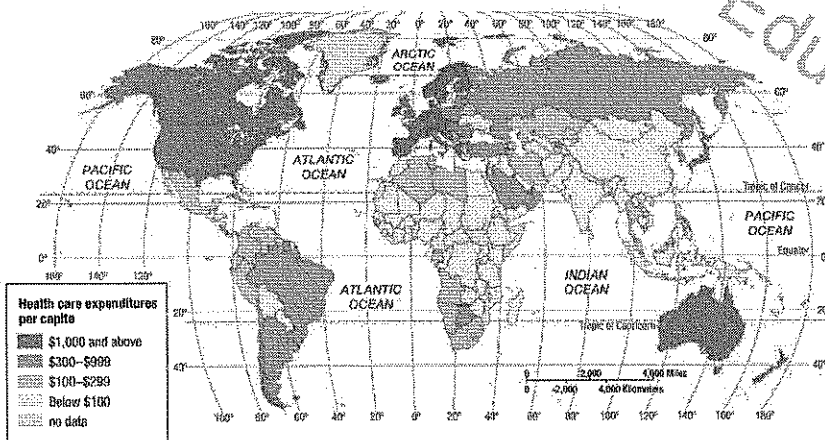
Even if they survive infancy, children remain at risk in developing countries. For example, 17 percent of children in developing countries are not immunized against measles, compared to 7 percent in developed countries. More than one-fourth of children lack measles immunization in South Asia and sub-Saharan Africa (Figure 2-41).

Developed countries use part of their wealth to protect people who, for various reasons, are unable to work. In these countries, some public assistance is offered to those who are sick, elderly, poor, disabled, orphaned, veterans of wars, widows, unemployed, or single parents. Annual per capita expenditure on health care exceeds \$1,000 in Europe and \$5,000 in the United States, compared to less than \$100 in sub-Saharan Africa and South Asia (Figure 2-42).

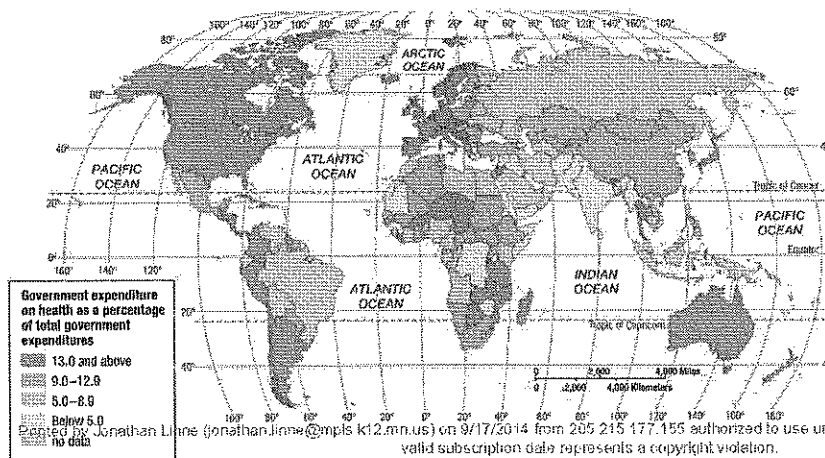
Expenditures on health care exceed 15 percent of total government expenditures in Europe and North America compared to less than 5 percent in sub-Saharan Africa and South Asia (Figure 2-43). Countries in Northern Europe, including Denmark, Norway, and Sweden, typically provide the highest level of public-assistance payments. So not only do developed countries spend more on health care, they spend a higher percentage of their wealth on health care.



▲ FIGURE 2-41 CHILDREN LACKING MEASLES IMMUNIZATION The lowest rates of immunization are in sub-Saharan Africa and South Asia.



◀ FIGURE 2-42 HEALTH CARE EXPENDITURES The lowest levels of per capita health care expenditure are in sub-Saharan Africa and South Asia.



◀ FIGURE 2-43 GOVERNMENT EXPENDITURES ON HEALTH CARE The lowest levels of government expenditures are in Africa and Asia.

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MEDICAL SERVICES

Learning Outcome 2.4.5

Understand reasons for variations in health between developed and developing countries.

Health conditions vary around the world. Countries possess different resources to care for people who are sick.

The high expenditure on health care in developed countries is reflected in medical facilities. Most countries in Europe have more than 50 hospital beds per 10,000 people, compared to fewer than 20 in sub-Saharan Africa and South and Southwest Asia (Figure 2-44). Europe has more than 30 physicians per 10,000 population, compared to fewer than 5 in sub-Saharan Africa (Figure 2-45).

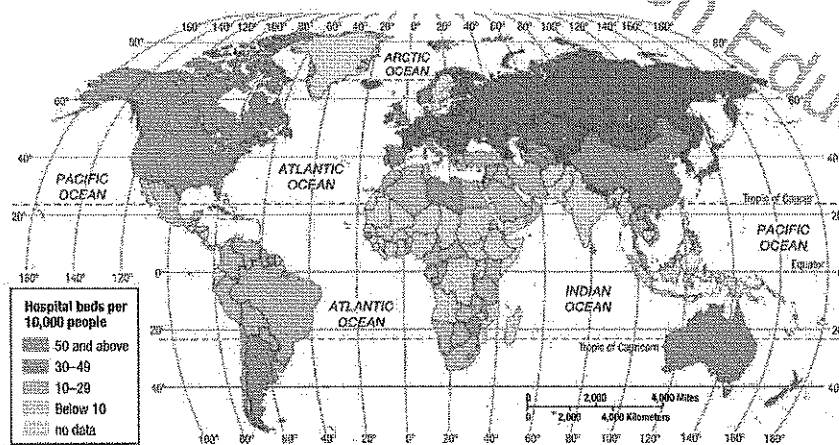
In most developed countries, health care is a public service that is available at little or no cost. Government programs pay more than 70 percent of health-care costs in most European countries, and private individuals pay less than 30 percent. In developing countries, private individuals must pay more than half of the cost of health

care (Figure 2-46). An exception to this pattern is the United States, a developed country where private individuals are required to pay an average of 55 percent of health care, more closely resembling the pattern in developing countries.

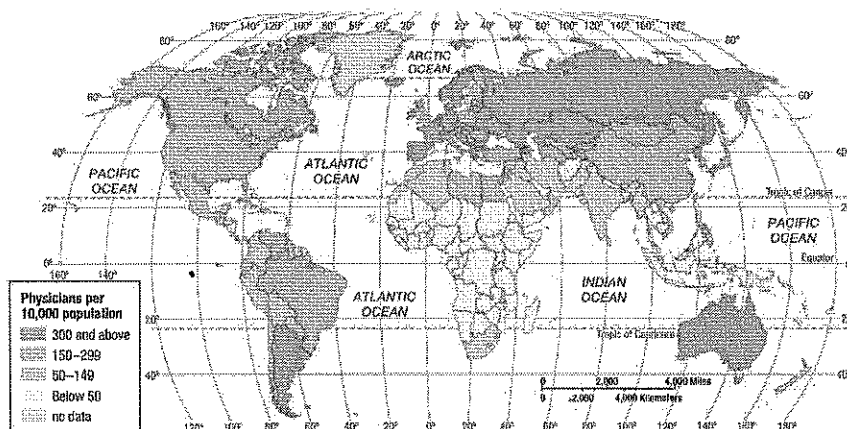
Developed countries are hard-pressed to maintain their current levels of public assistance. In the past, rapid economic growth permitted these states to finance generous programs with little difficulty. But in recent years economic growth has slowed, while the percentage of people needing public assistance has increased. Governments have faced a choice between reducing benefits and increasing taxes to pay for them. In some of the poorest countries, threats to health and sustainability are not so much financial as environmental. For a case in point, read the following Sustainability and Inequality in Our Global Village feature.

Pause and Reflect 2.4.5

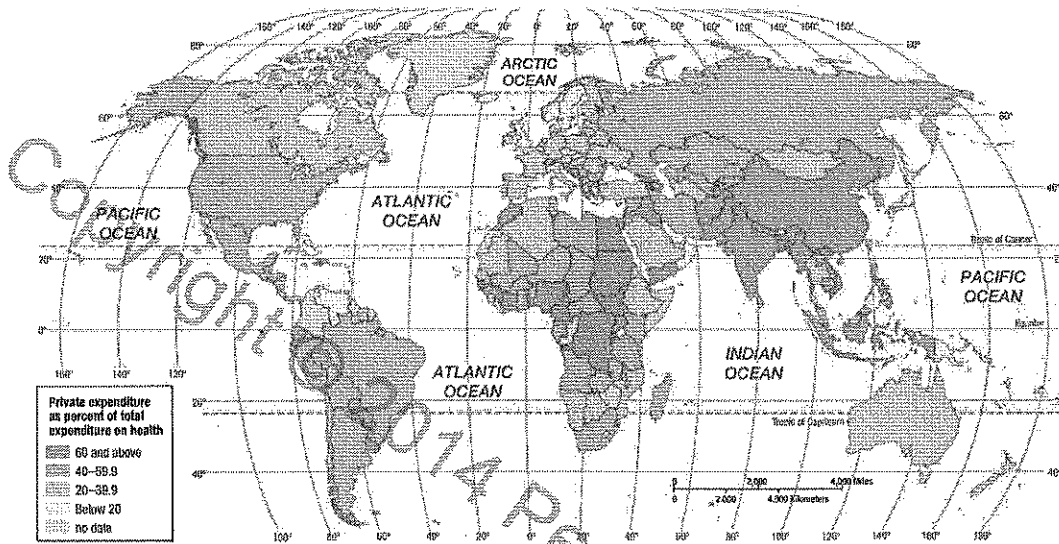
Why might levels of hospital beds and physicians be lower in North America than in other developed countries?



◀ **FIGURE 2-44 HOSPITAL BEDS PER 10,000 PEOPLE** The lowest rates are in sub-Saharan Africa and South Asia.



◀ **FIGURE 2-45 PHYSICIANS PER 10,000 PEOPLE** The lowest rates are in sub-Saharan Africa.



▲ FIGURE 2-46 PUBLIC EXPENDITURES ON HEALTH CARE AS A SHARE OF TOTAL HEALTH CARE EXPENDITURES The highest percentages are in Europe.

SUSTAINABILITY AND INEQUALITY IN OUR GLOBAL VILLAGE

Overpopulation in Sub-Saharan Africa

Overpopulation—too many people for the available resources—does not appear to be an immediate threat to the world, even in India, where the seven billionth human was said to have been born on October 31, 2011 (Figure 2-47). However, it does threaten areas within sub-Saharan Africa.

Sub-Saharan Africa was not classified in Key Issue 1 as one of the world's population concentrations. Geographers caution that the size, density, or clustering of population in a region is not an indication of overpopulation. Instead, overpopulation is a relationship between population and a region's level of resources. The capacity of the land to sustain life derives partly from characteristics of the



▲ FIGURE 2-47 THE WORLD'S SEVEN BILLIONTH HUMAN Nargis Kumar, born October 31, 2011, to Vinita and Ajay Kumar, of Lucknow, India, was declared the world's seven billionth person by Plan International, a nongovernmental organization for children's welfare.

natural environment and partly from human actions to modify the environment through agriculture, industry, and exploitation of raw materials. See for example, the image of Mali on page 44.

The track toward overpopulation may already be irreversible in Africa. Rapid population growth has led to the inability of the land to sustain life in parts of the region. As the land declines in quality, more effort is needed to yield the same amount of crops. This extends the working day of women, who have the primary responsibility for growing food for their families. Women then regard having another child as a means of securing additional help in growing food.

CHECK IN: KEY ISSUE 4

Why Do Some Regions Face Health Threats?

- ✓ The epidemiologic transition has four stages of distinctive diseases.
- ✓ A resurgence of infectious diseases may signal a possible stage 5 of the epidemiologic transition.
- ✓ The provision of health care varies sharply between developed and developing countries.