These questions refer to two measures of use, 'ever-use' and 'current-use'. Current use or contraceptive pervalence must only consider responses to the first question. Responses from the second question can be used if data on contraception are diffentiated by method of use in which case women who, for instance, had an injection a month prior to the date of the survey, are legitimately current contraceptors assuming a three-month protection. However, if differentiation by method is not made, as is the case of the ZRHS, a combination of responses to both questions inflates the contraceptive prevalence figures. If the contraceptive prevalence is indeed a true representation of reality, the implication is that Zimbabwe needs a much higher level of contraceptive prevalence to achieve an equivalent proportionate reduction in fertility.

In summary, then, it can be said that the ZRHS report provides invaluable information for planning and implementing programmes to effect fertility. However, it is disturbing to note that estimates of very important indices deviate from those of the national census. While the reconciliation of these differences is definitely beyond the scope of such a report, one cannot underplay the exigency of such an exercise if the estimates are to be meaningfully utilised for any future planning with an acceptable degree of confidence. Perhaps cautionary footnotes would have been helpful. There is also an inconsistency between the reported high (positive) determinants of contraception and the reported level of contraception. Perhaps the determinants in this report are of little significance to the adoption of fertility control in Zimbabwe, but this is doubtful. However, these few shortfalls must not overshadow the acceptability of the ZRHS report as an important document on Zimbabwean fertility. In this report lies a strong foundation for future research and planning.

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Reference

BONGAARTS J 1984 "A Simple Method for Estimating the Contraceptive Prevalence Required to Reach a Fertility Target" in **Studies in Family Planning** 15(4), 184-190.

David Sanders with Richard Carver, **The Struggle for Health: Medicine and the Politics of Underdevelopment.** Macmillan Publishers, London, 1986, £2,95.

This book has been written for the general public but is particulary useful to health professionals, the business community and politicians. It is written in clear and easy to understand language, makes use of extensive examples from developing and developed countries and is well illustrated. It is an excellent

exposition of the real causes of ill health in both developed and underdeveloped countries.

The first two chapters compare the disease pattern of late 19th century Europe and present day underdeveloped countries. The disease pattern is similar, consisting mainly of infectious diseases. It is noted that the decline in deaths in Europe was largely due to improvements in living and working conditions. Specific medical intervention had very little role to play. This is echoed by the fact that even in Britain today, where there is a National Health Service available to everyone irrespective of social class, there are clear differences in disease patterns amongst the different social classes. This reinforces the fact that living and working conditions are more important than medical services in improving the health of any population.

In Chapter 3 Sanders looks critically at the population dilema. He argues that the West would like us to believe that economic development in underdeveloped countries is hampered by unchecked population growth. We are told that the population explosion is the cause of famine, poverty and disease. It is this notion that led to the rapid proliferation of family planning programmes in the early sixties and even now such programmes are seen as a solution to poverty and underdevelopment. Massive resources have been and are still being poured into population control programmes for this purpose especially by the USA: Asians, Africans and Latin Americans are being told that they are poor because they have too many children.

Sanders and Carver argue that famine is due to inappropriate production of food and the inequitable distribution of the same. Poverty is due in part to grossly unfair land distribution systems and also to the fact that capital is in the hands of a few foreign and local capitalists.

The truth is that population growth is a natural phenomenon which takes its own course – the so called demographic transition. High mortality and fertility is usually followed, after a lag period, by a decline in fertility. Countries are in different periods of demographic transition and will stabilise with time, with or without active intervention. In underdeveloped countries, fertility is high because of high mortality. In India, for instance, a couple has to have about seven children in order to be 95% confident that one survives! It is therefore not surprising that family planning programmes have had no effect on population growth. Good examples of this notable failure are India and Pakistan where family planning programmes have been in existence for a very long time and yet they have not had a noticable effect on population growth. After all, European fertility declined without much reliance on modern contraception.

What has been the medical contribution in improving the health status of communities? Most resources have been spent in building, equipping and

manning large hospitals in urban areas. In underdeveloped countries these 'disease palaces' serve only 20% of the population since 80% of the population live in rural areas. Therefore the majority of the population has no access to any meaningful medical care system. It is therefore not surprising that these huge investments in medical care have failed to have any impact on morbidity and mortality. It has also been noted that even if there is equal access to medical care, the impact on the health status will still be negligible.

Chapter 5 is a review of the role played by the health professionals, business community and the state. It is concluded that the medical profession is there to serve the interests of those in power and in fact it helps to strengthen the status quo. The business community, too, resists pressure for improving living and working conditions. Lastly the drug industry is an economic burden on the already meagre resources available for health services, especially since most of the drugs may not have any therapeutic value. The drug industry therefore shifts resources away from the fundamental causes of ill health.

The last chapter addresses itself, more positively, to the solution to the problem of underdevelopment and ill health. It is now well recognised that health problems are rooted in social conditions. In developing countries this is worsened by the international system that seeks to perpetuate underdevelopment. An attack on these social conditions will no doubt go a long way to improve the well-being of communities. Two striking examples, China and Cuba, are discussed to show that revolutionary changes in the socio-economic conditions can bring about a decline in diseases and deaths due to preventable conditions. It must be stressed that a high degree of political commitment was a prerequisite for the success that both these countries claimed. Changes in the health sector follow rather than precede fundamental social change. Instead of depending on doctors a more appropriate health worker who is community based may be more acceptable to the people. A good example of this is the Chinese 'barefoot doctor'. China owes its success in the health sector to this cadre of health worker. Most developing countries now rely on this community health worker. He or she is chosen by the community and lives in the community and is therefore accessible to the community. This is the cornerstone of Primary Health Care which has revolutionised the medical myth. Through the Primary Health Care approach, health workers can help fight underdevelopment by stimulating communities actively to participate in promoting good health – thus struggling for their own health.

I would recommend this book to all health workers and policy makers, especially to those people who wish to know the real reasons for ill health. The central argument is that ill health cannot be separated from underdevelopment.

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