Journal of Social Development in Africa (1986), 1, 101-110

Book Reviews

Charles P. Gasarasi, **The Tripartite Approach to the Resettlement and Integration of Rural Refugees in Tanzania.** Research Report No 71, The Scandinavian Institute of African Studies, Uppsala, 1984.

All those concerned with the problem of refugees would be interested in reading this lucid account of the strategy undertaken by Tanzania in respect of the resettlement and integration of refugees, by Tanzanian researcher Charles P Gasarasi, a lecturer in Political Science at the University of Dar es Salaam.

Gasarasi evaluates the refugee problem initially from a continental perspective, pointing out that the number of refugees in Africa has been estimated at over 5 million, which represents roughly half of the world's total. He indicates that although the majority of African states have ratified international conventions relating to the protection of refugees, the principle of 'burden-sharing', enshrined in the 1969 OAU Convention, where member states are expected to assist one another in dealing with refugee problems, has on the whole been sadly neglected. We may view this inhospitality generously as does Gasarasi and other writers such as Kibreab (1983) who notes that hospitality – which is a function of 'resource availability' (1983:83) – is inconceivable in a state of poverty. Alternatively we may see this as an example of indifference and inhumanity on the part of many African governments which have failed dismally to meet their responsibilities and indeed have created this problem in the first place. Partly as a result of this lack of co-operation, host governments have had to seek aid from a variety of voluntary non-governmental agencies and from appropriate UN bodies.

In this context Gasarasi explores the Tanzanian experience of coping with refugees and in particular the tripartite arrangement made between the Government of the Republic of Tanzania, the office of the United Nations High Commissioner for Refugees (UNHCR) and the Lutheran World Federation/ Tanganyika Christian Refugee Service (LWF/TCRS). Tanzania has had an extensive experience of influx by refugees since 1959, principally from Zaire and Burundi, although refugees have also arrived from Rwanda, Malawi, Mozambique, Uganda, Kenya and South Africa. The Tanzanian record in dealing with these refugees presents as certainly one of the best in Africa, as

not only has Tanzania generously welcomed its refugee population, but has actively encouraged the integration of refugees through economic self-reliance – and in tens of thousands of cases the granting of Tanzanian citizenship. In recognition of his exceptional services to refugees, President Nyerere was awarded the prestigious Nansen Medal in 1983 (REFUGEES, 1983:13).

Gasarasi traces the involvement of the tripartite partners with refugees, in particular highlighting the large financial contributions made by the two non-governmental partners (for example, UNHCR spent US$ 11.5 million in sponsoring rural refugee settlements in Tanzania between 1963 and 1979 – Gasarasi p 23). On the other hand he points to the Government's contribution in granting refugees free land on which to settle (10 acres of agricultural land per family), free primary education, health services and assistance to build a new home in a rural refugee settlement. A major factor facilitating this process, as noted by Gasarasi, concerns the availability and ease of allocation of land (ie through state grant rather than purchase), which has meant that Tanzania has the ability to afford such generosity – unlike many other African countries. In particular he emphasises the inestimable value of granting asylum to needy people.

This tripartite approach has developed since the initial Memorandum of Understanding was signed in May 1964. Gasarasi notes the early conflicts which emerged between the partners which he views as reflecting a covert struggle for power. This mainly concerned the disbursement of funds with the two non-governmental partners seeking a greater degree of control over expenditure by government. Lack of mutual trust, different terms of reference and conflicts of interest have also contributed to a breakdown in communication at various times between the operational partners. Other problems concern such factors as poor planning in the allocation of land for the settlements which led to several disastrous failures in the early years. Despite these initial difficulties and continuing conflicts of interest, Gasarasi assures us that, with the increasing experience gained by the partners, more positive results of an incremental nature have developed over time.

The question of participation by refugees in the setting up and running of the settlements is also considered. Earlier settlements did not consider this dynamic, but in the more recent settlements both refugee participation in planning projects and local people's knowledge of the area concerned have been used to beneficial effect. However, Gasarasi is critical of Tanzania's Refugee Control Act (1965) which he feels is responsible for the creation of authoritarian 'Settlement Commandants' who have often developed antagonistic relations with the refugees.

Gasarasi indicates, through good use of tables, details of expenditure and sales production which highlight the relative success of the policy of

encouraging refugee settlements to take their place in the national economy. In addition a wide range of skills and services are provided through refugee co-operatives, which have developed a local economy for the settlements. Recently many of the earlier settlements have assumed the status of ordinary Tanzanian villages, either through voluntary repatriation or, in cases where this was not a possibility, the mass naturalisation of refugees.

Gasarasi emphasises that other African countries hosting refugees would greatly benefit from this tripartite experience and believes this deserves wide dissemination. I would endorse his view, with the reservation that the development of this co-operative approach requires a particular set of favourable circumstances to facilitate this process. In addition it seems evident tha the different terms of reference of the operational partners inevitably creates a degree of mistrust between them. However, we should bear in mind that in all likelihood these three agencies will need to develop a *modus operandi* in coping with refugee problems in any case. Other countries apart from Tanzania have experimented in a similar way, with one implementing donor agency working hand in glove with both Government and UN agencies such as UNHCR. Although beset with difficulties, a tripartite approach may be the only way to work towards the provision of effective co-ordination and planning for refugees in the long term.

Reviewed by N Hall, School of Social Work, Harare.

References

KIBREAB G 1983 **Reflections on the African Refugee Problem: A Critical Analysis of Some Basic Assumptions.** Research Report No 47, The Scandinavian Institute of African Studies, Uppsala. Sweden.

REFUGEES 1983 **Refugees Magazine,** Office of the United Nations High Commissioner for Refugees. Public Information Section, No 5, Dec 1983. 13-18.

Zimbabwe National Family Planning Council. Zimbabwe Reproductive Health Survey 1984. Harare, June 1985.

The Zimbabwe Reproductive Health Survey (ZRHS) Report is written with clarity and principled simplicity. These are important attributes for a pathbreaking report in the field of fertility in Zimbabwe. The ZRHS was conducted between July and October 1984, and the sample is comprised of 2 574 women aged 15-49 of whom two thirds are rural residents.

The report consists of eight chapters. The first chapter provides the historical, socio-economic and demographic backdrop on which the study

rests. The organisational structure of the Zimbabwe National Family Planning Council (ZNFPC), the national executing agency for family planning programmes, is presented. As Zimbabwe does not have an explicit population policy, the official support of family planning activities is for other than demographic reasons. Like other countries which fall in this category, family planning is supported for reasons of health and as a human right, and any antinatalistic effect is a by-product and not an objective. Yet the necessity of such a by-product is not underplayed in the report. Chapter two deals with the survey methodology while chapters three to five present the survey results on the socio-economic and demographic variables of age, place of residence, education, work status, nuptiality, desired family size and material and child health. The traditional concepts of knowledge, attitude and practice of family planning are the focus in chapters six and seven. In the last chapter, availability of contraceptive methods, a proxy for cost of fertility regulation, is discussed.

The socio-economic and demographic characteristics of Zimbabwe are not typical of most developing countries. Zimbabwe has experienced a significant mortality decline without a concommitant proportionate fertility decline and hence has suffered a consequent high growth rate. The sample shows a young age structure with an urban bias. The literacy rate of approximately 75 percent is fairly high particularly for women. However, while this may be a true reflection of the country's literacy rate, it is important to note that the liberal definition of literacy "the ability to read a letter or newspaper" was used. A modest female labour force participation rate of approximately 33 percent is reported.

The pattern of nuptiality, the socially sanctioned context within which fertility takes place, has important implications for the fertility level of any country. Universal and early marriage are characteristic of Zimbabwe. The authors rightly observe the "critical importance" of contraception to effect a significant fertility change given the reported mean age at first marriage of 17,8 years. While this mean age at marriage is quite plausible for a developing African country, the deviation from the census estimate of 22 years is a matter of concern. Can a 4,3 year difference be simply explained away by random error?

High fertility is a characteristic of the Zimbabwean population, although it is suggested that a decline is underway. If fertility continues at its present level, an average woman would have 6,5 births before the end of her reproductive career. The census total fertility rate estimate is 5,6. The total fertility rate estimates are consistent with those of the mean age at first marriage assuming an inverse relationship between these two variables. Fertility is reported to be higher among women who are rural, poorly educated with poorly educated spouses, and not employed outside the home.

'Demand' for contraception is affected by the proportion of women who do not want any more children, would like to delay further pregnancy or who wish a desired number of children vis-a-vis potential fertility. Apparently 25 percent of the women reported no desire for more children while ten percent of those who still want more children would like to delay the next pregnancy. The reported number of children is six with a minimal bias in favour of rural areas. Another subjective cost of fertility regulation is the attitudinal component which is reported to be very positive. Women reported their partners attitudes on family formation as similar to theirs. Indeed these results, not questioning their validity, suggest a substantial demand for contraception for spacing purposes rather than to stop altogether. Such contraception is of little relevance to fertility decline considering the deep rootedness of spacing in our culture. We may be just observing a simple replacement of traditional methods by modern methods and hope this will trigger the desire to limit family size.

High infant mortality has been hypothesised as underlying high fertility, a consequence of the 'hoarding' or 'insurance' mechanism. In such a context the rationale behind large families is explained by the perceived higher probability of a modest number of children surviving from a larger 'risk pool'. Zimbabwe is reported to be experiencing fairly high (although moderate by African standards) infant mortality. The infant mortality rate is approximately 79 deaths per thousand births. However, breastfeeding, an important determinant of infant mortality, is still high, a reported average of 19 months. Closely related to infant and maternal health is prenatal care for mothers which is reported to be almost universal, but with an urban bias.

It has been empirically proved that women under age 18 and over age 35, women with more than four births and those with interbirth intervals of less than two years, have a higher morbidity and mortality risk. Apparently 80 percent of the Zimbabwean women fall into at least one of these risk categories. The indispensability of family planning services simply for the protection of such mothers is obvious and well articulated by the ZNFPC. Knowledge of, and attitudes to, contraceptive methods are important determinants of the deliberate adoption of contraception. Perhaps of paramount importance is the attitude towards the whole notion of fertility regulation and also particularly that towards use of modern contraceptives. These attitudes are acquired and nurtured within a socio-cultural context in which the individual woman is 'constrained' to behave in a manner perceived as normal by the significant others and other societal members.

The ZRHS shows that 'ever-married' women display a very high level of knowledge of family planning methods. Approximately 90 percent of the women are reported to know at least one method while 70 percent reported to

know a family planning outlet. One is, however, bound to be wary of the suggestive nature of the question on knowledge:

> "As you know, there are various ways a couple can delay the next pregnancy or avoid having children if they do not want them. Do you know or have you heard about any of these family planning methods?"

The first part of this question is not necessary if a more objective response to the question is expected.

Favourable attitudes towards family planning are characteristic of the sample. Approximately 63 percent of the women reported partner's approval of family planning, 80 percent of them would like additional information about family planning. It is interesting to note that approximately 56 and 16 percent of the respondents are reached by radio and television programmes, respectively. while family planning brochures reach about 32 percent of the women. It is abundantly clear that these sources of information do not provide adequate information to enable women to make a final decisioin on the adoption of contraception. Perhaps one of the weak components of the programme is communication. And perhaps the 'knowledge' reported here is not a valid measure of that attribute expected to have a great bearing on the adoption of contraception. The following questions were used to elicit information on knowledge:

> Have you ever heard a family planning announcement on the radio?
> Have you ever heard a family planning announcement on television?
> Have you ever seen a family planning brochure or pamphlet?

Note that **ever** heard or seen can mean once or a hundred times; the regularity is definitely not clear. Questions asking for ownership of radio and or television, and regularity of listening to family planning programmes, would be of great relevance to the measurement of dissemination of knowledge.

A pertinent, yet separate, issue is the effectiveness of these means of communication, especially since those initiating the communication and those receiving it may be very different. Perhaps more intensive face-to-face discussion would make a big difference. This definitely facilitates immediate correction on misinterpreted messages, and immediate filling-up of gaps in such messages.

Discussion of yet another determinant of deliberate fertility regulation, availability of contraception, is in order. This is, however, a reversal of the sequencing of chapters in the report. ZNFPC's community-based distributors (CBDs) and government hospitals and clinics are the principal service providers for women currently using contraceptives. These sources are also reported to be easily accessible – approximately 75 percent of all users either receive their contraceptive at home from a CBD or are within 30 minutes travel time of the source they prefer.

It is reported that users are generally satisfied with the services they get. However, those who rely on sources other than CBDs recommended that the number of clinics and staff be increased and that men be educated about family planning. CBD users recommended that these services can be improved by increasing the number of distributors, having them visit more often and having them 'be more polite and helpful'. A recommendation is, to a large extent, a subtle criticism which is difficult to tap in a large scale survey research. CBDs impoliteness and unhelpfulness is a negation of well-intended efforts – the often observed gap between planning and implementation. Also note the need mentioned here to educate the husbands who are elsewhere reported as generally supportive of family planning.

Contraceptive use, which is the dependent variable, is the highest ever reported in any country in Sub-Saharan Africa. Approximately 66 percent of the women report 'ever-use' of fertility control while 38 percent are current users of contraceptives; 27 percent rely on modern methods. The differential level of use is in favour of women aged 20-34, literate women and working women. The main reason for nonuse is lack of information about family planning. It is further reported that one out of seven currently in union women is in immediate need of family planning for limiting or spacing reasons since they are exposed to the risk of getting pregnant. A contraceptive prevalence of 38 percent on the one hand appears to be low, and yet further scrutiny suggests that this level is rather high. While I personally subscribe to the notion that fertility decline is country specific I do recognise that general trends are often discernible and deviations from these trends can be explained. It is important to evaluate the implications of a prevalence rate within a general theoretical model. Bongaarts (1984) formulated a model for the estimation of contraceptive prevalence required to achieve a particular target fertility level. In its application in Pakistan, he concluded that with a contraceptive use-effectiveness of 90 percent, a contraceptive prevalence of 28 percent would result in a total fertility rate of 5. A contraceptive prevalence of approximately 36 percent would translate into a total fertility rate of 4,5. Indeed a number of variants to these levels are included in his model. If one assumes this variant to be true of the Zimbabwean case, then it will be obvious that our contraception is basically for spacing and not for stopping which will make our fertility transition more protracted.

Not withstanding wilful misreporting by the respondents perhaps a relevant technical question is the one pertaining to the measurement of 'prevalence' of contraception. Contraception prevalence, in this report, is gleaned from responses to the following questions:

> "Are you or your spouse currently using some family planning method or doing something to avoid a pregnancy? Have you or your spouse used any method in the past month?"

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.

Reviewed by Marvelous Mhloyi, University of Zimbabwe, Harare

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.

Reviewed by Ephraim Minya, Ministry of Health, Bindura.