

BAS-ZAIRE FAMILY PLANNING PROJECT

TRIP REPORT

Jane T. Bertrand: July 7-28, 1982

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I. Purpose of the Trip

The current trip provided the opportunity to review progress on several aspects of the Bas-Zaire Operations Research (OR) Project, especially the recently initiated service program in the urban area of Matadi.

Specifically, the main objectives were:

1. To review progress and discuss problems regarding the service delivery program in Matadi.
2. To do the same for the service delivery activities in the rural area of Songololo, with special emphasis on reviewing the service statistics for the second round of home visiting.
3. To review the inventory data on the current stock of contraceptives and medications for children under five.
4. To examine the accounting records for the project.
5. To determine that all forms needed for the (eventual) cost effectiveness analysis of the project are currently in use.

6. To obtain a magnetic tape containing the remaining data for the urban survey, with which it will be possible to begin the data analysis of the baseline survey for both urban and rural areas.
7. To further explore the possibility of producing a 16 mm family planning film in Bas-Zaïre, to be used as an educational tool in this (and possibly other) project(s).

The itinerary of this trip was as follows:

July 8-10 Kinshasa
July 11-12 Matadi
July 13-20 Nsona Mpangu
July 21-28 Kinshasa

During this period Ms. Elizabeth Maguire, Technical Monitor for this Project from the Office of Population, USAID/Washington, traveled to Zaïre and visited the Project sites in both Matadi and Nsona Mpangu. In addition, Dr. William Bertrand, Consultant to the Project and Chairman of the Department of Biostatistics and Epidemiology at Tulane, provided technical assistance in regard to data processing procedures in Kinshasa and logistic assistance regarding the preparation of the film.

During the last week in Kinshasa, the Bertrands also served as lecturers for an AID-sponsored seminar on primary health care, attended by 45 doctors and health professionals in Zaïre. And some time was dedicated to working at USAID on the Social Analysis, to be included in the Project Paper for the proposed urban family planning project.

A list of persons contacted on this trip is attached in Appendix A.

II. Service Delivery in the Urban Area of Matadi.

Despite the political programs in Matadi which threatened to block project activity there, Dr. Nlandu Mangani, Citne. Matondo Mansilu, and other project staff have been able to establish the PRODEF project in Matadi. After some delays due to these problems, training of the team of 10 home visitors was conducted from May 6-18, 1982. This was followed by the training of 12 nurses, who work in the six dispensaries which will participate in the project; this was a five day course, held on June 14-20, 1982. The actual home visiting began on June 29, 1982, and had been in progress for two weeks at the time of this visit.

Two meetings with the Matadi staff suggested that the home visiting was going well. While there were occasional refusals (to be visited), the vast majority of women in the community were receptive to the home visit. Moreover, there had been no attempts on the part of individuals opposed to the project to disrupt the field activities.

The results of these first two weeks of home visiting are presented in table 1. Of the 458 women who were home and received a visit, 41% accepted a (free) contraceptive method. (This is slightly higher than in the rural area, where approximately 32% of the women accepted during the first round of home visiting.) The most frequently selected method was Neosampoon, followed by foam. The reason for this is that a large number of women desiring a method are lactating mothers. To date, the project directors have specified that lactating women should not be given the pill. Thus, large number select a vaginal barrier method. (The same was found to be true during the first round of home visiting in the rural area, although at that time Neosampoon was not yet available, and many women chose foam.) The project directors are now reconsidering their position, and it is probable that they will authorize the use of the pill among lactating mothers, once the infant is 6 or 9 months old.

Table 1. Results of First Two Weeks of Home Visiting in Matadi

June 29 - July 9, 1982

	<u>n</u>	<u>%</u>
<u>No. of Visits Completed</u>	458	100%
<u>Contraceptive Method Accepted:</u>		
None	271	59%
Neosampoon	69	15%
Fcam	45	10%
PMLs	40	9%
Condoms	21	5%
<u>Combination:</u>		
Neosampoon or Foam with Condoms	6	1%
Referral for Sterilization	5	1%
Referral for IUD	1	0%

Table 1 continued

	<u>n</u>	<u>%</u>
<u>Among those who did not accept a method (n=271), the reason:</u>	<u>271</u>	<u>100%</u>
Currently Pregnant	69	25.5%
Husband Absent [*]	63	23.2%
Woman Opposed	57	21.0%
Secondary Sterility ^{**}	33	12.1%
Desire to Have a Baby	15	5.5%
Husband Opposed	13	4.8%
Already Have Tubal Ligation	10	3.7%
Other (including parent's opposition or already using another method)		
Fear of Side Effects	1	0.4%

* The home visitors are not authorized to leave contraceptives if the husband is not present, unless he leaves written permission when visitor passes the following day.

** This includes both younger women who have difficulty to conceive and women who may have reached menopause. An effort will be made in the future to distinguish between the two.

Among the 271 women in Matadi who did not accept a method, the primary reasons were: the woman was already pregnant (25.5%), the husband was absent (and thus the visitors were not authorized to give her a contraceptive method (23.2%), the woman was opposed to family planning (21.0%), or the woman was subfecund or infertile, in many cases because of menopause (12.1%); see table 1. Thus, while more than half of the women visited did not accept a method, resistance to the idea of family planning, (on the part of either husband or wife) was encountered in only 15 percent (70 out of 458) of the cases.

During the Matadi trip visits were made to three of the six dispensaries participating in the project: two of which corresponded to the experimental area, one to the control area. In all three cases the nurse trained by the project was present, and the project posters were on display. Sales were higher in the experimental than in the control area, and in one case in the former, the nurse had already run out of some products. (Resupply was discussed.)

In the future, the resupply system is to be handled by a male employee of the project. A schedule will be established whereby he visits each dispensary on a monthly basis, conducts an inventory of supplies, collects 50 percent of the income from sales, and resupplies the dispensary nurse. This system was not yet in motion, but the individual designated to do it is very responsible, and it is expected that the system will be working within a month.

As the project becomes more firmly established in Matadi, the local radio station will be used to promote family planning. (In fact, the contact at the Voix du Zaire wants to start now, but Dr. Nlandu prefers to maintain a low profile for the time being.) Plans are also being made to produce a version of the pamphlet "Etre Mama, Etre Papa" in Kikongo, as an additional educational tool in this project.

In short, despite the previous delays and problems in Matadi, the service delivery activities are now in motion. The project provides contraceptives only (since the introduction of any of the products for children under

five would have represented competition for local providers of these products or services, and thus created further opposition). Arrangements have yet to be made whereby the project can offer low cost sterilizations, but it is hoped that something can be worked out such that a local physician recently trained in Tunisia will provide this service at low cost. (It was decided not to incorporate this person as a staff member of PRODEF, as mentioned in a previous trip report.)

In addition to continuing the ongoing activity, attention will be directed to establishing a system of group meetings in the experimental area; to establishing the resupply system for dispensary nurses and home visitors; and to supervising the work of the home visitors and nurses in the field, with special reference to the management of side effects.

III. Service Delivery in the Rural Area of Songololo

The home visiting for the rural area of Songololo began in October 1981. The first round ran from October 1981 to February 1982, after which there was a refresher course for the five home visitors. The second round began in March 1982 and was nearing its finish in late July.

The target area consist of 53 villages (estimated population :25,000), 32 of which have been designated as experimental, 21 as control. There are five dispensaries in the experimental area and four in the control area which serve as resupply points for the contraceptives and drugs for children under five. In those villages which do not have a dispensary, attempts have been made to identify and train a matrone. This is a woman selected by the community to participate in the project; i.e. to receive training in the use of the contraceptives and medications, and to serve as a resupply point within the community. To date, there are 24 matrones in the experimental area, 8 is the control. In summary, there is the following coverage:

Type of area	# Villages	# with Dispensaries	# with Matrones	# with no Dispensary or matrone
Experimental	32	5	24	3
Control	21	4	8	9
Total	53	9	32	12

The project directors are aware of that there are proportionately less matrones in the control area than is the experimental. This has resulted in part from the fact that there were several women who once selected, failed to appear for the training, or once trained, moved. Efforts to correct this discrepancy will be made in August, when the matrones are scheduled to receive a refresher course, and attempts will be made to recruit matrones from those villages that do not currently have one.

In general, the project activities have been well accepted by the target population. Communities with a high percentage of Angolan refugees continue to be more resistant to the idea of family planning than those which are predominantly Zairian. In almost all communities the population has requested that the project build and equip a dispensary and/or provide a wider range of medications than are currently available. In summary, they accept what has been provided but ask that it be expanded (something which can not be done in the present project).

With regard to the family planning aspect of the project, about one-third of the women visited in Round #1 accepted a contraceptive method when it was offered free of charge. (Among those who did not, approximately half did not because they were currently pregnant or because their husbands were not at home).

As the second round of home visits neared an end, it was of particular interest to examine the data on the extent to which previous "acceptors" actually used the methods given during the first visit. Data from the service statistics for Round #2 (except for a small part still to be done) are presented in tables 2 and 3. It should be noted that a number of women who had previously accepted were not at home for this second visit, and thus are excluded from this analysis.

Among the 247 previous acceptors who were present and were visited for Round #2, 78.5 percent reported that they had tried the contraceptive method. This percentage was higher among those who had selected condoms (88.7 percent) than foam (75.9 percent) or the pill (72.5 percent).

At the time of the second visit, 51.0 percent of the previous acceptors were still using the method. Again, this percentage was higher for those who had selected condoms (61.3 percent) than for foam (49.7 percent) or the pill (40.0 percent).

Data were also collected as to whether the previous acceptors had redeemed their coupon at a dispensary or with the matrone, which would entitle them to a free resupply of pills or condoms (but not foam, on the argument that the initial supply provides 2-3 months' protection). Eighty-percent of the women still had their coupon, indicating they had not attempted to resupply themselves with contraceptives. (In the case of the foam, it is not surprising that so few women "used" their coupon, since it would serve only as a referral card but would not entitle them to a free resupply.)

A number of previous acceptors took advantage of the second home visit to redeem their coupon with the home visitor. While this was allowed (to encourage continuation), it suggests that the mechanism of resupply at the dispensary or with the matrone needs to be greatly strengthened.

Data in Table 3 indicate the primary reasons why previous acceptors were no longer using the method by Round #2.

Table 2. Followup on the Actual Use of Contraceptives Distributed in Round #1.
 (Based on Data from Round #2)

Method	1 st Round		2 nd Round							
	Women that accepted:	Previous acceptors found at home and again visited.	Tried the method		Still using the method		Still has the coupon		Has Used the Coupon	
			n	%	n	%	n	%	n	%
Foam	261	145	110	75.9	72	49.7	124	85.5	19	13.1
Condoms	104	62	55	88.7	38	61.3	45	72.6	31	50.0
Pill	85	40	29	72.5	16	40.0	29	72.5	17	42.5
Total: All Methods	450	247	194	78.5	126	51.0	198	80.2	67	27.1

1. Among the 67 acceptors who had used their coupon, 45 were resupplied by the visitor (during round #2), 11 by the matrone, and 5 at the dispensary; (6, no data available).

Table 3. Reasons Given by Previous "Acceptors"
Who Were Not Using the Method by Round #2 (n = 121)

	<u>n</u>	<u>%</u>
Became pregnant ¹	19	15.7%
Doesn't know where to get resupplied	13	10.7%
Fear of side effects	8	6.6%
Husband has been absent	7	5.8%
Resupply - too far away	6	5.0%
Wants another child	3	2.5%
Husband opposed to family planning	3	2.5%
Other	35	28.9%
No reason recorded	27	22.3%
TOTAL	<u>121</u>	<u>100.0</u>

1. It is unknown whether the woman accepted a method and then discovered she was pregnant, or whether she became pregnant while using the method.

Similar data will be collected and analysed for the third round. In addition, an attempt will be made to determine the extent to which second and third visits succeed in recruiting additional acceptors, above and beyond those who accept a method on the first visit.

IV. Inventory of Contraceptives and Drugs for Children Under Five.

As of April 1982, an inventory system for controlling the flow of commodities had yet to be set up. The data on the movement of stock were available, but had yet to be put into systematic form.

Cit. MOMBELA, a local schoolteacher who worked part-time on the coding of the baseline survey, has been given responsibility for the inventory. This includes the receipt of new shipments; distribution of products (resupply) to the home visitors, dispensary nurses, and matrones, as well as to the team in Matadi; collection of funds generated by the sale of these products; and supervision of nurses and matrones regarding the project statistics.

The inventory of products has now been established and is working smoothly. Inventory figures on the amounts received to date, amounts distributed, and amounts in stock coincided fairly well for the contraceptive commodities (see Appendix B). However, there were larger differences with regard to the products for children under 5. Discussion of these differences with the project directors revealed that there had been "loans" of these products to the Hôpital Evangélique de Nsona Mpangu. However, when these were taken into consideration, all stock was accounted for. (The Hospital and Project routinely loan each other funds, which are then repaid; thus, the "loan" should be construed as just that.)

The system is now set up to provide data on the distribution of products within the larger population, which will be used in the evaluation of the project and in the cost-effectiveness analysis.

V. Accounting System.

As mentioned in previous reports, the accounting system has not been the strong point of this project. While retrospective patching together of financial documents has led to the conclusion that the project finances are being handled with integrity, the administrator has not had a firm grasp on the global financial situation of the project at any given time.

The situation has improved somewhat. There is now a system which the administrators uses which indicates where the project stands vis-à-vis reimbursements from Tulane and other key points. While there are still weaknesses in this area, the situation is now passable.

VI. Forms for the Cost Effectiveness Analysis.

One of the question marks regarding this project was whether the PRODEF staff would be able to bear the burden of the set of 11 forms designed to provide data for (1) ongoing management of the project, (2) evaluation, and (3) cost-effectiveness analysis.

With the recent efforts directed toward the inventory system, the entire set of forms is now in use. One form has been modified considerably, and others have been adapted to meet the needs of the project at different stages (such as the second round of home visiting).

While the project staff spends considerable time in preparing these forms (more than would be justified if this were not a research project), there seem to be no major problems in doing so. (The one problem to date has been a tendency on the part of home visitors to provide incomplete information in some cases, but efforts are being made to remedy this). One important consideration here is that the project directors have delegated the responsibility for these forms to the appropriate individuals on the staff, such that the work load is shared by several people.

VII. Data from the Baseline Survey in the Urban Area

Whereas all of the data for the baseline survey in the rural area are now on the computer at Tulane, this is true of only half the data for the urban area. The remaining data were to be keypunched from the questionnaires by CEPLANUT staff in Kinshasa.

During this trip it was possible to obtain a copy of the remaining data on magnetic tape, which will now be transferred to Tulane computer for processing.

Also, since the urban questionnaires were all being stored at CEPLANUT, it was possible to go back to the original questionnaires to correct errors which were identified in the computer editing of the first half of the urban data set at Tulane.

It is expected that the results of the baseline survey in both areas will be available in tabular form within a month, and that a first draft of the findings will be done within 2-3 months.

VIII. Production of a Family Planning Film.

Efforts to identify educational films on family planning, produced in Francophone sub-Saharan Africa, indicate that very little is available. Since films are a very popular medium in Bas-Zaïre, there is interest in producing such a film as part of the PRODEF project. While this film would include the larger issues of maternal and child health, the main objectives would be to reinforce the desirability of childspacing, which is already a well-established tradition; to indicate the availability of modern methods for doing so; to legitimize the use of these methods by showing that others are already using them; and to provide information to counter rumors regarding family planning. Ideally, the film would be scripted and produced such that it could be used in other projects as well (possibly with additional sound tracks for different languages, if needed).

Discussions with Père Henri Boïsschot, Director of RATELESCO (Radio-Télévision Educative et Scolaire),

indicate that RATELESCO would be interested in participating in the production of this film. The Tulane/PRODEF staff would be responsible for:

- Drafting the script of the film
- Providing the film stock to be used in shooting
- Providing transportation for a team of four RATELESCO technicians and their equipment
- Providing room and board or per diem expenses during the shooting.
- Providing a narrator for the Kikongo version of the film.

RATELESCO would be responsible for:

- Shooting the scenes outlined in the script.
- Recording sound in the field (during the shooting)
- Developing the footage in RATELESCO facilities in Kinshasa.
- Editing the film (in consultation with the Tulane/PRODEF staff).
- Making a sound track for the film (including two versions, one in French, one in Kikongo).

The optical print, to be made at the end of this process, will be done in the United States. Additional copies of the film will also be made there. This part of the process will be coordinated by Tulane.

The estimated cost of this film is \$10,000 (U.S.), which is far lower than the price of most 20-25 minute films. It will be covered with funds from the contract which Tulane has with USAID/Washington for this project.

In preparation for the shooting of this film, the RATELESCO technician who would serve as director, Cit. Lileka Manyili Baruti, visited Nsena Mpangu to see the site firsthand and discussed certain technical and logistic aspects of the shooting with the Tulane/PRODEF team.

(He grew up in Matadi, understands Kikongo, and has a familiarity with the area which should contribute to the success of this endeavor.) Thus, a working relationship has been established between PRODEF and RATELESCO.

A first draft of the script, prepared by the project directors and Jane Bertrand, is now available. It will be circulated to key individuals and organizations in Kinshasa (including RATELESCO, USAID, C.N.N.D.) for comments.

Modifications will be made in light of comments received, especially on possible technical problems in shooting certain scenes. Assuming these modifications can be made in time, the shooting of the film is tentatively scheduled for September 1982.

APPENDIX A.

LIST OF PERSONS CONTACTED.

USAID

Mr. Richard L. Podol, Mission Director
Mr. Walter Boehm, Acting Deputy Director
Mr. Richard Thornton, Population Officer
Mr. Edward Hirabayashi, Human Resources Dev. Officer
Ms. Claudia Cantell, Secretary/Admin. Assist., PHO
Cit. UTSHUDI LUMBU, Admin. Assist., PHO
Dr. Frank Baer, Basic Rural Health Project Manager.

RATELESCO

Père Henri Boisschot, Director
Cit. Lileka Manyila Baruti, Video Technician

CEPLANUT

Dr. Kabamba Nkamany, Director
Cit. Kinjanja, Head of Studies Section
Dr. Lusamba Dikassa, Consultant
Dr. Banea, Head of Communications Section

EGLISE DU CHRIST AU ZAIRE

Rev. Ralph and Mrs. Florence Galloway,
Family Planning Advisors.

APPENDIX B

Inventory Report: July 18, 1982.

(1)	(2)	(3)	(4)	(5)	(6)
Product	Stock Provided to	Stock Distributed	Expected Amount in Stock: Col. (2) - Col. (3)	Actual Amount in Stock	Difference: Col. (5) - Col. (4)
<u>Contraceptives</u>					
Pills (cycle)	127,200	6,360	120,840	119,190	- 1,650 cycles
Foam (can)	14,597	1,749	12,848	12,739	- 109 cans
Neo Shampoo (container)	16,760	1,640	15,120	14,280	- 840 containers
Condoms (piece)	450,000	16,536	433,464	433,300	- 164 Pieces
IUDs	2,700	-	-	-	-
<u>Drugs</u>					
Aspirin (tab.)	55,000	38,730	16,270	5,500	- 10,770 Tab.
Oralyte (pac)	30,000	4,823	25,177	23,526	✓ 1,651 Pac.
Chloroquine (Tab.)	99,000	32,910	66,090	48,000	- 19,090 Tab.
Mebendazole (Tab.)	55,000	16,697	38,303	25,100	- 13,203 Tab.

APPENDIX B

THE RURAL PRODEF PROGRAM

a. The Service Delivery Model. Service delivery consists of the following. The team of five home visitors and one supervisor send advance notice to the village chief as to the date they plan to arrive and the general nature of the visit. Upon their arrival they meet with the chief and discuss the purpose of their visit in much greater detail. Since Dr. Nlandu is well known in the area, the chiefs are generally favorable to the arrival of the team. The chief in turn calls a meeting of the community, in which he explains that the PRODEF team will be visiting all the women in the village; in some cases, he asks them to make a special point of staying home for the visit. This meeting is a key element in legitimizing PRODEF activities.

The team of home visitors arrives in the village with a general idea of its layout, based on maps made during the baseline survey. The village is subdivided into sections, and each home visitor is assigned a section.

The home visitor begins the visit by identifying herself and asking after the health of the children in the family. (If there are no children under 5 and no women 15 to 49 years old, she explains that the program is designed for these groups, and she terminates the visit).

If there is a woman with children under five, she inquires whether any of these children have the three specific health problems covered by the project: diarrhea, malaria, and intestinal worms. If a child has diarrhea, she explains the importance of oral rehydration and the availability of Oralyte (which is sold for 2 zaires or \$0.36 per packet). If the mother is interested (and the majority are), she shows the mother how the solution is prepared by doing so with her; afterwards, she asks the woman to repeat the instructions, to ascertain that she has understood them and could correctly prepare the solution at a later time. If no child has diarrhea, she explains the purpose and availability of Oralyte, and indicates where the woman could obtain this in the future (at the dispensary or from the matrone as described below). Also, to assist the mothers in the use of Oralyte in the future, the visitor marks one pot in the household (if available) with a "one liter mark," to show how much water should be used for one package of Oralyte. The mothers have generally been receptive to this.

If any child under five has a fever suspected to be malaria, the visitor is authorized to provide chloroquine tablets (at a cost of less than 2 zaires or \$0.36 for the treatment) according to preestablished dosages. Chloroquine is currently in short supply in Zaire, and this is an attractive part of this program to the community. If no child under five has malaria, the mother is referred to the local dispensary or matrone in case of future need. (Anti-malaria drugs are already widely known in the area and little explanation is necessary).

Since almost all children under 5 are likely to have intestinal worms if they have not been recently treated, the visitors encourage the mothers to purchase Mebendazole tablets for each child under five (unless he/she has been recently treated), at the price of 1 zaire (\$0.18) per tablet. The medication is then administered in the presence of the home visitor.

Although Dr. Nlandu originally planned to give a treatment of six tablets, the final decision taken in collaboration with the Hopkins consultants has been for two tablets (intended to reduce the worm load, rather than necessarily eliminating it entirely, with the justification that reinfestation is certain in the majority of cases). If no child under five has worms and/or the mother chooses not to buy the medication, the visitor explains that it is available at the dispensary and with the matrone in case of future need.

To create a climate of acceptance for the project, the visitors have been authorized to sell these medicines to other family members if they are present and suffering from either malaria or intestinal worms. However, they are not allowed to sell the products where there is no sign of the illness.

After the first part of the visit directed to children under five, the home visitor then moves on to the topic of family planning. She explains the different methods, including oral pills, foam ^{and} condoms (available from her); the IUD and female sterilization (available from the project, but on referral); and Depoprovera (which is not provided with USAID funds, but which Dr. Nlandu hopes to obtain via the local IPPF affiliate). If the husband is available at the time of the visit, he is encouraged to be present for this part of the talk.

If the couple is interested in a method, the home visitor can provide them with either 1 cycle of pills (after ascertaining that there are no contraindications), 12 condoms ^{or} one can of foam. Also, she gives the woman a coupon which entitles her to two more cycles of pills, ~~or~~ a dozen condoms, upon presentation of the coupon to the local dispensary or matrone, which will serve as the resupply points for this project. Women interested in the IUD or sterilization receive a referral coupon and are noted in the project records.

At the onset of the program, pregnant women were not given contraceptives or a referral coupon. However, this has recently been modified such that the pregnant woman is given a referral coupon which will entitle her to a free sample of a contraceptive once she has delivered.

Because the PRCDEF staff prefers to move cautiously at first, they have decided to provide the methods only when both husband and wife are in agreement. Apparently it would be culturally unacceptable to leave contraceptives with a woman whose husband is currently absent. Likewise, the visitors have been instructed to refuse condoms to those men who ask for them if the woman is known to be against the idea, on the assumption that he plans to use them elsewhere.

While these "restrictions" no doubt limit the potential impact of the program, they may be useful in increasing its acceptability, especially in the initial stages of the project. It is expected that there will be some liberalization of these rules as the project evolves and gains acceptance.

b. Recruitment of Matrones. In the original design of the project, the nine dispensaries in the region were to serve as resupply points for contraceptives and medications for approximately 50 villages. However, it was recognized that this would limit the impact of the program in the more remote areas where women would have to travel several kilometers to obtain the service from the dispensary.

Thus, it has been decided that in all villages where there is no dispensary, one woman is to be selected by the community as a matrone. This is generally an older woman, who has had children of her own and who is well respected and trusted by her peers. Selection generally takes place during the initial group meeting of the community (or even beforehand, if the village chief is informed that such a person is to be recruited). Apparently, in most villages the selection of the matrone is an "obvious choice," since the PRODEF staff report that this is done relatively quickly and with strong group consensus.

The matrone receives some "field training" from the PRODEF staff, in part by accompanying them on their round of home visits in the village and in part by special sessions with the supervisor. The PRODEF staff does not leave medication or contraceptives with the matrone until they are satisfied that she thoroughly understands and can correctly explain the use of them (including contraindications of the pill).

The matrone is supplied with a stock of products which she will sell to the community (at the same nominal prices as described above). She is not intended to replace the dispensary, which offers a much wider range of products and services, but rather to provide certain key medications for children under five and to make contraceptive methods more readily available.

APPENDIX C

RESULTS FROM PRODEF BASELINE SURVEYS

Table 4. Current Contraceptive Use among Women 15-49 (regardless of marital status)

	<u>Urban</u> (n=1789)	<u>Rural</u> (n=1747)
<u>Uses no method</u>	<u>47.3</u>	<u>38.5</u>
<u>Uses traditional method(s)</u>	<u>47.7</u>	<u>57.5</u>
Withdrawal	23.9	14.8
Abstinence, separate beds	13.5	22.2
Rhythm	7.8	10.4
Other	0.7	4.4
Two or more traditional methods	1.7	5.8
<u>Uses a modern method</u>	<u>5.0</u>	<u>3.5</u>
Pill	2.7	0.6
Female sterilization	1.1	2.1
Condom	0.6	0.3
Injection	0.6	0.2
IUD	0.0	0.3
Vaginal methods	0.0	0.0
<u>No response</u>	<u>0.0</u>	<u>0.4</u>