

June 10, 1982

MEMORANDUM

TO : See Distribution

FROM : ST/POP/R, Elizabeth S. Maguire

SUBJECT: Zaire Family Planning Operations Research Project Update

Attached is the 18-month progress report (November 1980 - March 1982) of the Zaire OR project, under Contract AID/DSPE-C-0089 with Tulane University. The report includes a review of: research activities in the rural (zone of Songololo) and urban (city of Matadi) target areas; service activities to date in the rural areas; various administrative and logistics problems encountered; and activities to be carried out over the next six months. Of particular interest is the summary of findings to date, outlined on pp. 8-9. There appears to be widespread approval of family planning, especially for spacing purposes and broad acceptance of the household FP/MCH distribution program in the rural areas. Data from the baseline surveys in the target areas show, as expected, low current use of modern methods of contraception (5 percent - Matadi; 4 percent - Songololo). However, a surprisingly high proportion of the women aged 15-49 interviewed (48 percent-Matadi; 58 percent-Songololo) were reportedly using traditional methods of family planning.

ZAIRE FAMILY PLANNING OPERATIONS RESEARCH PROJECT

18-MONTH PROGRESS REPORT

(November 1980 - March 1982)

Contract AID/DSPE-C-0089

Submitted by:

Jane T. Bertrand

Principal Investigator

Tulane University SPHTM

New Orleans, LA 70112

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ZAIRE FAMILY PLANNING OPERATIONS RESEARCH PROJECT
18-MONTH PROGRESS REPORT

The family planning (FP) operations research project being conducted in Bas Zaire, Republic of Zaire, has now been in progress for 18 months. The current report focuses only on those activities which have been carried out since the 12 month report, which are classified herein by type of activity (research vs. service) and location (urban vs. rural). Also included in this report are a list of problems encountered in the past six months, a description of activities foreseen for the next six months, and a summary of the major findings which have emerged from the project to date.

A list of the reports on the project from October 1981 - March 1982 is attached (Appendix A), as well as a description of project-related travel during this period (Appendix B). Since the general design of the project was described in the 12-month progress report and elsewhere, it is not repeated in this report.

I. Research Activities

A. Rural Area: Zone of Songolodo

1. Data from the baseline survey. Data from this survey (n = 1747) have been transferred to the Tulane computer and computer-edited to detect errors; corrections are now being made at Tulane; and in-depth analysis will begin shortly.
2. Service statistics regarding household distribution. With the initiation of the service program in the rural area in October 1981, data have been routinely collected on the number of women who have accepted contraceptives, the type of methods accepted, and (where applicable) the reasons for refusal. In addition, these service statistics indicate the extent to which the problems of malaria, diarrhea and intestinal worms were found among children of preschool age and the quantities of chloroquine, Oralyte, and Mebendazole (respectively) purchased to treat these problems. Findings for the period October 1981 to March 1982 (months 13-18 of the project) are summarized in Table 2, as part of the description of service activities.

B. Urban Area: City of Matadi

1. Completion of data collection for baseline survey.
Interviewing in Matadi was completed in March 1982, with a total of 1789 completed cases. Coding and keypunching have been done on approximately half of these cases; the other half should be completed by June 1982, at which time the data will be transferred to Tulane for editing and processing.

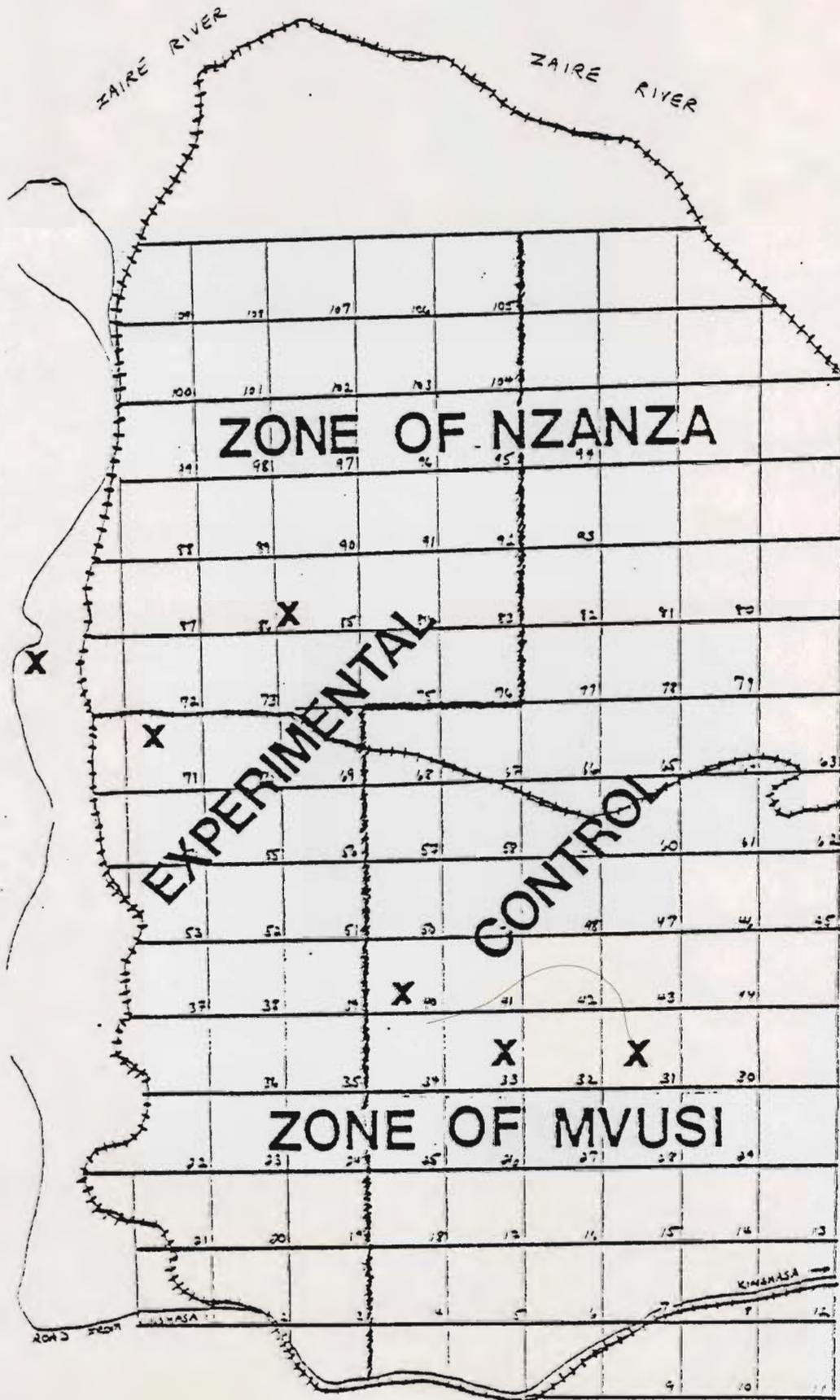
2. Designation of experimental and control areas. The area of Matadi to be covered by this program is administratively divided into two zones: Mvuzi and Nzanza. However, it would be politically inadvisable to choose one as the experimental group, while "neglecting" the other. Thus, the split into experimental vs. control has been made such that both zones will get some of the home visiting. It is also done such that the six dispensaries identified to date will be divided between the two areas. (While this has been achieved, the geographical placement of the dispensaries is not ideal; efforts will be made to identify and incorporate others in order to remedy this problem).

The final designation of the experimental and control areas is illustrated in Figure 1. The area to the left of the thick vertical line is to be the experimental zone, while the area to the right of it is the control. The line of demarcation is not straight but rather it turns a corner; this was done so as to obtain a more even split of what is the high-density area of the city. The six dispensaries identified to date are marked with an "X".

(Note: The problem of "contamination" between experimental and control area is not expected to be significantly greater with this split than it would have been by taking the two zones of Mvuzi and Nzanza and assigning one to each treatment, given that there is considerable movement between these zones.)

3. Total population count of three "divisions" of Matadi. For sampling purposes, the city of Matadi was divided into 109 "divisions" (as shown in Figure 1), of which 60 were sampled in the baseline survey. These were stratified as high, medium and low density areas. At the close of the survey in Matadi, one division of each type (the one with the median number of houses) was selected and a complete population count conducted. These data will be used in calculating sampling error. In addition, they will provide a basis for making a very crude estimate of the population in the target area to be served by this project.

FIG. 1 CITY OF MATADI



4. Hand-tabulation of Matadi data on education and contraceptive use. To determine that the areas of Matadi tentatively classified as "experimental" and "control" are indeed comparable on two variables expected to influence the success of the program -- education of the woman and current use of contraceptives -- data on these two variables have been hand tabulated. Results of this tabulation, presented in Table 1, indicate that the two areas are very closely matched.

Table 1. Comparability of the Experimental and Control Zones in the City of Matadi on Education and Current Contraceptive Use

<u>Education</u>	<u>Experimental (n=957)</u> %	<u>Control (n=832)</u> %
None	20.6	23.9
1-3 years primary	15.4	11.9
4-6 years primary	21.5	20.6
Home Ec. School	3.7	0.7
1-3 years secondary	26.2	32.0
4-6 years secondary	10.1	9.6
Vocational school	2.3	1.2
Higher than secondary school	0.0	0.1
Don't know	0.2	0.0
	<u>100.0</u>	<u>100.0</u>
 <u>Current Contraceptive Use</u>		
Uses no method	45.1	49.8
Uses traditional method(s)	49.4	45.8
Uses modern method	5.5	4.4
	<u>100.0</u>	<u>100.0</u>

II. Service Activities

A. Rural Area: Zone of Zongololo

1. Stocking of dispensaries in the experimental and control areas. The four medications for children under five (Chloroquine, Aspirin, Mebendazole, and Oralyte) and three types of contraceptives (pills, condoms, and foam) were stocked in all nine dispensaries before the program of home visiting began.
2. Initiation of home visiting. From October 20, 1981, to February 6, 1982, group meetings and home visiting were carried out in some 35 villages which constitute the experimental zone of the rural area. The general approach used has been to contact the village chief in advance, have him arrange for a group meeting of the community, use this meeting to explain the purpose of the project and the home visits; present the topics to be covered in general terms; and allow for questions and answers. At that point (45-60 minutes later) the meeting breaks up, and the home visiting begins. The average visit runs about one-half an hour, the majority of which is used to explain the use of Oralyte and the contraceptive methods.

In February 1982, the home visitors underwent 5 days of retraining, after which the second round of home visiting began. As of this 18-month report, Round Two is still in progress. The results of the home visiting to date are summarized in Table 2. Approximately 32 percent of the women 15 to 49 did not accept the free contraceptives, although in most cases this should not be interpreted as a rejection of family planning. Rather, there are other reasons for this as listed in Table 3, the first of which is that the home visitors are not authorized to give contraceptives to a woman whose husband is absent at the time of the visit.

3. Selection of "matrones" or respected village women. While there are over 50 villages in the project area, only nine have dispensaries. In the remaining, the community is to select a woman who will serve as a resupply point for the four project medications and three contraceptive products. Since the project is designed to make the drugs and contraceptives equally available in both experimental and control areas (but to provide education group meetings and home visits only in the former), the system of selecting

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Table 2. Summary of the Data from Service Statistics on Home Visiting, October 1981 to March 1982

	<u>n</u>	<u>%</u>
A. <u>HOME VISITS</u>		
Total number attempted by the team (includes no one is home, there are no eligible women, the house is uninhabited, etc.)	4298	-
Total number of completed visits (where the visitor discussed MCH and/or FP)	1950	-
B. <u>CONTRACEPTIVES</u>		
Number of eligible women, 15 to 49, visited	1994	-
Number already using a modern contraceptive method	188	4.4
Method accepted during visit:		
None	1355	67.9
Pill	90	4.5
Foam	281	14.1
Condom	114	5.7
Clients referred for:		
IUD	22	1.1
Female sterilization	26	1.3
Depoprovera	6	0.3
C. <u>MCH COMPONENT</u>		
Number of children under five in the homes visited	3009	-
1. <u>Diarrhea</u>		
Number of children with diarrhea	257	8.5*
Number of packages of Oralyte sold	299	-

Table 2. (cont'd)

	<u>n</u>	<u>%</u>
2. <u>Malaria</u>		
Number of children suspected of having malaria	529	17.5*
Number of Chloroquine sold	1743.25	-
Number of Aspirin sold	2444.5	-
3. <u>Intestinal Worms</u>		
Number of children suspected of having worms	1123	37.3*
Number of Mebendazole sold	2507	-

*Percentage based on total number of children under five

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Table 3. Reasons Given for Refusing the Free Contraceptives During Round #1 of the Home Visiting¹

<u>Reason</u>	<u>Percent</u> (n=1130)
- Husband was absent at time of visit ²	25.8
- Woman is currently pregnant	21.9
- Woman desires another child	9.6
- Woman is opposed to family planning	8.7
- Woman has reached menopause	3.3
- Husband is opposed to family planning	2.3
- Other (including subfecundity, no exposure to intercourse, preference for traditional methods, etc.)	28.4
	<hr/> 100.0

¹Data on the reason for refusal were not systematically collected until one month into the service project; thus, the number of cases reported herein (n=1130) is less than the total number of women who refused.

²This was not necessarily a refusal on the part of the woman, but rather a restriction established by the project directors.

a matrone has been used throughout the project area. As of March 1982 a few villages still did not have a matrone (or the woman they selected had yet to receive her training and products), but the system was functioning in the great majority of project villages. In fact, it is one of the aspects of the program which has been especially well accepted at the community level.

4. Provision of female sterilization and the insertion of IUDs. These two services were made available in February 1982 at the Nsona Mpangu Hospital to those women who had expressed interest in these methods during the home visiting. It had been planned that the project would provide transportation to and from the hospital, but this proved difficult because of a fuel crisis which greatly restricted project mobility at the time. Also, the rate charged for the operation (50 zaires, approximately \$9.00 U.S., a rate which is low compared to what a private doctor would charge, but nonetheless very high to certain villagers) may have served as a deterrent. Thus, the turnout for this service provision was lower than expected.

However, these sessions are to be repeated, if possible on a monthly basis, in the future. Efforts will be made to enhance the use of these services by providing transportation and lowering the cost of sterilization.

III. Problems Encountered: October 1981 to March 1982

A. Research - occasional delays, but no major problems

B. Service

1. Efforts to obstruct project implementation in Matadi.

In late 1981 project staff ran up against resistance on the part of certain physicians in Matadi, who undoubtedly viewed the introduction of low cost contraceptives in Matadi as a threat to their economic interests. At one point it appeared that their efforts to lobby against the project (especially since it was to be directed by Dr. Nlandu, who is officially assigned to work in the rural area outside Matadi, not in Matadi itself) might obstruct the implementation of the project. However, by March 1982 the situation had improved considerably, and the local medical authorities have made it clear that they support the project.

2. Problems regarding low-cost sterilization in Matadi. Although

two physicians from Matadi have recently attended the JHPIEGO course in Tunisia, it is uncertain that they will be willing to participate in the project unless they can charge either the patients or the project considerable sums for their services (equal to current rates for private patients). Rather than enter too hastily into an agreement with these individuals, the project staff has decided to launch the service program in Matadi with the temporary methods only (the pill, IUD, condoms, foam, and Neosampoon; and Depo-provera if it becomes available through the local IPPF affiliate). It is hoped that a solution to this situation can be found within 4-6 months.

3. Non-availability of Depoprovera. Project staff continue to

believe that this method would be very popular, if made available to the target population. However, to date the IPPF affiliate has not been able to provide Depo to the project, and although a stock has just been received in Kinshasa, it is unclear whether the project will be able to obtain an adequate and continuous supply.

C. Administration

1. Lax bookkeeping. Periodic auditing of the books by Tulane University shows that the project directors have managed the project funds with great integrity; the numbers add up if one carefully reviews all aspects of the project finances.

The problem is that the administrator of the project, who has perhaps the lightest workload of any of the better-paid staff members, has yet to demonstrate his ability to maintain the necessary records of project finances. Dr. Nlandu can not easily fire him, since he is a well-established member of the small community of Nsona Mpangu; thus, efforts continue to encourage him to improve his performance.

Given the potential problems which could occur with respect to finances, this one pales into insignificance. However, this individual's indifference stands out markedly in comparison to the dedication of all other staff members.

IV. Anticipated Activities for the Next Six Months

A. Research

1. Rural baseline survey: begin indepth analysis
2. Rural service statistics: review and analyze for trends over time.
3. Urban baseline survey: finalize coding, keypunching of data; transfer to Tulane; computer-edit the data; correct errors; and begin analysis.
4. Urban service statistics: implement routine data collection.
5. At Tulane: continue work on the cost effectiveness analysis (data collection).

B. Service

1. Rural area: finalize second round of home visiting; re-supply dispensaries and matrones.
2. Urban area: train 10 home visitors in Matadi; finalize arrangements for six (or more if possible) dispensaries to serve as resupply points; train nurses in the dispensaries and provide them with supplies; continue to explore means of providing low-cost sterilization in Matadi.
3. Both areas: begin production on a 20-25 minute, 16 mm film on family planning, which will be produced both in French and Kikongo, for use as an educational tool in the project.

V. Summary of Findings to Date

The following conclusions are based on data from the baseline survey, routinely collected service statistics, reports of project staff, and/or direct observation.

1. The value of family planning -- especially spacing -- is widely recognized, even in the rural areas studied. The vast majority of respondents in the survey claimed to approve of "methods of delaying or preventing pregnancy." However, this interest in fertility control is generally motivated by desire for spacing, not family limitation (at least at lower levels of parity).
2. In the urban area the most widely used method of fertility control is withdrawal (used by 24 percent of women 15 to 49, all marital status categories), and in the rural area withdrawal is also a highly popular method. This suggests erosion of the tradition taboo on post-partum abstinence from sexual relations, which is reported to have been "universally practiced in traditional African society" (J. Page and R. Lesthaeghe, Child-Spacing in Tropical Africa: Traditions and Change. London: Academic Press, 1981.) The widespread use of withdrawal suggests a potential demand for more convenient means of fertility control, if these were to become available to the population at low cost.
3. Household distribution of contraceptives is a highly acceptable activity, even in rural communities, when this is carried out according to standard cultural practices, such as working through the village chief and when the service is delivered by trusted individuals (such as women native to the area, directed by a doctor who is a well-respected figure in the region).
4. The acceptability of the program is heightened by the fact that the FP intervention is coupled with MCH services. Home visitor report that it is fairly easy to discuss contraception with local couples, once rapport has been established by first discussing the welfare of the young children in the family.

5. Much of the interest in family planning at this time is for spacing rather than family limitation. This is especially true for women who are currently nursing a baby. This would explain why contraceptive foam has been the most popular method in the household distribution of contraceptives (reinforced by the fact that home visitors probably discourage lactating women from using the pill).
6. The communities have been highly receptive to the idea of a matrone or respected women in the village serving as a resupply point for the drugs for children under five and the contraceptives. Inaccessibility of health services is a common complaint in the rural area, and this system serves the interests of these communities (although there is still widespread demand for a complete dispensary in the village). Whereas many of our informants prior to the start of this project suggested that community-based distribution would not be acceptable, quite the opposite has been found.
7. Acceptance of the concept of family planning and of the free distribution of contraceptives has been lower in those communities with a high percentage of Angolan refugees as compared to those communities which have primarily Zairian inhabitants. While there has been no open resistance to the program, nonetheless pronatalist attitudes are especially prevalent in these Angolan communities.
8. The current use of modern contraceptives is low in both urban and rural areas: 5 percent for women 15 to 49 in the city of Matadi; 4 percent in the rural zone of Songololo, as shown in Table 4. (Note: these statistics apply to all women 15-49; they will be calculated for those married or living in consensual union at a later date.) However, a surprisingly high percentage of women claim to be using a traditional means of fertility control, including withdrawal, abstinence, and rhythm (48 percent, urban; 58 percent, rural). This percentage of traditional use is far higher than is found in most developing countries outside SubSaharan Africa, and it reflects the deep-seated recognition for the importance of spacing among this population. Whether this interest will translate into the adoption of modern methods when they become readily available at low cost continues to be one of the major research questions to be answered by the Zaire project.

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>

APPENDIX A

Reports on Bas Zaire Project: October 1981-March 1982

<u>Date</u>	<u>Author</u>	<u>Title</u>
12/2/81	Jane T. Bertrand	Field Activities in Bas Zaire One Year into the Project. Trip Report: Zaire, Nov. 11-30, 1981.
4/26/82	Jane T. Bertrand	PRODEF: The Bas Zaire Family Planning Project: April 1982. Trip Report, April 8-23, 1982.

APPENDIX B

Travel related to the Bas Zaire Project: October 1981-March 1982

<u>Date</u>	<u>Person</u>	<u>Destination</u>	<u>Purpose</u>
Nov. 11-30, 1981	Jane T. Bertrand	Zaire	To consult with project staff on ongoing service and research activities.
Feb. 21-24, 1982	Jane T. Bertrand	Baltimore, MD. and Washington	To consult with Johns Hopkins regarding the cost-effectiveness analysis, and to discuss project activities and problems with AID/Washington
April 7-23, 1982	Jane T. Bertrand	Zaire	To consult with project staff on ongoing service and research activities.