TRADITIONAL METHODS OF BIRTH CONTROL IN ZAIRE

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from reports by Citoyen Lahema Lata Dihongu, Reverend Ralph K. Galloway, and Florence Galloway of L'Eglise du Christ au Zaire

INTRODUCTION

When those most familiar with the development process in Asia and Latin America take a world view of the population problem, they are likely to say that the initial battles of family planning—client acceptance, establishment of clinics and outreach services, and government support—are over. In these regions of the world the major challenges now seem to be contraceptive distribution, motivation of non-users, and refinement of contraceptive techniques. But Africa, the poorest and most rapidly growing continent, is still a family planning frontier. Despite decades of effort by concerned and energetic Africans, and despite the intensive aid of dozens of international agencies, the pace of development in many countries has been slow. Certainly, the magnitude of the obstacles to expanding family planning use in Africa is greater than elsewhere. The geographical vastness and harshness, the colonial heritage, nationalistic conflict, and cultural and linguistic diversity, all conspire against the best development efforts. Few countries epitomize the tremendous efforts expended and problems encountered as well as Zaire, the heart of central Africa.

The outside world did not reach the interior of Zaire until a little over a hundred years ago. The central lowlands are hot and humid, clogged with dense rain forests, traversed by the intricate Zaire River system extending over 8,000 miles. Zaire has rich mineral resources in the southern highlands, providing more than 50% of the
world's cobalt, and large quantities of industrial diamonds, copper, tin, uranium and other minerals. Approximately 27 million people live in an area of almost a million square miles. There are at least 200 different Bantu tribes. The crude birthrate is estimated at 45 per 1,000 population and the growth rate at 2.7% per year. At that rate, the population will double in size in about 25 years. Life expectancy is 44 years; the infant mortality rate is 160 deaths per 1,000 live births. Per capita income is U.S. $140. These statistics are representative of many African nations.

The Pathfinder Fund has aided several family planning projects in Zaire in the past decade. The goal of the project reported here was to organize a network of family planning clinics in three regions of the country—East and West Kasai, and Shaba—under the auspices of L'Eglise du Christ au Zaire (ECZ). ECZ is the organization which coordinates all Protestant missionary activities throughout the country. The project design was written in 1975. The establishment of this family planning service was to proceed in three stages:

1) A survey team would visit the three regions to investigate traditional methods of birth control among the tribes in the area. This information would be used to train family planning motivators in the local communities. The survey team would also examine the level of existing family planning activity in each region to determine what services were needed and where.

2) After the survey was completed, indigenous family planning motivators would be selected in each community and trained in traditional and modern methods of family planning.

3) Region-wide networks of ECZ clinics and dispensaries would be formed, staffed and supplied to deliver family planning services at low cost in the rural areas.

This paper reports on the first stage of this project. The survey team's reports contain a wealth of anecdotal material, not only on traditional methods and attitudes toward child spacing, but also on the hardships facing most Zairois because of an inadequate transportation system, insufficient medical supplies, and environmental hazards. This paper was written from the reports by the ECZ survey team—Citoyen Lahema Lata Dibongu, Reverend Ralph K. Galloway and Florence Galloway—filed between May 1976 and January 1977.

The survey team reached three important conclusions that have relevance to family planning in many developing countries:

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1) In the traditional societies of Kasai and Shaba there was widespread recognition of the importance of child spacing. Today's family planners must understand and respect these traditions, and use them to promote acceptance and continual use of modern contraception.

2) Traditional societies in developing countries are cultures in transition, and sometimes cultures in turmoil. Modern family planning can upset indigenous sexual practices to the point of contributing to the problem. But if modern family planning is sensitively introduced, it can offer a solution to some of the dilemmas caused by broken traditions.

3) The need for sensitive introduction and promotion of family planning, combined with the technical problems in Zaire of inadequate manpower, transportation, and supplies, point toward greatly increasing the use of paramedical personnel and nonclinical distribution of contraceptives for family planning delivery in this country.
METHODOLOGY

The survey team's goal in the first stage of the project was to investigate traditional methods of birth control in the Kasai and Shaba regions. In the process, the team could identify those community members best suited and most interested in serving as motivators for a family planning delivery system. The findings of the team's research would help prepare the motivators to conduct an educational campaign on family planning in the rural areas. Understanding traditional birth control practices would guide the motivators in discussing child spacing with couples and in explaining the advantages of modern family planning.

The survey team visited the West Kasai region in May/June 1976, East Kasai/South in October 1976, Shaba in November 1976, and East Kasai/North in January 1977. Seminars to discuss child spacing were conducted at churches and parish meeting halls. The team would first meet with community leaders and church elders to discuss the current use of and attitudes toward family planning, and to plan for the establishment of new services. Then meetings with all interested villagers or parishioners were held to discuss traditional methods of child spacing. Sexuality and birth control are extremely sensitive topics among the peoples in these regions, but the survey team approached the topic with openness and respect. A remarkable dialogue ensued, with modern as well as traditional birth control freely discussed. Participants in these meetings were universally stimulated and excited by the interchange.

Missions of several denominations were visited—Presbyterian, Methodist, Evangelical and Mennonite. The fact that this was a church-oriented study must be acknowledged. But though only 30% of the Zaire population is Christian, the missions have a very well organized administrative network in the country. They have their own air services and, consequently, their own supply systems. They also have their own health care system of hospitals and dispensaries. Thus, coordinating family planning with the ECZ means working within an already established administrative network.

TRADITIONAL METHODS OF BIRTH CONTROL

A wide range of contraceptive practices was revealed in the interviews with community leaders and villagers. The tradition of spacing births was impressive in its historical antecedence. Long before the influx of Western ideas, the understanding of the importance of child spacing to maternal and infant health was widespread in these cultures. Despite the unavailability of "modern" contraceptive methods, an array of techniques was developed to enforce taboos on fertility behavior. Of course, there is no way to document demographically the effectiveness or even the prevalence of such contraceptive practice in the past. But the fact that these procedures had their roots in deep-set tribal traditions has indicated to many that they were not only widespread, but perhaps more effective than the current mish-mash of broken traditions and poorly understood innovations. The message from these surveys is that those introducing modern family planning methods must not ignore the inherent traditions of child spacing that already exist, and must determine how to capitalize on that tradition to enhance both the acceptance and the continual use of modern contraception.

The people interviewed mentioned a variety of child spacing methods traditional in their heritage, falling into seven general categories: virginity, total abstinence, polygamy, withdrawal, medicinal plants, contraceptive rites and abortion. The first three are essentially cultural inhibitions regarding intercourse. They were consistently reported by almost all tribes in the three regions visited, and apparently have had the greatest impact on fertility behavior. The other four methods represent indigenous attempts at allowing intercourse without pregnancy, for which there is no basis for an accurate estimation of effectiveness.
Virginity. One means of preventing births in traditional societies was an adherence to strong taboos on premarital intercourse. Part of the wedding celebration itself was a determination of the bride's virginity. If she was found to be a virgin on her wedding day, the husband would give a goat to the bride's mother to honor "the woman who had preserved her daughter's virtue". Discovery that the woman had had premarital sex was often followed by a search for the man involved and forced marriage between them.

Total Abstinence. The traditional law forbidding a man to have sexual relations with a woman after she had just given birth was pervasive in the regions of Zaire visited. A nursing mother was not to be approached, and there were strong social pressures exerted to enforce this taboo. The couple (and particularly the woman) who had another pregnancy too soon were ridiculed and shamed. Special songs of contempt were sung at the woman, with descriptive gestures and laughter. A woman who followed the rule of abstinence, however, would be honored by a feast of chicken.
In Shaba:

Abstinence

In Shaba, a woman would not have another pregnancy after childbirth for 3 or 4 years. Famine and the threat of war in the old days made them more cautious about having babies too closely together. Since there were no calendars, they looked for certain signs of development which indicated the child was ready to be weaned — when the child could walk, say a few words, and could obey a simple command.

Whenever a man approached a nursing mother for sex, she knew how to defend herself. A husband who forced his wife would be called before the village chief and publicly punished.

Sometimes couples pretended to keep the rule of abstinence, but cheated. The husband would take his weapons and go into the bush, as if to hunt. A little later his wife would follow him into the bush to keep their sexual relations secret.

Contraceptives

A belt with medicine inside would be worn around the new mother’s waist to prevent pregnancy (supposedly still practiced in Lodja, East Kasai). At Kolwezi, a spiderweb, mixed with certain roots, was placed at the cervix every month before menstruation. The man who described this method said their ancestors knew there was a fertile period in the menstrual cycle.

Abortion

Leaves of the Lutela plant could be boiled, and the juice drunk to induce abortion. Also the roots of the Dilege plant could be crushed, mixed with water and drunk. Other plants used were Mweyeye, Lumona, Kolongolongo. (If the dose of the latter was too large, the woman died.)

Abortion may be sought when one becomes pregnant while nursing, or when the “cost of living is too high” and one cannot afford another child. “Abortion is a plague in the big centers in Shaba, especially for girls in secondary school”. Most girls seeking abortions are 14-20 years old and in their 3rd or 4th month of pregnancy.

Abstinence was physically enforced by strict separation of man and wife. At a minimum, they were to sleep in separate beds, preferably in separate rooms. (If there was only one bed, the man would sleep in it and the woman would sleep on a mat with her child). Sometimes the woman’s mother would move in for two or three years and act as a “sentinel”. Often this would drive the husband away. Or the new mother herself might return to her parental home and remain through the nursing period. Even longer periods of abstinence would be ruled in special circumstances such as after the birth of twins, stillbirths, or spontaneous abortions.

Abstinence was also reinforced by ritual taboo. In West Kasai red powder or paint would be placed on the body of the infant or the mother to frighten the man away. It was said that if he had sexual relations with his wife during this period, his sperm would enter the child through the mother’s milk and kill the infant. The woman, too, felt the threat of taboo: maternal death at childbirth was often assumed to mean the woman had been unfaithful to her husband. At the end of the period of separation, the husband would present a chicken to his wife in a special ceremony. If she had not abstained from intercourse throughout the period, she could
I. METHODS

Often abortion may be induced at home after which the woman goes to the dispensary for treatment of incomplete abortion. Abortions are induced by quinine, bluing, douches with potassium permanganate or crushed papaya leaves, and with implements inserted into the uterus.

Proverbs

"Te ke ndye te ke ndye ukadyanga ni bibishi" (When one cooks too fast, the meal is not well done)

A woman who had a baby too soon after a previous birth would be called "a guest house where everyone passed through"

In East Kasai (South):

If a woman did not want to get pregnant, the whole family would gather together and pronounce words against fertility, which would make her sterile. This method was reported to have "worked better in the old days".

A witch doctor would give the woman a magical snail to keep in the house to prevent pregnancy.

Several roots could be pounded, boiled and then drunk to induce abortion, including: Kaoula Mumo, Ndunga, and Tshikadikadi

In East Kasai (North):

A woman could warn a man she was nursing by wearing a belt with raffia bundles in front and behind.

Among the Batetela, if a man did not respect the full breasts of a nursing mother and stay away, she would say:

"Tu sumbola we nanga ka sumbulani?" (Do you want to kill me?)

At Lodja, it was believed that the dust from a blacksmith's forge, when mixed with water and drunk, could make a woman sterile.

Hiding a cloth or moss soaked with menstrual blood in the rafters of the house could also prevent pregnancy.

not accept the gift. In the South part of East Kasai, this ceremony was particularly dramatic in its expression of the male's dominance over the female:

When the feast was prepared and all was ready, the woman would advance on her knees to her husband, who held out a war knife with a piece of chicken on it for her to eat. If she advanced without fear, then all would rejoice for her fidelity; if she lied, she would die.

Polygamy. These strict rules of abstinence went hand-in-hand with the tradition of polygamy. Two years or more of female abstinence could be reasonably expected if the man had another wife (in effect, the "total" abstinence rule during nursing was total only for the woman). In most of the areas surveyed, polygamy was very common: "Ancestors always had more than one wife, even up to twenty wives if the man was rich." At a minimum a man had a wife and a "concubine" to go to after his wife gave birth. Thus polygamy and abstinence during nursing combined to provide "natural" child spacing.
Contraceptive Methods. Within this context of abstinence and polygamy, means were still sought to have intercourse without pregnancy. There were several recognized conditions for avoiding childbearing—high parity (over 8 children), difficult labor, or when the husband and wife were angry with each other. Simple withdrawal by the male before ejaculation (coitus interruptus) was frequently practiced. In addition, the researchers recorded a compendium of recipes for contraceptive potions and poultries. Various roots, barks, herbs, and berries could be crushed, boiled, pounded, and mixed, and then swallowed or rubbed or inserted (see box). Some of these treatments apparently worked for awhile at preventing pregnancy or inducing sterility, or at least were believed to do so.

Numerous specific contraceptive rites were also chronicled in this study (see box). In West Kasai, for instance, it was said that if a woman did not want any more children, she could heat her menstrual blood in a pan and then pour it into the bush, swearing never to have another child. In another technique, elders of the family could place curses of sterility on the mother for various reasons—to prevent another pregnancy after a series of difficult pregnancies or punish a daughter for marrying against the will of the family.

Abortion. Abortion was accepted under certain circumstances without undue controversy in some traditional Congress societies. Abortion might be attempted when there were disagreements or a lack of love between the husband and wife, or when the husband had abandoned the wife with her children, or when the woman wanted to end an extramarital pregnancy. Methods for inducing abortion usually consisted of various potions, such as the sap of a forest vine (see box). Having someone walk on the stomach of a pregnant woman was also believed to induce abortion.

East Kasai: North/South Differences. Not all traditional societies in Zaire had the same attitudes about child spacing. The contrasting cultures in the Northern and Southern parts of the East Kasai region are good examples. The Baluba tribe inhabits the south of East Kasai, and their traditions are close to those of the people living in the West Kasai and Shaba regions. A strict religious belief taught that the man's sperm contained the soul of a new person. Coitus interruptus therefore was a moral sin, "tantamount to murder," and "in the past, people were killed or sold for infractions of the moral code." The survey team reported that "the cultural traditions of the past have been reinforced by access to the Mosaic Laws of the Old Testament, creating a prejudice against family planning."

In the North of East Kasai, the traditions of the Batetela tribe in the Sankuru region are sharply different from those of the Baluba. Laws against premarital sex and abortion are not strict. Rather than being considered immoral, coitus interruptus and adolescent sexuality were actually taught and encouraged: "They believed that if a boy reached the age of puberty and did not become sexually active, he would be impotent." In that region, there is no special merit for a girl to be a virgin at marriage: "Young people are encouraged to play together to learn about sex." A Catholic Sister at Kole reported that "no girl is a virgin when she finishes primary school". Abortion was not looked on as a sin among the Batetela. In the past, a fetus was not considered a living person and abortion was common in order to avoid an unwanted birth: "This is common thinking even today."

The team found that this liberal view of sexuality in the North of East Kasai was moderated by missionary influence in the last few decades, but the concept of family planning is readily accepted. However, misinformation about modern contraception is widespread among the youth in the North of East Kasai. Much of what they have heard from other women are complaints about side-effects; the condom is derided as a "method used by Europeans when they are with Zairese prostitutes". The survey team concluded: "A tremendous task of instruction must be faced to correct the imperfect knowledge and hearsay that has spread about modern methods of fertility control."
CULTURAL TRANSITION

The problems surrounding the acceptance of modern contraception are representative of the dilemmas facing many aspects of development in countries in transition. There is legitimate value in the old ways, but they are not effective enough. Introduction of the new ways can disrupt the positive aspects of the old ways, without which the new ways cannot succeed.

This is what is happening to birth control in Zaire. Modern family planning—oral contraceptives, intrauterine devices, condoms, injectables—have no roots in social conduct. Now births can be averted without polygamy and abstinence. The double standard of sexual conduct between male and female can no longer be justified. A woman's relationship to her fertility is drastically altered. Adaptation to these new social conditions is slow, and the interim period is confusing—at some points, the innovation is counterproductive.

Specifically, modern contraception permits breaking the rule of abstinence without breaking the rules against conceiving during lactation. The couple can have intercourse in the postpartum period without "the semen killing the child". The woman's absolute sexual fidelity is no longer necessary; the man's polygamy is similarly made obsolete. But the old cultural pattern still has a strong influence, and jealousy and marital discord become angry symptoms of cultural upheaval. The women in Shaba told the survey team:

In the past, women were exploited by their husbands. The woman of former times was not jealous, but now women say to the men, 'You are my husband. I don't want you to leave me alone.' When he returns, there is a quarrel.

Now the infidelity is not tolerated, and the participants in the seminars blamed the dynamics of jealousy for the "lack of responsibility for child spacing among couples today". Separation of the beds is no longer followed. Women say "I don't want to sleep on a mat—I want a good mattress". In West Kasai, the survey team was told: "Today mothers tell their daughters, 'If you let your husband go you won't have him anymore.' Naturally when husbands are near there are sexual relations and pregnancies come too frequently."

In addition, the simple technical aspects of modern contraception can spoil the plan. When the pill or condom are first accepted, they are not always properly used; or, as is often the case in Zaire, supplies are not always maintained. The resulting pregnancy frequently comes much sooner than if abstinence was still followed. The accompanying reduction in breast-feeding threatens the tenuous nutritional status of infants.

Out of many viewpoints on a culture in transition, here are two from West Kasai—the first from a regional medical officer:

Every young girl even of 14 years of age, hardly married, wants to become pregnant in order to bring honor for her household... family planning of the Anglo-Saxons is far from being the idea of the inhabitants of West Kasai. To the contrary, it is polygamy and desirable births that reign here.

An older woman in a rural village declared:

The life of a woman is easier in the city. She does not go to a garden to work. She stays home and takes care of herself and the children. And to go to market she takes a taxi. To have another child is not a problem for her. That is why the tradition of abstinence is no longer respected.
SEXUAL PRACTICES IN EAST KASAI

A corollary product of this project's research was the accumulation of a wealth of information on male/female dynamics, sex education, and sexual practices in traditional societies of Zaire, particularly among the Baluba and Batetela tribes of East Kasai. The reports paint a clear image of woman's subservience to the male, of a double standard of sexual fidelity, and of sex education wrapped in mythology and mysticism.

In the South of East Kasai among the Baluba, sexual practices were in keeping with the general conservatism of the society. If a woman was not a virgin when she was married, she was pronounced "cursed". A woman was considered ready for marriage when she was "corpulent and her breasts began to hang". At Bibanga: if a girl had had her period for four cycles, she was ready. A dowry had to be paid to the family of the bride—"up to 40 or 50 goats". The woman could not approach the man until the dowry had been paid. Readiness of the young man for marriage was judged by his ability to cultivate a garden, build a house, and hunt—to care for and feed a family. Marriages were arranged early—around ages 14 to 16—but would not take place until much later. The man often did not marry until he was 25 or 30 years old: "if a boy begins having sexual relations too early, he will be weak" (dramatically opposite the belief of the Batetela). As for sex education, an aunt or an old woman of the village would teach the girls; there was no organized sex education for boys.

In sharp contrast to the Baluba, among the Batetela in the North of East Kasai, the encouragement of adolescent sexuality was an integral part of the culture. This is most graphically demonstrated in their preoccupation with the physical aspects of the sexual organs: "The village mothers were always concerned about the proper development of the sex organs. They would stimulate the male baby's penis to make sure he was able to have an erection, and before a girl reached puberty, they taught her how to enlarge her labia minora... The latter practice was thought to both make preservation of virginity easier and to enhance the woman's sexual pleasure.

The survey team writes:

With this in their cultural background, one can understand why the city girls, who are no longer in the intimate family contact of the village, feel a lack in their preparation for marriage. The break with the traditional past has left insecurity and dissatisfaction in the marriage relationship. They say that the lack of proper instruction is the reason for the increased divorce rate in modern times.

As for sex education among the Batetela, a boy was expected to "learn by doing." When he would get married, he was then supposed to "teach" his wife. At Kole, it was believed that a man could not abstain from sexual relations, even before marriage. If he did, it would result in diminished sexual capacity:

This belief is the reason adolescent boys give as to why it is necessary to have sexual relations. They say they will become sick if they do not. The result of this thinking is one of the reasons for the widespread venereal disease among teenagers today.
Christian Influence. The influence of the missionaries as an arm of modernization has had a mixed impact on the progress of family planning. Some church leaders are actively teaching modern contraception. Others tend to see it as "sinful man interfering with the will of God." These attitudes affected the conduct of the seminars:

Sexual matters were not discussed traditionally, except between members of the same sex. Even then, it could be discussed only between certain members of the clan. At the start of our seminars, there were barriers that had to be broken down... [In the beginning] it was hard for women to participate other than to be present and listen... one of the factors that enabled many to overcome their embarrassment about discussing sexuality was the fact that their children knew more about these things than they did.

The survey team met resistance in some of the conservative Christian communities of Shaba. A pastor would ask, "Is it not a sin to control fertility? Is it not against the will of God?" The team's response demonstrates the sensitivity of their technique:

We did not try to answer the question directly ourselves. Each time we asked if there was someone in the audience who could answer their question. There were always other pastors who could answer the questions in a very positive way... the reaction of the majority of the people everywhere was very favorable, especially after they had considered how their ancestors had been very strict about being responsible in spacing pregnancies.

At one seminar in Manono, a woman pointed out the contradictions of family planning promulgated by missionaries:

In Christian marriages there are a lot of children because the husbands are faithful to their wives. The Bible does not say that the couple should separate when a child is born... It is our religion that keeps us together and the result is that we have lots of children!
For an overview, the participants at one seminar neatly listed some of the adverse effects of modernization on traditional culture:

- no more social control
- the young no longer respect the old
- parents no longer advise their children
- children are left to fend for themselves
- girls and boys are no longer separated
- in the city, neighbors are considered as enemies since the clan is no longer united.

The meeting of old and new contains these problems and more, but there are also potential advantages that modern family planners must recognize and utilize. The survey team’s findings show how the tribes in the Kasai and Shaba regions of Zaire responded to a need for a means of child spacing before the introduction of modern contraception. Clearly, there was a recognition long ago that too many children too quickly was not good for infant and maternal health. Polygamy and abstinence during lactation were the culture’s response. The effectiveness of that response is undocumentable and may have been poor. But it demonstrates that there is cultural precedent for regulating fertility and spacing children, and this is what modern family planning must respect. As the chaplain of the hospital at Tshikaji told the team:

I learned things today that I was completely ignorant of. This showed me that our ancestors were responsible people and they knew very well how to space their children. Really, I see now that the idea of desirable births is not a foreign idea, but was well known and practiced by our ancestors.

A family planning program in Zaire, supplied with essential commodities and manpower, should approach the village with this ancestral precedent as its banner.

EXISTING FAMILY PLANNING SERVICES

To prepare for the project’s long-range plans for improving family planning delivery in Zaire, the survey team investigated the existing family planning services during their travels. They found that the services that were available were scattered, often inadequately staffed, and undersupplied. No organization (government, church or business) offered the same services in all its branches. Usually only a handful of nurses and a physician or two were involved in family planning delivery in sub-regions with many thousands of inhabitants. At one time or another most modern contra-
ceptive methods had been offered—oral contraceptives, condoms, injectables or intrauterine devices—but the choice available at any given time depended on what had come through the pipeline that month. Pills and injectables were popular among contraceptive users but supplies could not be consistently maintained.

The team found these conditions existing in a health environment where infant mortality is high and venereal disease increasingly widespread:

East Kasai is a region where food production is not keeping up with population growth. The result is an increase in malnutrition. The people are especially low on proteins in their diet. The area is ravaged frequently by childhood diseases, tuberculosis, and in the cities, venereal disease. A good family planning program is vital to the development of the region.

Infant mortality has been a long-standing problem but VD is new in its rapidly accelerating incidence, particularly in Shaba. Medical personnel interviewed in a mining town said that a syphilis epidemic was centered in the fish distribution center for the entire region, and was threatening to spread: "At all dispensaries, no penicillin or similar medicines could be found." Black market antibiotics sales flourished whenever a truck arrived from Lubumbashi.

ACCESSIBILITY AND SUPPLY

Because of a lack of well-developed government services, Zaire is connected by a spider web of private service systems. In addition to the churches, the national railway and the mining companies also have their own medical and transportation networks. In some areas these services are only available to employees; in other areas the services are more open. When it comes to getting from one town to another, everyone is on his own, and competition for scarce resources is intense.

The survey team often discovered that some days it was impossible to find transportation from one area to another. Flights of Air Zaire are often canceled or subject to long delays. ECZ and other church organizations have their own small planes, but they too are often stumped by ground fog or fuel shortages. Without planes, one must search for a truck to handle the roads (there are virtually no cars available that can traverse the bush). If a truck is found, often there is no gasoline. Once, when the survey team was able to find a drum of gasoline, the one truck available did not run. In October of 1976, gasoline (if you could find it) cost US$7.00 per gallon in Mbuji-Mayi, East Kasai. The team was stranded in that town when the Presbyterian planes were grounded because of lack of fuel, and they had no radio contact with the Methodist pilots. Later, when the team flew in to Lomela, located in the midst of the dense forest of East Kasai, they found no cars at all. Teachers from the Methodist school took them from the airstrip to town by Vespa motorscooter, one by one.

This quote from the team's Shaba report summarizes the Zaire transportation challenge well:

At Kananga the fuel situation was bad. Taxis were hard to find and there was not enough fuel for the city generators to pump water or give lights every day. Since Shaba is even farther from the source of fuel supply [than other parts of Zaire], it was already evident that it would be impossible to do our itinerary by car... We are indebted to the Pentecostal missionaries... who arranged for our housing and greatly assisted the team with their pick-up truck, using some of their precious gallons of fuel to get us to the churches in Manono.

Even once the team arrived, the problems did not end. In Djalo, East Kasai, "the seminar at one church was delayed when they found a big snake in the building's rafters! It was eliminated before we proceeded."
The health manpower statistics for West Kasai region, for example, are striking. In 1976, for a population of over two and a half million people, there were only 29 doctors, 16 nurse-midwives, 101 nurses and 18 assistant midwives. That is a physician/population ratio of 1 to 86,000. Only one doctor was a gynecologist and only one a specialist in public health. Half of the doctors and nurses were foreigners, as were almost all of the nurse-midwives, who were mostly sisters of the Catholic church not trained for family planning “nor very interested in this work”. With all the pressing demands on the time available to this handful of health workers, the family planning personnel needs are overwhelming.

The survey team also visited health services in Shaba and East Kasai regions. There are three hospitals in Kalemie, Shaba but none offered regular family planning services. The private physicians in town could buy 100 IUDs for Z100 (Z1 = US$1.15 in 1976). They charged their patients Z25 for an IUD; at the Methodist dispensary the fee was Z1.50. The pharmacies in Kalemie had some supplies of condoms (three for Z1.50).

At Sandoa, the team was told there was not much family planning: “Women keep on having babies until they reach menopause.” At the state hospital in Kamina, the last four boxes they received from the capital marked “oral contraceptives” were filled with stones used for railway ballast. At Manono:

... a city which seemed somewhat abandoned, we found almost a complete ignorance of modern methods of fertility control. It was like introducing a completely new thing... Only the doctor at the Zaire Tin Company hospital and the head nurse of the Methodist dispensary knew... even the nurse at the Baptist clinic confessed total ignorance... [but] our visit stirred up a lively interest.

The team also found some bright spots. At Kolwezi, though “nothing is done at the state hospital for family planning,” there was a woman gynecologist delivering family planning services at the hospital of a mining company. At Kapanga there was a physician who had been inserting IUDs at Samutet Memorial Hospital for the last ten years. These services are tenuous, however, not only because of unreliable supply lines but because of the personalities involved. At present there is only a handful of committed doctors and nurses delivering family planning. When they leave an area, family planning sometimes leaves with them. Even in Lubumbashi, Shaba’s capital of over a half million people, family planning is offered by only a few doctors. The cost of the service (Z25 for an IUD insertion) is too high for the general population, yet the team reports “great demand” for affordable family planning.

In East Kasai, family planning services were similarly scarce. At Mbuji-Mayi, the gynecologist at the government hospital, Dr. Bodo, had been very active, holding conferences on family planning all over the region and delivering services with the help of a midwife. Seventy percent of his patients were using the pill and 20% were using injectables, but supplies were extremely short and could not keep up with demand. Some supplies were available at a mining company hospital, but only for company employees. At Lodja, the only town in East Kasai/North that has regular Air Zaire service, there was only one doctor in the area. He was very interested in family planning but had little time for it. He greatly desired the services of a trained midwife to help in this area. In Wembo-Nyama works Ms. Dorothy Gilbert, a midwife whom Pathfinder supported between 1973 and 1975 to establish family planning services and train personnel at hospitals, dispensaries and maternity centers of L’Eglise Methodiste Unie au Central Zaire. The survey team reported:

It is through her efforts in the region in the past decade that family planning has been taught and is being accepted. The influence of her program is demonstrated in the fact that in every outlying dispensary of the Methodist community, the nurses have had special training or at least know about family planning.
The state hospitals are in a difficult situation: "The lack of fuel for trucks and trains makes it impossible for hospitals to receive medicine regularly." If supplies do arrive they often have been "systematically pillaged" en route. "Only the network of Methodist dispensaries offers family planning at low cost"; even these centers severely lack enough trained nurses, midwives and other auxiliary personnel. Citoyen Lahema and the Galloways concluded that "the only way to enlarge the family planning services in the region" is training of new, low-cost personnel for service delivery.

DISCUSSION AND CONCLUSION

During four trips to three regions of Zaire, from their home base in Kinshasa, Citoyen Lahema and Ralph and Florence Galloway documented in detail many traditional sexual practices as well as the obstacles to development and family planning. Their work represents not only a family planning motivational effort, but includes elements of a public health survey, anthropological research, sociological analysis and even a religious conclave. This paper has tried to present some of this material to give other family planning professionals an insight into the realities of life in Zaire and the important interaction of old traditions and new methods in birth control.

The church seminar and clinic survey technique of the research team served them well. They were welcomed in all parishes visited, and by all government and private authorities. Some of their impact was unanticipated. At Kapanga, one of the seminar participants said at the end: "It impressed us to see here the close cooperation between the Whites and Zairois of the team."

Another participant said:

You did not come here as tourists. You came to learn. In the past no one dared talk openly about sexuality. What was said today is like a light to show us how to teach our own children. What you have given today, you have planted. You have opened our ears; you have taught us to talk openly.

In all three regions visited, the cultural mechanism of abstinence and polygamy, supplemented by abortions, potions and magic when taboos failed, showed a well-established precedent for child spacing in traditional Zaire societies:

The seminars brought out the fact that in ancestral times, great pains were taken and a high degree of discipline shown in order to space births, so that a mother could properly nurse her child... we got to the subject of family planning through their traditions and this captured their interest. The people were shown how child spacing was necessary in traditional society in order to survive and continue the clan.

Even within this small survey, cultural differences were found; the sexual liberalism of the Batetela dictates a different approach for family planners than the relative conservatism of the Baluba. But the overall message of a culture in turmoil was clear. Everywhere the team heard the people talk of a lack of discipline in modern society, and a breakdown in morality resulting in adolescent pregnancies. One participant said:

Today we do not make any decisions about spacing the births of our children. In general, we do not follow anything. Our ancestors had stronger children because they were not born too close together. Today parents no longer worry about their children getting sick. They think that they can always buy medicine and then the child will get well. This is why couples no longer separate their beds after the birth of a child, as they used to in the time of our ancestors. We are no longer so afraid of small children dying.
Family planning, sensitively introduced, can speed the transition and ease the turmoil. As the recent First Inter-African Seminar on the Protection of Mother and Child and Family Planning (held in Kigali, Rwanda in October, 1978) concluded:

The changes which have affected African societies since colonization have had effects on traditional morality. Thus sexual taboos and interdictions are less and less respected. There then develops, under our sometimes unseeing eyes, an imbalance in the socio-cultural system leading often to dramatic consequences. Family planning can ease and accelerate the achievement of a new balance.

But Dr. S. Okun Ayangade of the University of Ife in Nigeria warns:

The practice of prolonged breast-feeding and a long period of sexual abstinence has important implications for family planning programs. The impact of a carelessly designed family planning program that may interfere with local beliefs and constraints can only serve to increase fertility levels.*

Action. Citoyen Lahema and the Galloways concluded that at least three important steps are needed to improve family planning acceptance and use in these regions of Zaire—education, paramedical training and nonclinical contraceptive distribution. These proposals are in direct response to both the strong tradition of child spacing already present in the villages, and the frustrating obstacles of poor transportation and limited manpower supply.

Ignorance of modern family planning methods was widespread, even among many hospitals and their staffs. Yet everywhere the team found people eager to learn. Organized sex education is nonexistent, and the growing epidemic of adolescent pregnancy and venereal disease in these areas cries out for remedy. Many pastors and parents in the parishes where the seminars were held were eager to start programs of sex education, and appealed to the ECZ for help. They felt the courses should emphasize preparation for adulthood and marriage as well. Simple pamphlets “on sexuality, reproduction, sterility, menstruation and impotence” are needed.

But a newly educated populace is a frustrated one without services available to help them. These regions of Zaire urgently need well-trained family planning personnel—motivators and communicators as well as nurse-midwives and auxiliaries:

Doctors who can insert IUDs are too few and too scattered to be able to meet the needs of the population. In the centers where doctors are to be found their service charge is too high for the majority who greatly need family planning... In a region as big as Shaba [and Kasai] only trained paramedical personnel can establish a family planning service for the poorest of the region.

Increased use of paramedical personnel for service delivery and motivation must go hand in hand with nonclinical distribution of contraceptives in these areas. The current system of contraceptive distribution in Zaire is totally dependent on the clinical model, which is undermined by inadequate transportation and communication systems. Though clinic-based family planning is certainly necessary for IUD insertion and operative procedures, Zaire’s rudimentary supply system cannot keep the too few clinical centers stocked with oral contraceptives and condoms. The research team found an “almost total lack of medicines” in many state hospitals. Further, “one medical service was not aware of what the other was doing”.

The team contends that family planning had been practiced on a wider scale by the general population when products such as the pill and condoms were sold in the pharmacies that are much more accessible to the people than the medical centers. The government ordered centralization of commodity distribution “in order to ensure more equitable distribution between those who could afford medicine and those who could not”. But the country’s transportation and manpower resources are not up to the task. Modern contraceptives have been taken from people-accessible stores to physician-dependent hospitals that can be expensive and intimidating, and are few and far between. Many other countries around the world have successfully implemented nonclinical contraceptive distribution, and the survey team strongly urges that it be tried in Zaire.

Whatever the program design for family planning services delivery, the lesson of this project is that the tradition of child spacing among the peoples of Zaire must be respected and utilized. Dr. Ronald Freedman of the University of Michigan, testifying before the United States House Select Committee on Population in 1978, summarized this approach: “...adoption of contraception and rapid fertility decline are consistent with the persistence of many aspects of traditional family forms and attitudes.”

The seminar participants movingly described the breakdown of their traditions in the face of modernization, with the resulting rejection of child spacing, threatened maternal and child health, marital discord, adolescent pregnancy and venereal disease. Modern family planning can offer a tremendous service to a society in this situation if it is sensitively promoted, adequately supplied, and properly staffed.
Postscript. Reverend Galloway recently wrote The Pathfinder Fund from Kinshasa (August 1978) about conditions in Zaire since the last report of this project was filed:

You asked for any significant changes since our report in 1976. Some things have worsened. This is because of inflation, the chronic fuel shortage, bad roads, and a near breakdown in the postal service in some areas. Air service to the interior is completely uncertain.

Shaba is of course in much worse shape than it was in 1976. Dr. Eschtruth of the Kapanga Hospital was killed in April 1977. The hospitals at Kapanga and Kasaji were stripped of their equipment and supplies in 1977, and the same thing happened to Kolwezi this time (1978). The village people who have returned [from Angola] are almost starving.

There will be a great demand for family planning. As you read in one of our reports, the people told us that the times they did not want to give birth were in war and famine. And famine there is now, though relief operations are under way. The people have no gardens, seeds to plant, or even simple hoes for cultivation. Many have returned to find their houses and gardens destroyed. Now is when I would say that the people in Shaba would be highly motivated for family planning.

Acknowledgements

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Pathpapers Number 4

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Pathpapers

1  Training Village Midwives for Family Planning Services Delivery in Rural Turkey by Robert L. Bertera & Nuran Ustunoglu (July 1977).

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3  Indigenous Paramedical Personnel In Family Planning In Rural Durango, Mexico by Roberta Rivera, Maria Umaña de Tanco, Gloria de Velasquez, Margarita de Mier, Eva Ortiz, Hector Pizarro & Cesar Navarro (June 1978).

and

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4  Traditional Methods of Birth Control In Zaire by Ronald S. Waife (December 1978).


Uterine Aspiration Techniques in Family Planning by Hugh R. Holtrop & Ronald S. Waife, 1976. 66 p. US$2.00


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