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The Acceptability of Household Distribution Of Contraceptives in Zaire

The Bas Zaire experience indicates that the household distribution of contraceptives is a culturally acceptable activity that has yielded promising results and is worthy of further testing in other francophone African countries.

By Jane T. Bertrand, Nlandu Mangani and Matondo Mansilu

Summary

One of the first programs of community-based distribution of contraceptives in francophone Sub-Saharan Africa was undertaken among both rural and urban residents of Zaire, where only five percent of women exposed to pregnancy were using a modern contraceptive method. In the rural area, the program was combined with the delivery of drugs to combat malaria, intestinal parasites and dehydration from diarrhea among children younger than five; integration of the program with child health services and the promotion of contraceptives as a method of childspacing were believed to be prerequisites to the acceptance of family planning in a society where infant mortality is high and pronatalist attitudes prevail.

In the first of three rounds of home visits by program personnel, 37 percent of urban residents and 25 percent of rural women chose a contraceptive method and were given a limited free supply of that contraceptive. Among women who were premenopausal, who were not pregnant and whose husbands consented to the use of contraceptives, the proportions were 52 and 40 percent, respectively. In the urban area, vaginal tablets were selected by 39 percent of women and the pill by 35 percent. The proportion selecting the pill increased in the second and third rounds of home visits because of a change in project policy that allowed lactating women to select the pill. In the rural area, vaginal tablets were not available in the first round of home visits, and 54 percent of women chose foam, 23 percent, the condom, and 17 percent, the pill.

Among women who refused a method, the major reason given was opposition to family planning, reported by 34 percent of urban women and 18 percent of rural women. Another 23 percent of urban women and 15 percent of rural residents said they wanted to become pregnant, and 13 per-

cent of urban women and eight percent of rural women said that they were already using a method.

In the second and third rounds of home visits among urban residents, an additional 17 percent and 10 percent of women, respectively, obtained a contraceptive for the first time. In the rural area, the comparable figures were 17 and nine percent.

In the urban area, more than half of the women who had obtained a contraceptive during the first round were revisited four to six months later. Eighty-three percent reported that they had at least tried the method they selected, and 51 percent reported that they were still using it. Continuation rates were highest among users of the pill and lowest among users of foam. Among women who were no longer using their contraceptive method, the main reason given was that the woman had become pregnant (22 percent of urban women and 33 percent of rural residents).

Introduction

During the 1970s, an important model emerged for the delivery of family planning services in developing countries: the community-based distribution of contraceptives. There are different approaches to community-based distribution: household canvassing vs. stationary distribution posts, integration of family planning with other health services vs. delivery of family planning alone, and contraceptives distributed free vs. services for a fee. The purpose of all of these approaches is to make contraceptive methods more readily available to the target population at low monetary and psychological cost.¹

Community-based distribution programs have been implemented in more than 30 developing countries. Although physicians have voiced some opposition to community-based distribution, the populations served have found the programs convenient alternatives to clinic-based services.²

Reports on the feasibility of community-based distribution programs are based on experiences in Asia, the Caribbean, Latin America and North Africa. There has been almost no experimentation with this approach in Sub-Saharan Africa, except for the Calabar project, which has been carried out in Nigeria, an anglophone country,³ and several pilot projects that have been funded by international family planning donor agencies but have not yet been described in the literature.

There are no published reports of community-based distribution from francophone Sub-Saharan countries. In part, this can be explained by a lower level of family planning effort in Sub-Saharan Africa than in other developing regions.⁴ However, it may also reflect the belief that community-based distribution would not be acceptable in pronatalist societies, where family planning could be interpreted as being in direct opposition to societal norms.

The PRODEF Project

The current project, undertaken by the Communauté Baptiste du Zaïre Ouest (the Baptist Community of West Zaire) in collaboration with Tulane University, was designed to test the acceptance of community-based distribution in both an urban and a rural setting of a francophone Sub-Saharan country, the Republic of Zaire. The area chosen for this project was the region of Bas Zaire. Specifically, the project includes the port city of Matadi (with an estimated popu-

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Table 1. Number and percentage distribution of women who obtained free contraceptives for the first time, by round of home visits and method chosen, according to urban-rural residence, Zaire, 1981-1983

Round and method	Urban		Rural	
	No.	%	No.	%
1st round	2,260	100.0	438	100.0
Pill	779	34.5	76	17.4
Vaginal tablet	870	38.5	4	0.9
Foam	381	16.9	235	53.7
Condom	230	10.2	102	23.3
Combination*	u	u	21	4.8
2nd round	1,016	100.0	283	100.0
Pill	493	48.6	35	12.4
Vaginal tablet	313	30.8	15	5.3
Foam	101	9.9	155	54.8
Condom	41	4.0	45	15.9
Combination	68	6.7	33	11.6
3rd round	687	100.0	121	100.0
Pill	297	43.2	29	24.0
Vaginal tablet	206	30.0	28	23.1
Foam	29	4.2	25	20.7
Condom	29	4.2	14	11.6
Combination	126	18.4	25	20.6

*The reporting system, which originally forced a single response for contraceptive method, was changed for the rural area and later rounds.

Note: In this table and Table 2, u=unavailable.

lation of 150,000-200,000, approximately 133,000 of whom live in the target areas of the project) and the neighboring rural zone of Songololo (which has an estimated population of 36,000, approximately 25,000 of whom live in the 53 villages covered by the project).

Known locally as PRODEF (le Programme d'Education Familiale), the project was launched in late 1980 with a baseline survey that indicated widespread knowledge of fertility control methods.⁵ Ninety-five percent of both urban and rural women knew at least one traditional fertility control method,* and about 80 percent had heard of at least one modern method.† Moreover, 73 percent of ever-married women had used a traditional method at some time. By contrast, only seven percent had ever used a modern method (10 percent of urban and seven percent of rural women), and only five percent of women aged 15-49 who were married or in union were currently using a modern method.

It was originally expected that PRODEF would be integrated with the delivery of three health services for children younger than five years of age. These services would provide drugs to combat malaria and helminths (an intestinal parasite) and rehydra-

tion salts. In fact, it was believed that this integration would be a prerequisite for the acceptance of family planning in a society where infant mortality is high and pronatalist attitudes prevail.

In Matadi, however, there were existing interests that might have been threatened by the introduction of low-cost medication for children. Thus, politics dictated that the family planning services, for which there were virtually no competitors, be launched without the other health interventions in the urban area. In the rural area, both the family planning and the child health services were provided.

To increase the availability and acceptability of family planning in the project area, four activities were carried out: group meetings, home visiting (including household distribution of contraceptives), supplying of existing dispensaries with contraceptives and drugs for children and establishment of community-based distributors (matrones) in rural communities where there were no dispensaries. This article focuses on the home visiting, which began in the rural area in October 1981 and in the urban area in July 1982, and specifically on the household distribution of contraceptives.

Teams of 10 home visitors in the urban area and five visitors in the rural area were responsible for canvassing the designated territory and visiting all women of reproductive age to discuss family planning and (in the rural area only) child health. The project called for three rounds of visits to the same population of women in each community with intervals of four to six months between visits. The visits lasted for 20-40 minutes each.

The home visitor approached each household and explained that she was part of the team from the local hospital that was visiting all the women to talk about the health of mothers and children. In rural areas, the visit began with the child health counseling regarding malaria, intestinal parasites and dehydration due to diarrhea. This segment included a participatory demonstration of the preparation of the rehydration solution. Interested women were then able to purchase chloroquine, aspirin, mebendazole and rehydration salts in limited quantities at nominal cost.

During the family planning discussion that followed, the husband was encouraged to be present. The discussion included the benefits of childspacing and an explanation of different contraceptives (the pill, foam, vaginal tablets and condoms, which the visitor carried, and the IUD and female sterilization, for which she could make referrals). If the woman was interested, the visitor would pro-

vide her with a free limited supply of one of the methods (one cycle of pills, one container of foam, a packet of vaginal tablets or one dozen condoms).

As part of the program's effort to establish a source for contraceptive resupply, each woman who obtained contraceptives was also given a coupon entitling her to one month's resupply free at an existing dispensary or, in rural communities with no dispensaries, from the matrone. The home visitor explained that after the coupon was used, additional contraceptives could be obtained at a nominal charge from the local dispensary or matrone.

Method Preference

The results presented here are based on information routinely collected by the home visitor during each of the three rounds of home visits. It should be noted that these are service statistics and not survey data; thus, it was not always possible to obtain all of the desired information.

In assessing the impact of the PRODEF home visits, it is important to estimate the percentage of the population that was reached. While there are no census data available for this region, it is possible to obtain a very rough estimate of the number of inhabitants in the project area from the baseline survey conducted prior to the initiation of service delivery.

The estimated study population was 133,000 in the urban area and 25,000 in the rural area. It was further estimated that women aged 15-49 made up 21 percent of the population. About 50 percent of the urban women (13,965) and 60 percent of the rural women (3,150) were scheduled to receive home visits.

Although the visitors returned several times if an eligible woman was not at home, only about half of the designated population was contacted during the first round—approximately 43 percent of urban women (6,057) and 56 percent of rural women (1,752). The number of women contacted would have averaged about five per visitor per working day if averaged over the six-month period allowed for each round. In fact, each round took less than six months because of the many women who were not at home. The proportion of women visited was slightly lower in the urban area than in the rural area, probably because more urban women have outside jobs or other activities during the day. Also, in the rural area, the village leaders usually announced the arrival of the PRODEF team in advance so that women would be more likely to be at home.

Not all women contacted by the home visitors were eligible to receive a free supply of

*Withdrawal, abstinence, rhythm, douche and folk methods.

†Pill, IUD, female sterilization, condoms, spermicides and injectables.

contraceptives. During the first round, ineligible women were defined as those who were pregnant, those whose husbands were not present to participate in the decision-making and those who were postmenopausal. The reason for requiring the husband's presence was to avoid criticism that PRODEF was encouraging women to use a contraceptive method without their husbands' knowledge. This conservative approach was considered advisable in this new and potentially controversial project.

Twenty-nine percent of urban women and 37 percent of rural women were ineligible to receive contraceptives during the first round of home visiting. Half of the women were ineligible because their husbands were not present. In later rounds of home visiting, the husband could give written consent for his wife to use contraceptives if he could not be present for the visit. In addition, pregnant women, who accounted for approximately one-third of ineligible women, were allowed in later rounds to receive contraceptives for use after delivery.

Among those who were eligible during the first home visit, 52 percent of urban women (2,260) and 40 percent of rural women (438) obtained a free supply of contraceptives. Another five percent and three percent, respectively, were referred to other sources for a method not available through the home visitor: the IUD, female sterilization or Depo-Provera.* The remainder did not want any method.

The percentage distribution of women who selected a method is shown in Table 1. These data reflect the personal preferences of the women, recommendations made by project personnel and the availability of the products in the different rounds.

During the first round, project personnel were instructed to recommend a barrier method (foam, vaginal tablets or condoms) rather than the pill to lactating women. Since research has shown that lactating women are the subgroup of this population most motivated to avoid pregnancy,⁶ it is not surprising to find a relatively large proportion of the women using barrier methods. However, vaginal tablets were not available to the project for use in the rural area until the end of the first round; this accounts for the negligible percentage of rural women selecting vaginal tablets in the first round.

Method preference varied somewhat between the urban and rural areas and from one round to another. In the urban area during the first round, vaginal tablets were the method most frequently selected (39 percent), followed closely by the pill (35 percent). However, the proportion of new users selecting the pill increased during the second

and third rounds, and the pill became the most frequently selected method, followed by vaginal tablets. It is probable that this increase in pill preference was more the result of a change in PRODEF policy than in consumer attitudes; after the first round, the PRODEF medical consultants recommended that the pill no longer be restricted to nonlactating women.

In the rural area, the majority of women who received a method during the first round chose a barrier method (54 percent, foam; 23 percent, condoms), and only 17 percent selected the pill. Again, this distribution reflects the large number of lactating women who were advised not to use the pill. A similar pattern was found in the second round of visits. However, in the third round, the proportion selecting the pill increased, as did the proportion selecting vaginal tablets, which had not been readily available earlier.

It is difficult to say what proportion of the study population would have selected the pill if it had not been restricted to nonlactating women during the first round. Even with the subsequent change in policy, there was probably some carry-over of the original policy in the minds of both the home visitors and the eligible women. Nonetheless, these results suggest the importance of making vaginal methods available in a population where the most motivated women are likely to be lactating mothers. Moreover, if vaginal tablets and contraceptive foam are both available, the data show that there is a preference for vaginal tablets.

During the first round of visits, 42 percent of urban women and 57 percent of rural women who were eligible to obtain free contraceptives did not want any. These women were asked their reason, and their responses are shown in Table 2. In the rural area, the home visitors neglected to record the reason in approximately 30 percent of the cases; also, an additional 21 percent were classified as "other," which included such responses as subfecundity, postmenopausal, no exposure to intercourse and preference for traditional methods. Some of these reasons were listed separately in round one in the urban area, and the urban data on reasons for refusal are more complete.

Thirty-four percent of the urban women who refused did so because they were opposed to family planning. Another 23 percent desired a pregnancy, 13 percent claimed that they were already using a contraceptive and 11 percent said they were sterile. Only two percent cited fear of side effects as their reason for refusal.

In the rural area, the two main reasons for refusal were also opposition to family planning methods and desire for a pregnancy.

Table 2. Number and percentage distribution of eligible women who refused contraceptives during the first round of home visits, by reason for refusal, according to urban-rural residence

Reason	Urban		Rural	
	No.	%	No.	%
Total	1,829	100.0	624	100.0
Opposed to family planning	613	33.5	109	17.5
Desired pregnancy	423	23.1	93	14.9
Using a method	242	13.2	48	7.7
Sterile*	191	10.5	u	u
Lacked parental consent†	166	9.1	na	na
Husband opposed	148	8.1	22	3.5
Fear of side effects	36	2.0	36	5.8
Other	10	0.5	128	20.5
No data	0	0.0	188	30.1

*During the first round in the rural area, sterility was classified under "other." This round was conducted later in the urban area, and more detailed data were obtained on reason for refusal.

†In the urban area, home visitors spoke to all women 15-49, including a number of unmarried teenagers. However, no contraceptives were supplied to these teenagers unless the parents were present and consented.

Note: na=not applicable.

While the rural data were less complete than the urban data, the rank order of reasons was similar in both cases. The only exception was a slightly higher proportion (six percent) of rural women than urban women who mentioned fear of side effects.

Follow-Up Data

In designing the PRODEF project, we decided to carry out three rounds of home visits to reach women who might have been absent on an earlier visit, to provide a second opportunity for women who had not obtained a method previously and to answer questions and provide reinforcement for those women who had received a contraceptive method. Given that the population had very little previous experience with modern contraceptives, it seemed necessary from an educational point of view to provide them with repeated opportunities.

As the results in Table 3 (page 24) indicate, the repeat visits did result in additional new users, although progressively fewer with each round. The percentages are based on all women 15-49 years old who were visited in each round, including those ineligible for contraceptives.

*Although some women in the study population requested Depo-Provera (which is available from a dispensary in Matadi from time to time), it has not been available and cannot be supplied with funds from this project in any case. Data on the number that actually obtained services for which visitors provided referrals are not available.

Table 3. Number and percentage distribution of all women visited who obtained free contraceptives for the first time, by urban-rural residence, according to round of home visits

Geographic area, number and percentage	Round		
	1	2	3
Urban			
Total visited	6,057	6,092	6,813
No. that accepted	2,260	1,016	687
% that accepted	37.3	17.0	10.1
Rural			
Total visited	1,752	1,691	1,409
No. that accepted	438	283	121
% that accepted	25.0	16.7	8.6

In the urban area, 37 percent of the women visited in the first round obtained a free contraceptive method; an additional 17 percent of the women visited in the second round and 10 percent in the third round obtained a method for the first time. How many of the women who took a method in the second and third rounds had previously refused, how many had been ineligible and how many had simply been absent in previous rounds is not known. Nonetheless, the data suggest that the second and third rounds of visits resulted in a substantial number of new users.

Data for the rural area show similar results. The percentage of women who first obtained a method declines in each subsequent round; however, new women are added to the project as a result of repeat visits to the same communities.

One of the criticisms of free household distribution of contraceptives is that many women may choose a contraceptive to please the home visitor or to take advantage of something free, but may never actually use it. In the second round, an attempt was made to obtain information on actual contraceptive use among women who obtained a method in the first round. The rural data on continuation lack internal consistency, and, thus, only urban data are included in this report.

In the second round, the PRODEF home visitors reached more than half (56 percent) of the women in the urban area who had been provided with a method in the first round. In each case, they inquired whether the woman had ever used the method and, if so, whether she was still using it and whether she had redeemed her coupon for a free supply of contraceptives at the dispensary.

Of the 1,261 urban women who had obtained a method in the first round and were revisited in the second round four to six months later, 83 percent indicated that they had used the method. The percentage having used the method was slightly higher

among those who had chosen condoms (92 percent) and pills (87 percent) than among those who had chosen foam (80 percent) and vaginal tablets (79 percent). Furthermore, 51 percent reported that they were still using the method when visited the second time. Continuation was higher for users of the pill (57 percent) and vaginal tablets (50 percent) than for users of the condom (47 percent) and foam (42 percent).

Data regarding redemption of the coupons are consistent with the reports of continued use. That is, in order for a woman to have been using contraceptives at the second visit, she would have to have used the coupon to get a resupply, unless she had not started use immediately after the first round, had interrupted use between rounds or had resupplied herself without using the coupon.

Women who had chosen the pill not only reported the highest continuation rate, but also were the least likely to still have the coupon (33 percent). Similarly, users of foam, who had the lowest continuation rate, were the most likely to still have the coupon (56 percent).

Among the women revisited in the second round were 615 urban residents and 73 rural residents who had obtained a contraceptive in the first round but were not using it by the time of the second visit. As Table 4 shows, the main reason given by both the urban and the rural residents was that the woman had become pregnant. Whether she was already pregnant before she began using the method or whether she became pregnant while using a contraceptive is not known.

The second most frequently cited reason in both areas was that the women did not know where to get resupplied. Other women knew where to get resupplied but felt it was too far away.

Fear of side effects, cited by only a few women as a reason for refusing the free supply of contraceptives initially (Table 2), did surface as a more important reason for non-use or discontinuation of the contraceptives once obtained. This reason was the third most important in the urban area and fourth most important in the rural area. The remaining reasons mentioned were desire for another pregnancy, husband's opposition or absence and an unfavorable attitude of the woman herself.

A high proportion of reasons were classified as "other" (46 percent among the urban nonusers, 21 percent among the rural nonusers). This resulted from use of a precoded form on which several important reasons were apparently omitted. For example, the women were not asked whether the cost of contraceptives after they used their free supply was a reason for nonuse.

Discussion

The Bas Zaire experience has provided a number of valuable lessons about the household distribution of contraceptives in a francophone Sub-Saharan country. Although these findings cannot necessarily be generalized to other populations, they suggest the feasibility of the community-based distribution approach in this region of the world. The following conclusions are based either on the data or on impressions from field experience.

- *The household distribution of contraceptives is acceptable in this population, provided that certain cultural norms are respected.* At no point in the PRODEF program has any city or village official complained about the distribution of contraceptives. Nor has there been any collective opposition among community members, although individuals may disapprove of family planning.

To the contrary, the PRODEF activities have been well received, and several factors have worked to enhance acceptability. First, the director of the program is a physician native to the area who is well known by the rural population for his public health programs and outreach activities on other aspects of maternal and child health.

Second, all efforts have been made to respect the conventional channels of authority in introducing the program. The zone commissioners in the urban area and village chiefs in the rural area were fully informed of the project before it began, and they assisted in such program activities as assembling the village population for group meetings.

Third, in the planning phase, special consideration was given to social norms governing male-female relationships and the potentially disruptive effect of introducing contraceptives. As Ronald S. Waife has pointed out, modern family planning has no roots in traditional social conduct in Zaire.⁷ If births can be averted without polygamy and abstinence, there is little justification for a double standard of sexual conduct between men and women. As such, the introduction of contraceptives may threaten old cultural patterns. In an effort to minimize problems stemming from this cause, home visitors were authorized to distribute contraceptives to a woman only if her husband was present or gave his written consent. (Likewise, no contraceptives were given if the husband was interested but the wife was opposed.) While this restriction may have decreased the number of women who obtained a method, it undoubtedly enhanced the overall acceptability of the program.

- *The promotion of family planning services is facilitated if they are integrated with child health services, but this does not seem to be*

essential in urban areas. Home visitors in the rural area reported that it was easier to establish a rapport with the women by discussing the health of their children before broaching the more sensitive topic of family planning. Data on the volume of drugs sold to combat diseases in children under five (not shown) indicate that child health counseling is a strongly valued aspect of the program.

On the other hand, the urban program consists of family planning alone, and this has not represented a major problem. In part, this may be because other health services are more accessible to this population than they are to the rural population.

• *Emphasis in family planning services should be placed on childspacing, not family limitation.* The designated population for the PRODEF project is typical of traditional societies in Sub-Saharan Africa in which there is a widespread recognition of the importance of childspacing.⁸ The traditional method of achieving adequate intervals between births has been a taboo on postpartum sexual relations. However, with modernization, abstinence is no longer acceptable to some members of society.⁹

Thus, it is appropriate to promote contraceptive use as a means of childspacing, but family limitation is as yet an unpopular concept in this pronatalist society. As John and Patricia Caldwell report from their experiences in Nigeria, the adoption of contraceptive methods would have been more rapid "if the main thrust in legitimization had presented [contraceptives] as being the most 'natural' or 'decent' or 'satisfying' method of childspacing."¹⁰ It is probable that many spacers will come to use contraceptives for limitation, but this does not need to be a focus in the early stages of the program.

Table 4. Number and percentage distribution of women who obtained a contraceptive method in the first round of home visits but were not using it by the second round, by reason for nonuse, according to urban-rural residence

Reason	Urban		Rural	
	No.	%	No.	%
Total	615	100.0	73	100.0
Became pregnant	132	21.5	24	32.9
Did not know where to resupply	64	10.4	10	13.7
Fearred side effects	38	6.2	5	6.8
Resupply too far away	36	5.9	4	5.5
Desired pregnancy	28	4.6	2	2.7
Husband opposed	18	2.9	2	2.7
Husband absent	14	2.3	9	12.3
Woman opposed	4	0.6	0	0.0
Menopause	0	0.0	2	2.7
Other	281	45.7	15	20.5

• *In an area where there is a scarcity of trained health personnel, the use of para-professionals to distribute contraceptives is acceptable to community officials and the general population.* The original team of home visitors for the rural area consisted of women with some previous training in health, although one was replaced by a woman with no such training. None of the home visitors in the urban team had previous health training, although they did undergo a three-week course in family planning before beginning their job. They referred clients with questions of a medical nature that they were unable to answer to the nearby dispensaries.

• *Household distribution of contraceptives achieves levels of awareness and initiation of use that would take much longer to achieve if the methods were simply made available in service outlets.* According to the baseline survey conducted prior to the onset of service delivery, 90 percent of ever-married urban women aged 15-49 and 93 percent of comparable rural women had never used a modern contraceptive method.¹¹

Of all the women visited in the first round, 37 percent of urban residents and 25 percent of rural residents took a free supply of contraceptives. Among those considered eligible, the proportions were 52 and 40 percent, respectively. Eighty percent of the women who chose a method reported that they tried the method at least once, and 50 percent were still using it several months after first use.

• *Spermicides are more popular in this population than would be expected from the experiences in other regions of the developing world.* One reason is that lactating women represent a prime target group for family planning services and there is some resistance from nursing women and service providers to use of the pill by this group. Spermicides are a viable alternative.

Second, vaginal douching is common among women in this region, and there is no particular embarrassment or taboo associated with vaginal methods of contraception. While there may be the usual complaints that these methods are messy, they appear to be culturally acceptable, even in areas where there is no running water. Although we have no data to explain why, vaginal foaming tablets are more popular among this population than contraceptive foam. One possible reason is that the tablets have no applicator to wash.

• *A coupon system for encouraging resupply at an existing service outlet yields mixed results.* In the urban area, 54 percent of the women who took contraceptives during the first home visit subsequently redeemed their

coupon, thus establishing a link between the client and a regular source of supplies. By contrast, almost 80 percent of rural women did not redeem their coupon.

There are several possible explanations for this difference. First, the urban women may be more motivated to practice contraception than their rural counterparts. Second, the urban women may have the advantage of greater anonymity in redeeming their coupons at a dispensary. In fact, rural women admitted to the home visitors that privacy was a problem, and many waited until the second round of home visiting to redeem their coupon from the home visitor. While the community was very willing to use the matrone's services for purchasing drugs for children under five, contraception is a more delicate issue.

A follow-up survey conducted in late 1983 and early 1984 will provide more data on the extent of increased knowledge and use of modern contraceptives in this population as a result of the PRODEF project with its various components (group meetings, home visiting, stocking of dispensaries and matrones). The service statistics reported herein and the firsthand accounts of the PRODEF staff suggest that the household distribution of contraceptives is a culturally acceptable activity that has yielded promising results. Thus, the Bas Zaire experience to date would indicate that this is an approach to the delivery of family planning services that is worthy of further testing in other francophone African countries.

References

1. J. R. Foreit, M. Gorosh, D. G. Gillespie and C. G. Merritt, "Community-Based and Commercial Contraceptive Distribution: An Inventory and Appraisal," *Population Reports*, Series J, No. 19, 1978, p. 3; and M. Burkhardt, "Issues in Community-Based Distribution of Contraceptives," *Path Papers*, No. 8, 1981, p. 36.
2. Ibid.
3. O. A. Lapido, E. M. Weiss, G. E. Delano and J. Revson, *Community Delivery of Low-Cost Family Planning and Maternal and Child Health Services in Rural Nigeria*, Department of Obstetrics and Gynecology, University College Hospital, Ibadan, Nigeria, 1982.
4. D. Nortman, "Changing Contraceptive Patterns: A Global Perspective," *Population Bulletin*, 32:15, 1977.
5. J. T. Bertrand, W. E. Bertrand and M. Malonga, "The Use of Traditional and Modern Methods of Fertility Control in Kinshasa, Zaire," *Population Studies*, 37:129, 1983.
6. J. T. Bertrand, N. Mangani, M. Mansilu and E. G. Landry, *The Dynamics of Fertility Control in Bas Zaire*, Tulane University, 1983.
7. R. S. Waife, "Traditional Methods of Birth Control in Zaire," *Path Papers*, No. 4, 1978, p. 9.
8. Ibid., p. 4.
9. M. Sala-Diakanda, N. A. Pitshandenge, D. Tabutin and E. Vilquin, "Fertility and Child-Spacing in Western

Zaire," in H. Page and R. Lesthaeghe, eds., *Child-Spacing in Tropical Africa: Traditions and Change*, Academic Press, London, 1981, p. 287.

10. J. C. Caldwell and P. Caldwell, "Cause and Sequence in the Reduction of Post Natal Abstinence in Ibadan City, Nigeria," in H. J. Page and R. Lesthaeghe, 1981, op. cit., p. 198 (see reference 9).

11. J. T. Bertrand, W. E. Bertrand and M. Malonga, 1983, op. cit. (see reference 7).

Resumen

Uno de los primeros programas de distribución de anticonceptivos con base comunitaria en la zona francófona del África al sur del Sahara se llevó a cabo entre residentes tanto rurales como urbanas del Zaire, donde sólo el cinco por ciento de las mujeres expuestas al riesgo de embarazo estaban utilizando a la sazón un método moderno anticonceptivo. En la zona rural el programa se combinó con la entrega de medicamentos para combatir el paludismo, los parásitos internos y la deshidratación producida por la diarrea entre niños menores de cinco años. La integración del programa en los servicios de puericultura y la promoción de anticonceptivos como método para espaciar el nacimiento de los niños se creía que eran requisitos previos para la aceptación de la planificación familiar en una sociedad donde la tasa de mortalidad infantil es elevada y predominan las actitudes pronatalistas.

En la primera de tres series de visitas a domicilio, el 37 por ciento de residentes urbanas y el 25 por ciento de las mujeres rurales eligieron un método anticonceptivo y se les suministró gratis una cantidad limitada de ese anticonceptivo. Entre las mujeres premenopáusicas, que no se encontraban embarazadas y aquellas cuyos maridos consintieron en la utilización de anticonceptivos, las proporciones fueron del 52 y el 40 por ciento, respectivamente. En la zona urbana las tabletas vaginales fueron seleccionadas por el 39 por ciento de las mujeres y la píldora por el 35 por ciento. La proporción de las que eligieron la píldora aumentó en la segunda y tercera serie de visitas domésticas debido a un cambio en la política del proyecto que permitía a las mujeres lactantes elegir la píldora. En la zona rural no se tenían disponibles tabletas vaginales en la primera serie de visitas a domicilio, y el 54 por ciento de las mujeres eligió la espuma, el 23 por ciento el condón, y el 17 por ciento la píldora.

Entre las mujeres que se rehusaron a seguir un método, la razón principal que se expuso fue la oposición a la planificación familiar, manifestada por el 34 por ciento de las mujeres urbanas y el 18 por ciento de las rurales. Otro 23 por ciento de mujeres urbanas y el 15 por ciento de residentes rurales expresaron que deseaban quedar embarazadas,

y el 13 por ciento de mujeres urbanas y el ocho por ciento de las rurales declararon que ya estaban utilizando un método.

En la segunda y tercera series de visitas a domicilio entre residentes urbanas, un 17 por ciento adicional y el 10 por ciento de las mujeres, respectivamente, obtuvieron un anticonceptivo por primera vez. En las zonas rurales las cifras comparables fueron el 17 y el nueve por ciento.

En las zonas urbanas, más de la mitad de las mujeres que habían obtenido un anticonceptivo durante la primera serie de visitas fueron entrevistadas de nuevo de cuatro a seis meses más tarde. El 83 por ciento comunicó que por lo menos habían ensayado el método que habían seleccionado, y el 51 por ciento informó que todavía lo seguían utilizando. Las tasas de continuación fueron más altas entre las usuarias de la píldora más bajas entre las usuarias de espuma. Entre las mujeres que ya no estaban utilizando su método, la razón principal que se adujo fue que habían quedado embarazadas (el 22 por ciento de las mujeres urbanas, y el 33 por ciento de las residentes rurales).

Résumé

L'un des premiers programmes de distribution communautaire de contraceptifs dans les pays d'Afrique francophone au sud du Sahara a été entrepris parmi les populations rurales et urbaines du Zaire, où cinq pour cent seulement des femmes aptes à procréer utilisent une méthode contraceptive moderne. Dans les zones rurales, ce programme a été combiné à la fourniture de médicaments pour combattre le paludisme, les parasites intestinaux et la déshydratation causée par diarrhée chez les enfants de moins de cinq ans. L'intégration de ce programme aux services de santé infantile et la promotion des contraceptifs comme moyen d'espacer les naissances étaient considérées comme les conditions préalables à l'acceptation du planning familial dans une société où la mortalité infantile est élevée et où dominant des attitudes pronatalistes.

Lors des trois premières séries de visites à domicile, 37 pour cent des femmes des zones urbaines et 25 pour cent des femmes des zones rurales ont choisi une méthode contraceptive et ont reçu gratuitement une provision limitée du contraceptif correspondant. Parmi les femmes qui n'avaient pas atteint la ménopause, qui n'étaient pas enceintes et dont le mari a consenti à l'utilisation de contraceptifs, les proportions ont été de 52 et de 40 pour cent, respectivement. Dans les zones urbaines, 39 pour cent des femmes ont choisi les tablettes vaginales et 35 pour cent la pilule. La proportion des femmes ayant choisi la pilule a augmenté lors de la deuxième et de

la troisième série de visites à domicile à la suite d'un changement dans la politique du projet qui a permis aux femmes qui allaient choisir ce contraceptif. Dans les zones rurales, les tablettes vaginales n'ont pas été offertes lors de la première série de visites à domicile, et 54 pour cent des femmes ont choisi la mousse, 23 pour cent le condom et 17 pour cent la pilule.

Parmi les femmes qui ont refusé toute méthode, la principale raison invoquée était l'opposition au planning familial, affirmée par 34 pour cent des citadines et 18 pour cent des femmes rurales. Vingt-trois pour cent des femmes des villes et 15 pour cent des femmes des régions rurales ont déclaré qu'elles désiraient une grossesse, et 13 pour cent des femmes des villes et huit pour cent des femmes rurales ont déclaré qu'elles utilisaient déjà une méthode contraceptive.

Au cours de la deuxième et de la troisième série de visites à domicile dans les zones urbaines, 17 et 10 pour cent de femmes, respectivement, ont reçu des contraceptifs pour la première fois. Dans les zones rurales, les chiffres correspondants étaient de 17 et de neuf pour cent.

Dans les zones urbaines, plus de la moitié des femmes qui avaient reçu des contraceptifs lors de la première série de visites ont reçu une nouvelle visite de quatre à six mois plus tard. Quatre-vingt-trois pour cent d'entre elles ont déclaré qu'elles avaient au moins essayé la méthode qu'elles avaient choisie, et 51 pour cent ont affirmé en poursuivre l'usage. Les taux de continuation étaient les plus élevés parmi les femmes qui utilisaient la pilule et les plus faibles parmi celles qui utilisaient la mousse. Parmi les femmes qui n'utilisaient plus leur méthode contraceptive, la principale raison invoquée était que la femme était enceinte (22 pour cent des femmes des zones urbaines et 33 pour cent des femmes des zones rurales).