



Fatouma had a baby every single year. All of her children were malnourished - they didn't walk until 15 months. We spoke to her about family planning, and she came with her husband to choose a method.

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VOICES from the VILLAGE:

Improving Lives through CARE's Sexual and Reproductive Health Programs

Meeting Needs for Reproductive Health Services in Post-Conflict Environments: CARE's Family Planning Project in the Democratic Republic of the Congo



USAID
FROM THE AMERICAN PEOPLE



The need for reproductive health care, including family planning, does not diminish during or after crises; rather, the need grows, while supply diminishes. Yet the health delivery system, including health care providers, donors and NGOs, often relegates family planning to a second- or third-tier intervention after the more “urgent” needs of a population are met. This article reviews how CARE and USAID introduced a family planning program to remote, war-torn Maniema province in the Democratic Republic of the Congo (DRC), and describes the results achieved and lessons learned to date. Midway through the three-year project, its impressive progress speaks to the real need that women, men and households have for reproductive health and family planning in the wake of crisis.



Introduction

“The armed men came,” remembers Lukumu Yandangi, a peer educator in CARE’s Family Planning Project in southern Maniema province. “They destroyed everything – they raped, they killed. They totally upended life as we knew life. Farmers couldn’t farm, our children couldn’t go to school.” During the DRC’s chaotic war,¹ Yandangi’s village was attacked by the Mayi Mayi, the national army, the police and various militias, including the Interahamwe. “And we never really understood,” he says, “what the rebellion was about.”

Yandangi and millions of other Congolese emerged from the war with far less than the little they originally had. Similarly, state services, including the healthcare system, were bankrupt: the war, with its pillage and destruction, had finished off what 35 prior years of government neglect and corruption had begun. By 2001, maternal mortality

¹ Often defined as two wars: 1996-1997 and 1998-2002. Note that horrific violence against civilians continues in northwest DRC at the hands of militias that did not sign the 2002 peace accords.

in the DRC had reached an outrageous 1,289 deaths per 100,000 live births,² and child mortality stood at 243 per 1,000 live births in rural areas.³ Remote, nearly inaccessible and severely affected by war, Maniema ranked as the poorest province in the DRC.⁴

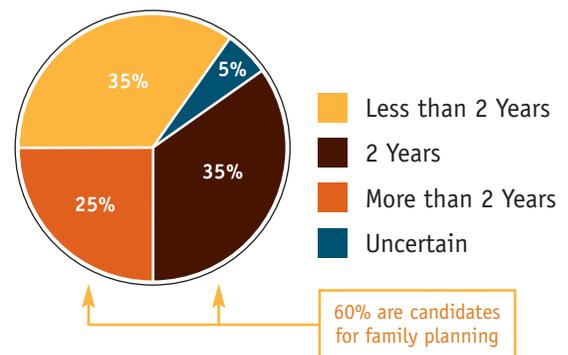
In late 2002, as the government and rebel factions edged toward a peace accord, CARE arrived in southern Maniema and, with funding from ECHO (the European Commission’s humanitarian aid branch), launched an emergency program to restart the health care system in 10 health zones across this isolated region.⁵ The program provided training to health workers in basic curative and preventive services, rehabilitated and reequipped certain facilities, and reinstated logistics for essential medical supplies.

Yet the original ECHO program did not include reproductive health services. Using data collected during a study of morbidity and mortality in two of Maniema’s health zones, CARE persuaded ECHO to fund certain services – prenatal care, safe deliveries, obstetric emergency referrals and, eventually, family planning and modern contraceptive methods – in the top-tier health facilities in southern Maniema. Convinced of the value of reproductive health services in post-conflict Congo, ECHO then went on to add these services to all its emergency health programs in the country.

CARE’s Family Planning Project (2004-2007)

The addition of family planning methods and limited services in Maniema was a good start, but it did not begin to address the tremendous, unmet need. In 2004, with funding from USAID (see box on page 4), CARE introduced the three-year Family Planning Project (FPP) in southern Maniema. The FPP delivers family planning services and products to some 228,000 women of reproductive age in Maniema and, starting in 2006, 370,000 women in East and West Kasai provinces. CARE’s goal is to reduce unplanned and unwanted pregnancies, and eventually

WHEN DO YOU WANT YOUR NEXT CHILD?
(Women only, n=614) FPP Baseline



² According to the DRC government’s Programme National de la Santé Reproductive, pre-war maternal mortality rates varied from 550 to 870 deaths per 100,000 live births between 1982 and 1991. See <http://www.minisanterdc.cd/leministere/pnsr.htm>.

³ UNICEF. “Enquête nationale sur la situation des enfants et des femmes MICS2/2001, Rapport d’analyse.” <http://www.childinfo.org/MICS2/newreports/drc/mics2%20rapport%20final%20.pdf>. 2002.

⁴ CARE DRC. “Integrated Baseline Survey, Kasongo Health Program.” 2005.

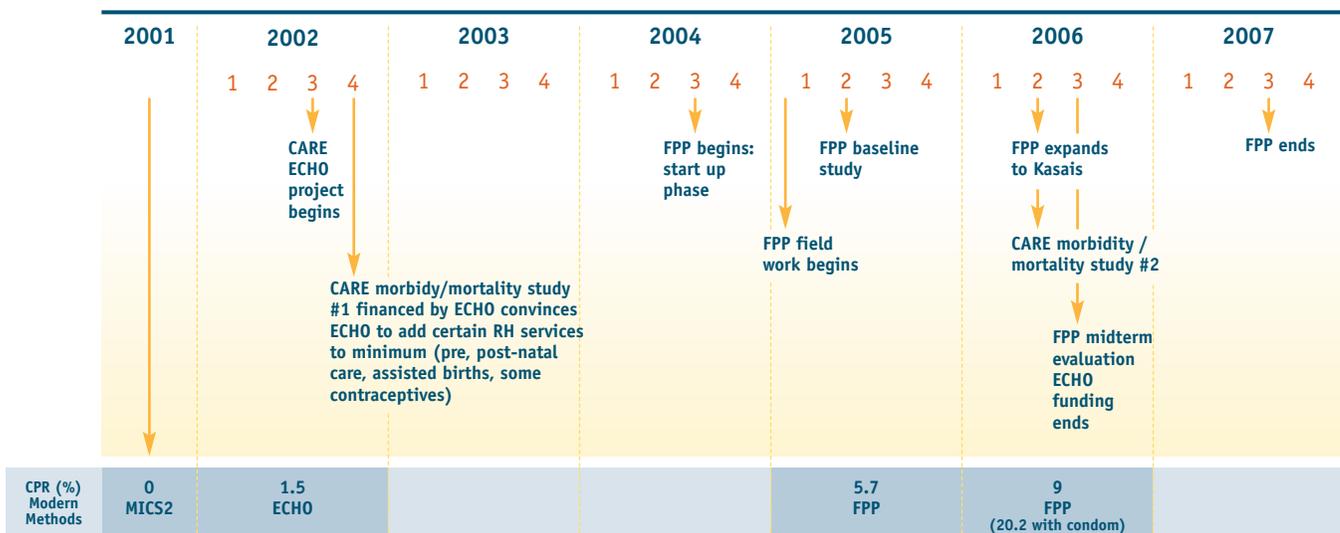
⁵ A health zone is a government-mandated administrative division.

help reduce maternal morbidity and mortality, by providing quality products and services, and increasing awareness of and demand for family planning. When CARE designed the FPP in 2004, it set certain targets to reach by the end of the project in September 2007: (a) increased availability of family planning services; (b) increased contraceptive prevalence rate (to 10 percent) for modern methods; (c) improved quality of reproductive health services; (d) positive behavioral changes in birth spacing; (e) reduced percentage of health facilities that run out of contraceptive supplies in any given month (fewer than two percent); and (f) an increase of 50 percent among women wanting to space their pregnancies.

Because of the work completed under the ECHO-funded rehabilitation project, CARE’s FPP is able to operate in a more development-oriented manner, complete with local partnerships. CARE works with the Ministry of Health (MOH) – this includes the district health apparatus and 160 health facilities, from hospitals to remote health posts – in southern Maniema, supporting providers’ ability to deliver quality family planning services. For CARE, this means regular training in the specifics of family planning and in the general management and logistics of health services, and continuous support for health worker supervision. CARE has formed alliances with community-based organizations and trained them as proponents of family planning and birth spacing in the villages they serve. Similarly, 1,500 CARE-trained peer educators are partners in the FPP; recently, 100 became community-based distributors of several types of contraceptives. The FPP has also recruited a local radio station and theater troupe to spread information on birth spacing.

The FPP promotes and supplies Depo Provera, contraceptive pills and male condoms throughout the 10 health zones. The intrauterine device and sterilization are available at certain health facilities. CARE has recently introduced the female condom, standard days and lactation amenorrhea methods to the array of options available to women and men in southern Maniema.

CARE IN KASONGO: A TIMELINE



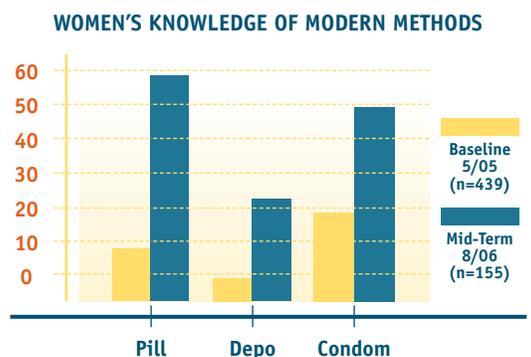
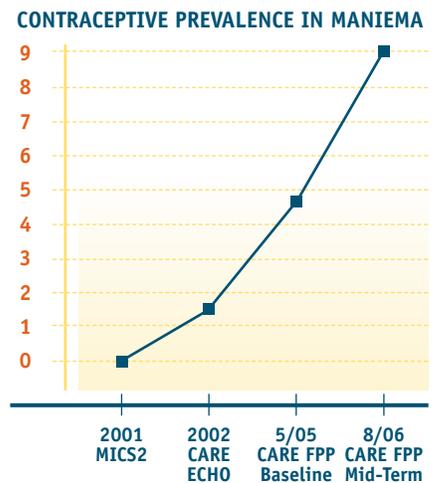
The Results at Mid-Project

After just 20 months of work with the MOH and civic organizations, CARE's three-year FPP shows clear, positive results. The mid-term evaluation found that the contraceptive prevalence rate among women had climbed to nine percent – just short of the three-year goal of 10 percent.⁶

A growing number of women are aware of modern methods. At baseline, less than 20 percent could identify a modern method of family planning; by midterm, two methods (the pill and Depo Provera) were each cited by roughly 50 percent of women surveyed.⁷ The proportion of respondents who know where to obtain contraceptive services nearly doubled, from 34 to 62 percent of women, and 44 to 77 percent of men. And the number of women wanting to space births by two years rose from

⁶ CARE DRC. "Projet Planning Familial, Maniema, Evaluation à Mi-Terme." 2006.

⁷ Men's knowledge of any contraceptive method (modern or traditional) rose from 65.1 percent at baseline to 84.8 percent at midterm; unlike women, their method-by-method knowledge was not tallied.



USAID did not initially include family planning services in its portfolio of urgent, post-war interventions in the Congo. But a handful of agency health experts, in Kinshasa and in Washington, D.C., recognized the tremendous need. "Word got around about how terrible the family planning situation was in the DRC (a fertility rate of 7.1 and so little activity during USAID's 11-year absence)," recalls a former USAID staffer, "and when USAID Washington realized they had dedicated people in Kinshasa to follow activities, they started allotting us larger sums of money each year." In 2002, Washington provided seed money to insert family planning services into USAID-funded health programs in the DRC, and in 2005 helped finance a workshop called National Repositioning of Family Planning, in which stakeholders from around the country met in Kinshasa to recommit to family planning programming. In mid-2004, USAID issued a request for proposals for a project wholly dedicated to improving access to quality family planning services – and FPP was born.

approximately 24 percent at baseline to 35.3 percent at midterm, representing the full 50 percent increase that CARE hoped to see by project's end.

CARE found an unexpected reduction in the total number of children desired by men and women in the project area. Does the change have any relation to the FPP? Does it reflect instead the extreme difficulty of rebuilding livelihoods after the war? The evaluation did not answer these questions. It did, however, measure changes in people's knowledge of the purpose of family planning. At baseline, 62 percent of women and 74 percent of men agreed with the statement, "The main role of family planning is to limit the number of children" that a couple has, rather than an opportunity to plan pregnancies no matter the number of children a couple wants. At midterm, 46 percent of women and 69 percent of men still believe that family planning's primary purpose is to limit births. The high proportion of people holding this belief seems at odds with the reduction in desired number of children, yet it illuminates certain weaknesses in the FPP's approach to understanding people's concerns about and building their demand for family planning.

TOTAL NUMBER OF CHILDREN DESIRED

Baseline 5/05	Men	10
	Women	8
Mid-term 8/06	Men	7.3
	Women	6.5

"I find the link between needs and perceptions of family planning fascinating," says Susan Igras, CARE's senior program advisor for reproductive health, who has helped guide the FPP from its inception. "During and after a crisis, the needs are huge, and service gaps are equally huge. Lives are being rebuilt from nothing, and people's desires to space births do not respond easily to simple yes/no questions. People...need children and labor to help them rebuild, and some may wish to 'replace' those they lost to war. Yet people also realize how few assets they have to create a good life for a large family. These currents of need and desire are changing over time – even as short a time as the FPP's three years – as people address their basic needs."

The Challenges

Disseminating MOH Policy Post-War In the mid-1990s, as the international community embraced the Cairo Programme of Action's call for universal access to reproductive health services, the Congo was at war and losing many of the health and service infrastructure gains made by a national family planning program that ran from 1982 to 1991. The nation did adopt a reproductive health strategy, encompassing family planning and eight

other components, and created its Programme National de Santé Reproductive in 2000, but the war prevented the translation of policy to action. This was especially true in the eastern part of the country, occupied and cut off from distant Kinshasa, and it fueled, at least in part, the Maniema provincial health system's initial skepticism that family planning was a vital, life-saving post-war intervention (see "What CARE Has Learned" below). One way that CARE tried to fill the knowledge gaps was to bring in technical partner EngenderHealth, a U.S.-based NGO, to work on concepts and approaches to quality family planning services. Another was to bring in John Snow International's DELIVER project to design a logistics and supply system.

Struggling with a Difficult Physical and Financial Environment By the time CARE arrived in Maniema province, war and pillage had finished the destruction of infrastructure – including roads and bridges – that more than three decades of kleptocracy and neglect had begun. Jean Makalele, a CARE nurse supervisor, describes the tremendous difficulty of working in a large zone without roads or bridges. "To get to the health center in Tunda, for example, takes three days by motorcycle from Kasongo [CARE's office in Kasongo is 190 miles distant from Tunda]. You have to put the bike into a pirogue to cross the Congo River. Still, it's worse to get to Pangi, where you have to cross a stream on two logs laid from bank to bank. One log is for you, the other's for your motorcycle. Once the log broke underneath me: I went right into the water and my bike followed me. Anyhow, you sleep in whatever village you find yourself in at nightfall. And remember, this is just to get to the health center. Then you have to choose which health posts to visit. You simply can't visit them all in the time allotted."

Given these difficulties, the FPP staff is probably larger than it would be in a more accessible region, and its transportation budget is higher. CARE must constantly plan for the amount of time and stress that staff members expend to reach communities and health facilities, and adjust its expected outcomes accordingly.

What CARE Has Learned

What are some hard-won lessons that CARE will carry into its future reproductive health work in the Congo?

What does CARE urge others working in post-conflict environments to consider?

- **"Do it,"** says FPP Manager Prince Kalenga, when asked what advice he would give to others who are thinking of offering family planning services in a post-crisis environment. "Family planning responds to real needs." The



formal health system may initially object, but the needs are real. In Maniema, Kalenga divides these needs into two broad categories and urges others to consider them when designing their project and especially their outreach:

1) Women’s physical and psychological needs. “I have three children,” says Sophie, a family planning user.⁸

“I want more in the future, but I need to rest. Every year I had a baby, and every time it got harder. The last time, I nearly died. When I’m pregnant, I can’t eat. In fact, when I heard about the FPP and came for a method, they first referred me to the nutritional recuperation center to gain weight.”⁹ Women in rural Maniema begin their sexual lives early, marry young and experience numerous pregnancies throughout their reproductive lives. The war added crushing burdens: displacement, violence and rape, loss of family members and economic assets. Family planning represents, in many cases, a respite and an opportunity to control at least one aspect of one’s body and life. Women and men may not express the need for contraceptives directly, but, as seen in the FPP baseline, they clearly wish to manage their reproduction. “My health is better, and mentally I’m feeling better, too,” says Anastasie, another woman who uses family planning. “Life is still very tough; it’s difficult to raise children and meet all their needs. But I’m really happy to have chosen a method. I am free to try my best for my children.”

“Now that I can control my pregnancies, I can be sure that my children go to school. I never had the time to finish my studies, but they will. I will see a better life through my children.”

**– Anifa,
contraceptive user**

2) Households’ social and economic needs. The war’s effects on the people and economy of rural Maniema have been profound, and families are still struggling to recover from the loss of animals, houses, crops and tools. “People who use family planning have time to work,” says Omari Sibazuri, president of the community-based organization and CARE partner Mamans Muselmanes de Maniema. “Family planning lets the household rebuild its economy, get some income. A woman can work in the fields freely – she doesn’t have to worry about leaving the baby at home. In the long run, she will have to work less, and her resources will go further.” Dieudonné Abombo, director of the theater troupe Amis de Bondo, which works with CARE to spread the word about planned pregnancies, speaks of family planning as a personal and even social responsibility. “It’s wrong to bring children into the world only to expect others to take care of them,” he says. “My older children had to carry the younger ones on

⁸ Only women’s first names are used to protect their privacy.

⁹ The nutritional recuperation center is a program run by the NGO Concern.

their backs.” Since he and his wife Charlotte, lead actress in Amis de Bondo, began to space their children, he says, “We were able to buy land. Now we live on our own land. We bought a radio and some goats. All our children are in school.”

- **The health system may initially doubt that family planning is an urgent, post-crisis need, but evidence will overcome doubt.** “You’ll have lots of resistance, because in a post-crisis context the people have so many needs: food, health care, clothing, everything,” says Kalenga. “They have no crops, no livestock. This is your first obstacle. People will say, ‘Why a family planning project, when what we really need is food?’”

As noted, national reproductive health policy and priorities, including family planning services and information, had not filtered down to Maniema when CARE began the FPP. Many workers in the provincial health pyramid needed evidence – through training and hands-on service provision to women – to grasp the fundamental role that family planning plays in the health of individuals and households.

Timothée Kitoko, formerly a MOH nurse supervisor, recalls his reaction when he first heard about the FPP. “I wasn’t happy, especially with all the other needs. Why not bring in a project that would help, for example, with food supply? But eventually I understood that in the post-war days especially, there were so many maternal deaths and even illegal abortions, and that family planning responded directly to these problems.” CARE’s Jean Makalele echoes this notion: “With time – in fact, when they saw that women were truly grateful – health workers realized that the need was real, even if it hadn’t manifested itself as obviously as other needs.”

- **Get to know the population in the project zone – their traditions and concerns – before introducing family planning.** CARE’s FPP began with an emphasis on building a supply of services, and secondarily turned to building demand. Staff members were certainly aware that the project zone was home to Christians (Catholics and Protestants) and Muslims in roughly equal numbers, and that everyone had been affected by the war. However, this knowledge remained largely theoretical even as CARE planned its education and information campaigns.

Aruna Saleh, head nurse at 18 Kilometer Health Center, notes, “On the social plane, you must be sure that your approach meshes with the character of the population. With Muslims, for example, you must take polygamy into account. Rather than attack their beliefs, find a way to show them how family planning will benefit them within their system, within their culture.” With time and dialogue, CARE has reached a certain détente with leaders of both religions. Notably, both Muslim and Christian women have shown less resistance to the concept of family planning than their religious leaders.

*“If you ignore the culture,
you reject its people.”*

– Aruna Saleh,
health center head nurse

More difficult to overcome have been people’s fears and perceptions linked to their traditions and their war experiences. Marie Louise Kilundo, FPP education specialist, recounts some rumors she has encountered in the field. “People said that the pill would stop procreation, that its purpose was to prevent Congo from rebuilding its population after the war. Worse, some thought that the condoms were imported from Rwanda [an enemy during the war], where they had all been infected with the AIDS virus.”

CARE’s educational approach with communities did not initially respond to local beliefs that fear of pregnancy is the sole deterrent to women’s promiscuity (“if my wife uses contraceptives, she will become a prostitute” is men’s most common objection), nor did it link communities’ desire to space pregnancies by traditional efforts (such as separation of spouses until the child is old enough to walk) to modern methods. CARE now must expand its information and education component – which currently focuses on knowledge of family planning methods and the physical and economic benefits of planned pregnancies – to address these deep-rooted concerns.

• **Step back from a directive role when transitioning from emergency to development programming.** CARE began the ECHO health system rehabilitation project even before Congo’s warring factions signed their peace accord. Because the system had deteriorated so badly, CARE’s role vis-à-vis the MOH was more directive than suggestive, more active than supportive. Three years later, the transition to the development-oriented family planning project required staff to take a different, more egalitarian approach with counterparts in Maniema province, and the change did not always come easily. The FPP’s system of supportive supervision is a good example.

CARE’s FPP staff includes five nurse supervisors, who provide ongoing guidance to health workers and build supervisory capacity within the MOH by arranging regular, joint supervisory tours of the 160 health facilities in the project zone. But local health officials have been ambivalent: they argue that CARE should limit itself to project monitoring and evaluation, and leave staff supervision to the MOH. Yet they also recognize that CARE – and not the MOH, at present – has the resources to manage a proper supervisory system. As CARE transfers skills to the MOH, its staff must remain aware of the tensions inherent in the changing relationship.

Next Steps

The success of CARE's FPP to date speaks eloquently to women's and families' need and desire for reproductive health services in times of crisis and post-crisis, and offers further counterpoint to those who would relegate family planning services to second- or third-tier interventions in the wake of war. The FPP has increased contraceptive prevalence rates in Maniema dramatically, and built a base of quality services and supplies where virtually none existed.

CARE is now transforming the solid, successful FPP into a project that meets the needs of far more people, can sustain its quality over the long term, and serve as a model for others. In the remaining months of the original project – and with an invitation from USAID to extend the project well into 2008 – CARE is:

Increasing people's knowledge of, favorable attitude toward, and use of contraceptive methods well beyond originally intended levels. CARE staff and partners are dismantling barriers to contraceptive use, including misinformation about the purpose of family planning, rumors about effects of contraceptives, and fears that contraceptives will upset the current social balance between men and women. CARE is undertaking original research to better define misinformation, fine-tuning and expanding its educational activities and materials, and increasing the role that men and youth play in the project.

Better assuring sustainability of family planning services and supplies. CARE is helping the health system and communities take increasing responsibility for the provision of quality family planning services to help meet the challenge of maintaining services and service quality over a large, difficult terrain and with a resource-poor health system. To do this, FPP is reinforcing the logistics system that moves contraceptive supplies to sales or distribution sites, doubling the number of community-based sales agents and of peer educators, and working intensely with communities to develop a monitoring and evaluation process that will allow them and their local health facility to track progress, measure impact and detect and resolve problems in local family planning services.



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