Routledge Studies on Gender and Sexuality in Africa

FIFTY YEARS OF FAMILY PLANNING IN THE DEMOCRATIC REPUBLIC OF THE CONGO

THE DOGGED PURSUIT OF PROGRESS

Jane T. Bertrand

ROUTLEDGE

"Jane Bertrand has advanced a compelling narrative of how national policies cannot be implemented in isolation of geopolitical dynamics. DRC, an FP2030 commitment maker, has had a long resolve to provide family planning. The tenacity of key actors to provide skillful leadership has yielded results. Undoubtedly, a lot still needs to be done."

Dr. Samukeliso Dube, *Executive Director FP2030*

"A passionate advocate for women's rights and a keen evaluator of healthcare systems, Dr. Bertrand's meticulous examination of fifty years of family planning policy in the DRC is enlightening. This thought-provoking book unveils the remarkable tenacity of family planning in a challenging environment and highlights the boundless potential of the ongoing contraceptive revolution."

Dr. Fatimata Sy, *Former Director of the Ouagadougou Partnership Coordination Unit*

"Professor Jane T Bertrand has used her passion for Reproductive Health and her profound knowledge of Congolese people to produce a book that will stand as a must read for a wide range of professionals both inside and outside of the Democratic Republic of Congo. Her book has the ability of making the tortuous history of the country in the heart of Africa comprehensible if not attractive, including through inspirational stories."

Dr. Malonga Miatudila, *former World Bank official and co-author of Beyond the Storm*

"A treasure trove for those committed to accelerate progress in family planning in today's context of decolonization and locally led development. Powerful insights on leadership, stakeholder engagement, courage, and women's agency – key factors that family planning champions will need to consider for sustaining the gains made in recent decades. A gift to the family planning community."

Pape Amadou GAYE, *Founder and President, Baobab Institute for Health and Development*

"The DRC is facing the development challenges posed by a very young population of nearly 100 million, likely to double in 22 years. How will the reproductive health needs of the Congolese be met? This book offers discerning insights into the prospects of a complicated country with exceptional promise."

Dr. Amy O. Tsui, *Professor Emerita, Johns Hopkins Bloomberg School of Public Health*

Fifty Years of Family Planning in the Democratic Republic of the Congo

This book chronicles five decades of struggle to introduce family planning into one of the largest, most complex countries in sub-Saharan Africa: the Democratic Republic of the Congo (DRC).

Interweaving details of major political, social, and economic events into the history of family planning in DRC (formerly Zaïre), the book analyses the achievements and setbacks of five decades of programmatic work. President Mobutu's 1972 discourse on *Naissances Désirables* (desirable births) opened the door to organized family planning programs, which gained considerable momentum in the 1980s despite societal norms favoring large families. Two pillages and armed conflict paralyzed development work during the decade of the 1990s, and family planning was one of multiple public health programs that struggled to regain lost ground in the 2000s. With new donor funding and implementing agencies, the 2010s witnessed rapid programmatic expansion and improved strategies. By 2018, family planning was operating as a well-oiled machine. But progress is fragile. The book ends by tracing the deleterious effects of the colonial period to contemporary programming and individual contraceptive use. It asks hard questions about donor financing. And it details the six conditions needed to accelerate family planning progress in the DRC, in pursuit of providing millions of Congolese women and men with the means of controlling their own fertility.

The book will be of interest to development and public health researchers and practitioners, as well as to historians of the Democratic Republic of the Congo.

Jane T. Bertrand is the Neal A. and Mary Vanselow Professor at Tulane School of Public Health and Tropical Medicine, New Orleans, Louisiana, USA. For over four decades, Bertrand has combined an academic career of classroom teaching and publication with active engagement in family planning programs in Guatemala, Morocco, and Zaïre/DRC. A specialist in Monitoring and Evaluation, she has researched barriers to contraceptive use and assessed program performance. As director of the Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health from 2001 to 2009, Bertrand supported programs worldwide in Social and Behavior Change Communication across multiple public health topics.

Routledge Studies on Gender and Sexuality in Africa

6. Women, Agency, and the State in Guinea
Silent Politics
Carole Ammann

7. Women and Peacebuilding in Africa
Edited by Anna Chitando

8. Gender, Conflict and Reintegration in Uganda
Abducted Girls, Returning Women
Allen Kiconco

9. The Politics of Biography in Africa
Borders, Margins and Alternative Histories of Power
Edited by Anaïs Angelo

10. Gender, Judging and the Courts in Africa
Selected Studies
Edited by J. Jarpa Dawuni

11. Girls Negotiating Porn in South Africa
Power, Play and Sexuality
Deevia Bhana

12. Gendered Spaces, Religion and Migration in Zimbabwe
Implications for Economic Development
Edited by Ezra Chitando, Sophia Chirongoma and Molly Manyonganise

13. Fifty Years of Family Planning in the Democratic Republic of the Congo
The Dogged Pursuit of Progress
Jane T. Bertrand

14. Gender-Inclusive Higher Education in Tanzania
Transforming Academia
Edited by Susan P. Murphy and Perpetua John Urio

For more information about this series, please visit: https://www.routledge.com/Routledge-Studies-on-Gender-and-Sexuality-in-Africa/book-series/GSA

Fifty Years of Family Planning in the Democratic Republic of the Congo

The Dogged Pursuit of Progress

Jane T. Bertrand

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2024
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-032-71887-3 (hbk)
ISBN: 978-1-032-71890-3 (pbk)
ISBN: 978-1-032-71889-7 (ebk)

DOI: 10.4324/9781032718897

Typeset in Galliard
by Taylor & Francis Books

Contents

Figures

Boxes

Preface

I began my career in international family planning in the 1970s, focusing on Latin America. I taught a course in Mexico, worked on a communication program in El Salvador, and conducted research on family planning in Guatemala. In short, my real-world education in family planning came from Latin America.

In 1979, my husband Bill Bertrand encouraged me to accompany him to Kinshasa, Zaïre (the former Belgian Congo), where he had recently started a project. To close the deal, he quipped, "You have to go through Paris to get there." A year later, I found myself starting a small USAID-funded project in Bas Zaïre, which I then visited 3–4 times a year. Yet it was not until 1986 that as a family with small children, we took up full-time residence for four years in Kinshasa.

By the mid-1980s, Latin America was making remarkable progress in family planning. The percentage of women using modern contraception was rising steadily, and the desire for small families was so strong that voluntary female sterilization had become the leading method in several Latin countries. Yet my initial foray into family planning in Zaïre had made me keenly aware that most *Zaïrois* aspired to large families. I would need to work within a very different set of cultural norms in Zaïre than I had experienced in Central America and Colombia.

In 1986, family planning programming in Zaïre was in its infancy. My job was to set up an evaluation unit within this new Family Planning Services Project (PNSD). One of the perks of the position was having a driver, Kasui, who would pick me up from home each morning in a cream-colored Land Rover, the classic vehicle for development work in Africa at the time.

Kasui and I would spend hours together in the Land Rover, driving through Gombe, the administrative center of the city built by the Belgians in the 1940s and 50s. On other days we would navigate the almost impassable roads of the *cité*, the sprawling slums that encircled Gombe, to reach a remote health center. We traveled together down Highway 1 en route to the port city of Matadi, some five hours from Kinshasa, where we also had project activity. Kasui hoisted my three-year-old daughter on his shoulders as we strolled through Lac Ma Vallée, the park on the outskirts of Kinshasa.

Kasui looked to be around 40, medium height, with dark-rimmed glasses. Whatever personal struggles he might have had in raising a family on the meager salary of a driver, he never complained. Rather, he would arrive each morning with

a smile, ready for the day's assignment. His casual observations as we bounced around in the Land Rover were my daily education in "how things worked" in Zairian society. Yet decades of colonial rule were ever present in interpersonal relations between Zairians and *mundeles* (whites), invariably in positions of power. Kasui was open, outgoing, and friendly, but always deferential.

We had engaged in these casual conversations for several months when Kasui finally screwed up the courage to ask me the question that was on his mind.

"Madame Jane, I need your advice on a personal matter. You work in family planning."

"Yes?"

"My wife and I have eight children, and we need to find a way to stop having more."

I curbed my immediate instinct to suggest the option taken by so many women in Latin America: female sterilization. Instead, I asked: "Has your wife tried the oral pill?"

"Yes, but she didn't tolerate it well."

"How about the IUD? Have you heard of that method?"

"No, that wouldn't work for her," he replied.

"You could use condoms."

"No, I don't like condoms."

And so the conversation went on until I had mentioned every available contraceptive method except sterilization. Having exhausted all other options, I asked, "Are you aware there is a permanent method? A woman can get her tubes tied, and she never has to worry about pregnancy again."

There was a long pause in the conversation. Finally, Kasui turned to me. "Madame Jane, you don't understand. We have eight children, and our marriage is rocky. I'm not sure we are going to stay together. And if we do split up, my wife will need to have another child with her new husband."

I quickly came to realize that I still had a lot to learn about family planning in this country.

******

By 2023, I had been a university professor for 44 years – 36 at the Tulane School of Public Health and Tropical Medicine and eight at the Johns Hopkins Bloomberg School of Public Health. For 24 of those 44 years, I worked on family planning in the Congo: from 1980–89 when the country was named Zaïre, and then from 2010–23 by which time it had been renamed the Democratic Republic of the Congo (DRC). As I neared the end of my 44-year academic career, I felt compelled to write this book on the five decades of family planning in Zaïre/DRC. To satisfy my curiosity, I wanted to better understand how the pieces of the puzzle fit together, especially during the years when I was working elsewhere. For professional reasons, I felt that it was important to document the progress made and the challenges encountered in implementing family planning in a fragile country shaped by extreme political turmoil and devastating economic crises.

The financial support for this family planning work came from international donor agencies. From 1980–89, USAID contracted with Tulane to collaborate with Congolese organizations – both government and private – on different aspects of family planning programming. Between 2010–2023, multiple donors funded Tulane's work: the Bill and Melinda Gates Foundation, the David and Lucile Packard Foundation, DFID (the UK development agency, renamed FCDO in 2020), the Norwegian government via the Central African Forest Initiative/FONAREDD, UNFPA, The Clinton Health Access Initiative, and a private individual in Boston who made his donations anonymously. The funding since 2010 supported project work across a range of activities: advocacy/policy, service delivery, pilot testing of innovative strategies, monitoring and evaluation, and other types of applied research.

During most of these 24 years of working in family planning in Zaïre/DRC (divided by a 20-year hiatus from 1990 to 2009), I maintained my residence in New Orleans, Louisiana, but traveled 3–5 times a year to the country to work with Congolese and expatriate colleagues on our projects. Only from 1986–89 did I live full-time in Kinshasa. During this highly rewarding period, I was able "to do international family planning" ten minutes from my front door.

This book is not a memoir, although it does capture some of the work Tulane has undertaken in Zaïre/DRC. Nor is it an attempt to distill the published literature of over 40 years on the topic. Rather, it is an individual narrative, based on three main sources: existing publications (books, articles, reports, news stories), some hundred interviews conducted with individuals who played a role in this history, and the 24 years of working off and on in-country. My aim is to capture this slice of history and to extract the lessons it provides for the future of family planning in the DRC.

Whereas the history of family planning in the Congo starts in 1972, the factors that have shaped the country to this day date back to the colonial era: King Leopold II's Congo Free State (1885–1908) and the Belgian Congo (1908–1960). The book is written in three parts. The early chapters provide an abbreviated history of the political, economic, and social context leading up to the 1970s, with an emphasis on events that shaped women's lives and their reproductive aspirations. Part II starts with the 1970s; each chapter provides a historical account of family planning against the backdrop of the political and social conditions of each decade. The 50 years of family planning captured in this narrative run from 1972–2022, although the chapters are organized by decades. Part III summarizes the influence of the country's history on individual contraceptive practice and family planning programming today. It addresses a series of provocative questions about future funding, and it concludes by identifying six conditions that need to be in place to accelerate progress in family planning in the future.

Since independence in 1960, changes have occurred in the name of the country; the number, names, and delineation of the provinces; and the names of the major cities, the currency, and the major river running through the country. Where provinces are cited in a given chapter, they refer to the administrative delineations in effect in that decade.

True to my academic roots, I have peppered the book with citations, especially for the decades prior to the 1970s when I depended entirely on the work of other authors and sources for historical insights. When multiple ideas came from a single source, I have indicated the page range rather than repeatedly naming the source. Starting in the decade of the 1970s, much of the material draws on interviews with colleagues who worked in family planning in Zaïre/DRC at some point in the past five decades. I have not cited the source of these interviews in the endnotes of each chapter, especially where I obtained sensitive information given to me in confidence. Often the reader will be able to surmise my sources from the names in the narrative.

I have tried to make this book as factual as possible, yet there is inevitably an aspect of subjectivity that creeps in: in the topics included, interpretation of events (especially those I experienced personally), and reflections in the final chapter.

Some readers may wonder why I have chosen to focus narrowly on family planning when the field has expanded to a more inclusive approach known as sexual and reproductive health and rights (SRHR). Contraception is one component of SRHR, alongside maternal and newborn health, HIV/AIDS and other sexually transmitted diseases, gender-based violence, safe abortion, infertility, and reproductive cancers, among others. In fact, family planning is often delivered through "integrated programs" that offer a range of services as part of a more comprehensive approach. But as one Congolese colleague put it, "What good is it to have family planning in name only in an integrated project if there are no contraceptives on the shelves?" Whereas the field has benefited from colleagues who have dedicated their lives to other aspects of SRHR or have worked to promote SRHR as a package of interventions, I have opted to work specifically in family planning. I remain as convinced as I was when I started graduate school in family planning in 1972: contraception is a game-changer for women, for their families, and for entire countries.

This book was written as a tribute to the men and women who have worked tirelessly to promote family planning in a country where public health work is often challenging and this topic remains controversial. To this group, I hope I have been faithful in telling the story that is rightfully yours.

Jane T. Bertrand
October 9, 2023, New Orleans, LA, USA

Acknowledgments

I owe a debt of gratitude to the many individuals whom I interviewed for this book, most worked in family planning in Zaïre/DRC in one or more of the decades since the 1970s. To a person, they were generous in sharing insights that allowed me to weave together a narrative spanning over 50 years. I am particularly appreciative of those to whom I returned repeatedly to review entire chapters, provide context, or confirm obscure details of events occurring decades ago: Franklin Baer, Julie Hernandez, Malonga Miatudila, Thibaut Mukaba, Bitshi Mukengeshayi, Mbadu Muanda, and Théophile Nemuandjare.

I was fortunate to have four superb research assistants in compiling this book: Lindsay (Charlie) Brink, Jennie Racher, Sydney Sauter, and Gael Compta. Awen Southern edited all aspects of the French. Others who supported this effort included Pierre Akilimali, Maria Carolina Herdoiza, Emma Powers, Annie Mongay, and Candelaria Martinez.

Bill Bertrand, who correctly takes credit for my first visit to Zaïre in 1979, had valuable institutional memory for all things public health in the DRC. His insights, acts of service, and excellent culinary skills contributed greatly to the completion of this book.

Sadly, Ruth Anne Galloway, who provided documents and photos of her parents Ralph and Florence Galloway, passed away before she could see their work memorialized in this book.

Tulane's project activity in the DRC over the past decade would not have been as effective or rewarding without the hard work of the Tulane International staff, based in Kinshasa: Arsène Binanga (Country Director), Franck Akamba, Rianne Gay, John Kimfuta, Deborah Kiwele, Paul Lusamba, Zénon Mujani, Claude Nduku, Delphin Ngoie, Cathy Putela, Maria Sebo, and Joyce Visi.

Thanks to Helena Hurd, Senior Editor/Global Development and African Studies, and Katerina Lade, Editorial Assistant, at Routledge for their patience and advice at all stages in the publication process. Nick Taylor did a superb job with copy editing, and Matthew Twigg oversaw the production process. I am grateful to Ashley Farley of the Bill and Melinda Gates Foundation (BMGF) for encouraging the open-access publication of this book.

Finally, I am appreciative of the organizations and persons who supported my efforts in writing this book. I am fortunate to hold the Neal A. and Mary Vanselow Endowed Chair at the Tulane School of Public Health and Tropical Medicine,

and I thank Dr. Thomas LaVeist, Dean, for granting my sabbatical year. The BMGF (INV-033621) and the David and Lucile Packard Foundation (grant 2022–73375) also supported my sabbatical. I am grateful to Perri Sutton and Temple Cooley for their invaluable oversight of Tulane's work in the DRC, as well as the friendship of many years.

Acronyms

ABEF-ND: *Association pour le Bien-Être Familial–Naissances Désirables* (the Association of Family Wellbeing – Desirable Births)

AcQual: *Accès et Qualité* (Access and Quality)

ADFL: *Alliance des forces démocratiques pour la libération du Congo-*Zaïre (Alliance of Democratic Forces for the Liberation of Congo)

AED: Academy for Education Development

AFEAC: *Association des Femmes Avocates de la RDC* (Association of Women Lawyers in the DRC)

AFP: Advance Family Planning Project

AfriYAN: African Youth and Adolescent Network

ASD: *Action Santé et Développement* (Action for Health and Development)

ASF: *Association de Santé Familiale* (Family Health Association)

ASSP: *Accès aux soins de santé primaires* (Access to Primary Healthcare Project)

ASSR: *Appui au système de santé en RDC* (Supporting the Health System in the DRC)

AVSC: Association for Voluntary Surgical Contraception

AXxes: Integrated Health Services Project

AZBEF: *Association Zaïroise de Bien-Être Familial* (The Zaïre Association for Family Wellbeing)

BCK: *Compagnie du chemin de fer du Bas-Congo au Katanga* (Bas-Congo Railway Company in Katanga)

BCZ: *Banque commerciale du Zaire* (Commercial Bank of Zaïre)

BHR: Bureau of Humanitarian Affairs, USAID

BMGF: Bill and Melinda Gates Foundation

BRH: Basic Rural Health Project

CA: Cooperating Agency (of USAID)

CAFCO: *Cadre Permanent de Concertation des Femmes Congolaises* (Permanent Consultative Group of Congolese Women)

CAFI: Central African Forest Initiative

CBD: Community-based distribution (or distributor)

CBZO: *Communauté baptiste du Zaire-Ouest* (Baptist Community of West Zaïre)

CCP: Center for Communication Programs, John Hopkins University

CDC: Centers for Disease Control and Prevention

CDR: *Centrale de distribution régionale* (regional warehouse for commodities)

CECAP: *Cellule de coordination des activités en matière de population* (Population Activities Coordination Unit)

CEPLANUT/ PROPLANUT: *Centre de planification de nutrition / Programme national de nutrition* (Center for Nutrition Planning / National Nutrition Program)

CMC: Mennonite Church of Zaïre

CNND: *Comité national des Naissances Désirables* (National Committee of Desirable Births)

CNPPND: C*onseil national pour la promotion des Naissances Désirables* (National Council for the Promotion of Desirable Births)

CODESA: *Comité de développement sanitaire* (community health committee)

CONAPO: *Conseil national de la population* (National Population Council)

COP: Chief of Party

CPF: Counterpart fund

CPS: Contraceptive prevalence survey

CRESAR: *Cellule de recherche en santé de la reproduction* (Research Unit on Reproductive Health)

CSM: Contraceptive social marketing

CTMP: *Comité technique multisectoriel permanent* (Multisectoral Permanent Technical Committee)

CYP: Couple-years of protection

D4I: Data for Impact

DEP: *Direction des études et planification* (Direction of Research and Planning)

D6: *Direction de l'enseignement des sciences de santé (*Direction of Health Sciences Education)

DFID: Department for International Development of the UK

DHIS2: District health information software 2

DHS: Demographic and Health Surveys

DPP: *Direction provincial du plan* (Provincial Department of Planning)

DPS: *Division provinciale de la santé* (Provincial Department of Health)

DRC: Democratic Republic of the Congo

DSSP: *Direction des soins de santé primaire* (Primary Healthcare Directorate)

EC: Emergency contraception

ECC: *Église du Christ au Congo* (Protestant Churches of Congo)

ECZ: *Église du Christ au Zaïre* (Protestant Churches of Zaïre)

EGPAF: Elizabeth Glazer Pediatric AIDS Foundation

EPSS: *Evaluation des prestations des services de soins de santé* (Evaluation of Healthcare Service Delivery)

FAA: Foreign Assistance Appropriation

FAO: Food and Agriculture Organization (United Nations)

FCDO: Foreign, Commonwealth & Development Office of the UK

FESPACO: *Festival Panafricain du Cinéma d'Ouagadougou* (Ouadadougou PanAfrican Film Festival)

FOMECO: *Fonds médical de coordination* (Medical Coordination Fund)

FOREAMI: *Fonds Reine Élisabeth pour l'assistance médicale aux Indigènes du Congo belge* (Queen Elisabeth Fund for Native Medical Assistance)
FP CAPE: Family Planning Country Action Process Evaluation
FP: Family planning
FPIA: Family Planning International Assistance
FSN: Foreign service nationals
GAO: Government Accountability Office
GEAS: Global Early Adolescent Study
GFF: Global Financing Facility
GHSC-PSM: Global Health Supply Chain – Procurement and Supply Management project
GNP: Gross national product
GOZ: Government of Zaïre
GUG!: Growing up Great!
HCB: *Huileries du Congo belge* (Oil mills of the Belgian Congo)
HPP-Congo: Humana People to People – Congo
ICFP: International Conference on Family Planning
ICPD: International Conference on Population and Development
ICRC: International Committee of the Red Cross
IEC: Information-Education-Communication
IFFLP: International Federation for Family Life Promotion
IMCK: *Institut médical chrétien du Kasaï* (the Christian Medical Institute of Kasaï)
IME: *Institut médical evangélique* (Evangelical Medical Institute)
iNGO: international non-governmental organization
IPPF: International Planned Parenthood Federation
IRC: International Rescue Committee
IRH: Institute for Reproductive Health/Georgetown University
IUD: Intra uterine device
IYDA: Integrated Youth Development Activity
JSI: John Snow, Inc
KSPH: Kinshasa School of Public Health
LAD: Large anonymous donor
LAM: Lactational amenorrhea method
LMIC: Low- or middle-income country
LMIS: Logistics management information system
MAF: Mission Aviation Fellowship
MCH: Maternal and child health
MCPR : Modern contraceptive prevalence rate
MCZ: *Médecin chef de Zone* (Chief District Medical Officer)
MDGs: Millennium Development Goals
MERLIN: Medical Emergency Relief International
MICS: Multiple Indicator Cluster Surveys

MNCH: Maternal newborn and child health

MOH: Ministry of health

MONUC: *Mission de l'Organisation des Nations unies en République démocratique du Congo* (United Nations Organization Mission in the DR Congo)

MONUSCO = *Mission des Nations Unies pour la stabilisation en RD Congo* (United Nations Stabilization Mission in DR Congo)

MSF: *Médecins Sans Frontières* (Doctors without Borders)

MSH: Management Sciences for Health

MSI: Marie Stopes International

NGO: non-governmental organization

NIAID: National Institutes of Allergy and Infectious Disease

NIH: National Institutes of Health

ODSEF: *Observatoire démographique et statistique de l'espace francophone* (Demographic and Statistical Observatory of the francophone Area)

OR/TA: Operations Research and Technical Assistance

OTI: Office of Transition Initiatives

OXFAM: Oxford Committee for Famine Relief

PARSS: *Projet d'appui à la réhabilitation du secteur santé* (Project of Support for the Rehabilitation of the Health Sector)

PDSS *: Projet de développement du système de santé* (Health Services Development Project)

PEPFAR: President's Emergency Plan for AIDS Relief

PES: Post-enumeration survey

PEV: *Programme élargi de vaccination* (Expanded Vaccination Program)

PHC: Population and Housing Census

PI: Principal investigator

PID: Project Identification Document

PMA: Performance Monitoring for Action

PMA2020: Performance Monitoring and Accountability 2020

PMTCT: Prevention of mother-to-child transmission (of HIV)

PNAM: *Programme national d'approvisionnemet en médicaments* (National Program for Essential Medicines)

PNND or PND: *Programme national de Naissances Désirables* (National Program for Desirable Births)

PNSA: *Programme national de santé de l'adolescent* (National Program for Adolescent Health)

PNSR: *Programme national de santé de la reproduction* (National Program for Reproductive Health)

PPE: Personal protective equipment

PRODEF: *Projet d'éducation familale* (Family Education Project)

PROMIS: *Programme de mise à l'échelle de la planification familiale* (Project to Scale up Family Planning)

PROSANI: *Programme de santé intégré de l'USAID* (Integrated Health Program, USAID)

PSI: Population Service International

PSND: *Projet des services des Naissances Désirables* (Desirable Births [Family Planning] Services Project)

RAISE: Reproductive Health Access, Information and Services in Emergencies

RAJECOPOD: *Réseau des Adolescents et Jeunes Congolais en Population et Développement* (Network of Adolescent and Young Congolese in Population and Development)

RAPID: Resources for the Awareness of Population Impact on Development

RBF: Results-based financing

REEJER: *Réseau des Éducateurs des Enfants et Jeunes de la Rue* (Network of Educators of Street Children and Youth)

RIG: Regional Inspector General

RPF: Rwanda Patriotic Force

SANRU: *Projet des soins de santé primaires en milieu rural* (known in English as the Basic Rural Health Project)

SCEV: *Service central d'éducation à la vie* (Central Office for Family Life Education)

SCOGO: *Société congolaise de gynécologie et d'obstétrique* (Congolese Society of Gynecology and Obstetrics)

SCOSAF: *Société congolaise de la Pratique Sage-Femme* (Congolese Society of Midwives)

SDGs: Sustainable Development Goals

SDM: Standard Days Method

SGBV: Sexual and gender-based violence

SIAPS: Systems for Improved Access to Pharmaceuticals and Services

SIDA: Swedish International Development Cooperation Agency

SIFPO: Support for International Family Planning and Health Organizations

SNIS: *Système national d'information sanitaire* (National Health Information System)

SPA: Service Provision Assessment

SPHTM: School of Public Health and Tropical Medicine

SSA: Sub-Saharan Africa

SSP: *Soins de santé primaires* (Primary healthcare)

SSR: *Soins de santé de la reproduction* (Reproductive healthcare)

TASOK: The American School of Kinshasa

TIPPS: Technical Information on Population for the Private Sector

ToR: Terms of Reference

UMHK: *Union minière Haut Katanga* (Haut Katanga Mining Union)

UNAZA: *Université nationale du Zaïre* (National University of Zaïre)

UNDP: United Nations Development Program

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

UNIKIN: *Université de Kinshasa* (University of Kinshasa)

USAID: United States Agency for International Development

VYA: Very young adolescents

WHO: World Health Organization

WISH: Women's Integrated Sexual Health project

Part I

The Decades that Shaped the Congo

1 The Congo Free State (1885–1908)

Leopold II claims Congo for his own

"Dr. Livingstone, I presume?"

These were the fabled words that Henry Morton Stanley claimed to have spoken to David Livingstone when he came upon a pale white man debilitated by illness in the heart of Africa. For eight months, Stanley had trudged through 700 miles (1,100 km) of tropical landscape in search of the famed missionary and explorer who had fallen out of touch with the outside world for almost six years. The date was 1871. The place was Tanganyika.[1]

In the years that followed, Henry Morton Stanley would go on to play an extraordinary role in the exploration and exploitation of the Congo Basin in central Africa. His fame as an explorer soared with the grueling four-year trans-Africa expedition, commissioned by the *New York Herald* and *Daily Telegraph*. He set out from Zanzibar in East Africa in 1874 on the *Lady Alice* to complete the exploration and mapping of the Central African Great Lakes and rivers.[2] After mapping the Great Lakes, he pushed westward. His team suffered from torrential rains, hunger, festering sores, malaria, and dysentery. They were attacked by local populations with poisoned arrows and spears. But Stanley persevered.[3] By 1877 he had reached a major river that natives confirmed to be the Congo. The expedition continued downriver to the rapids at Stanley Pool (current day Kinshasa) and from there to the mouth of the Congo in Boma.[4] Against all odds, Stanley became the first man to successfully traverse the African continent. Of his original party of 228, 114 were still alive at the journey's end. Of the four white explorers on this adventure, Stanley alone survived.[5]

In 1878, Henry Stanley would sign on with King Leopold II of Belgium to do his bidding in the Congo Basin, a partnership that would have a calamitous impact on history. Stanley would have preferred to represent England in his further explorations of Africa, but his reputation for looting and atrocities committed on the African continent had proceeded him.[6] For that very reason, King Leopold II felt Stanley would be well suited to the mission he envisioned for him.

King Leopold II was the monarch of a small "insignificant" European country with grandiose ambitions for personal wealth.[7] Stanley's excursions into Africa caught his

DOI: 10.4324/9781032718897-2

imagination, and as the craze for annexation of territory in faraway lands began to sweep Europe, Leopold II strategically positioned himself in the mix. In 1876, he convened the Brussels Geographic Conference, to which he invited celebrated geographic scientists and wealthy philanthropists. From this meeting, he created the International African Association for the purported purpose of discovering the largely unexplored Congo and "civilizing" the population.[8] He went on to form the Committee for Studies of the Upper Congo two years later, which would be renamed the *Association internationale du Congo*. He claimed to be opening the African interior to European trade along the Congo River. It was not by coincidence that he was the primary actor in each of these endeavors.

When Stanley set out for Africa in 1879, Leopold II's orders were clear. "It is not about Belgian colonies. It is about establishing a new state that is as large as possible and about its governance. It should be clear that in this project there can be no question of granting the Negroes the slightest form of political power. That would be ridiculous. The whites, who lead the posts, have all the power."[9]

Between 1879 and 1882, under orders from Leopold II, Stanley set about to explore, map, and acquire as much land as possible along the banks of the river.[10] As he traversed the Lower Congo, he made contact with the local chiefs, rented lands from them, and set up some 50 trading posts. In 1881, at a crossroads for trading, he set up the most important outpost and named it Leopoldville in honor of his patron.

Initially, Stanley's tactics were merely unethical; later they turned brutal. He would trick unknowing chiefs – most of whom were illiterate – into signing over

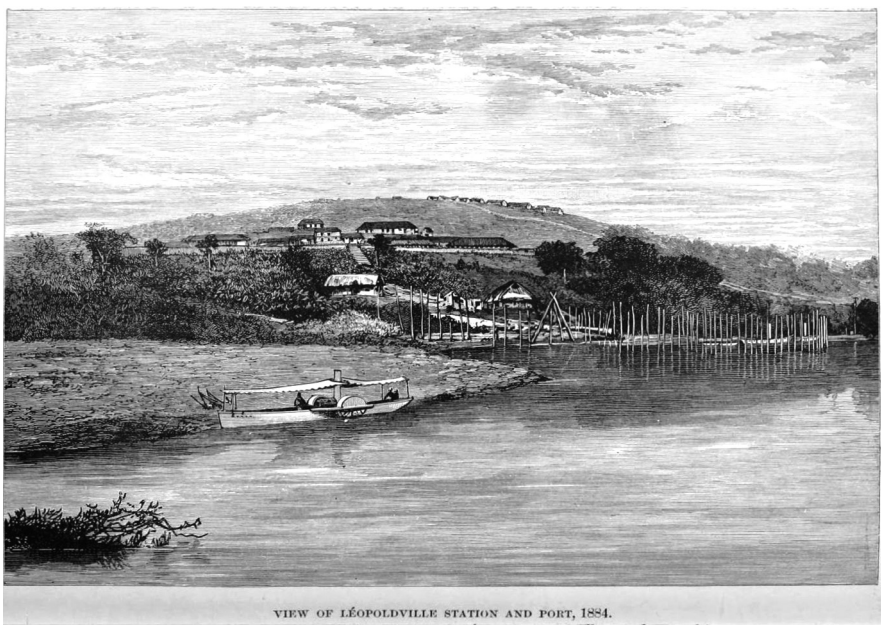


Figure 1.1 View of Léopoldville station and port, 1884

their lands, waterways, and forests to Leopold II with the mark of an X on a contract written entirely in French or English. He would acquire these lands and concessions with bolts of cloth, crates of gin, and trinkets. As Leopold II became anxious that others might get there first, he pressured Stanley into more aggressive techniques. Where locals resisted, Stanley and his men would resort to shooting the obstructive chief and negotiating with his cowed successor. In 1883–84, Stanley continued on to the Upper Congo, extending Leopold II's domination over additional territory. By 1984, the *Association international du Congo* had signed some 450 treaties, which strengthened Leopold II's claim that he had the right to govern this territory.[11]

Stanley's own writings showed a worldview that aligned well with that of Leopold II. "Only by proving that we are superior to the savages, not only through our power to kill them but through our entire way of life, can we control them as they are now, in their present stage; it is necessary for their own wellbeing, even more than ours."[12]

As the fever for colonization escalated, the European powers gathered for the Berlin Conference on Africa in 1884–85 to discuss the partitioning of Africa and establish rules for amicably dividing up Africa among Western powers. In 1885, agents for King Leopold II effectively laid claim to a vast portion of the Congo Basin by convincing fellow European leaders that he was involved in humanitarian and philanthropic work and would open the area to free trade.[13] He also pledged to combat the slave trade that had been rampant in western and central Africa since the 1500s. At the time, no one knew exactly where the borders of Leopold II's empire lay, least of all Leopold himself. Annexing Katanga – later found to be the most mineral-rich area of the country – was an afterthought. Leopold simply doodled it onto the map.[14] At last, Leopold II had secured for himself "*le magnifique gâteau africain*" (the magnificent African cake).[15]

The plunder of Congo commences

In this "scramble for Africa," other European countries had annexed territory to be run by their governments. By contrast, King Leopold II had acquired this massive territory as his personal property, which he named the Congo Free State. In return for full control, he would be responsible for bankrolling the operation from his own wealth, with the hope that the colony would pay for itself and eventually send money to Belgium.[16] Ironically, the monarch of one of the smallest countries in Europe had laid claim to the largest territory on the continent.

To reap the rewards of his investment, Leopold II began to aggressively exploit the abundant natural resources from his new colony. He essentially privatized the Congo, and his government became a system of organized plunder.[17] It was not his intention to develop this territory of central Africa, but rather to use the wealth he could extract to bring a new pride to the Belgium people.[18]

Initially, he set his sights on acquiring ivory, which was greatly valued in Europe for a range of products from jewelry to false teeth. The pursuit of ivory was already booming in the Congo, and Leopold II's agents joined the chase. Joseph

Figure 1.2 King Leopold II, King of Belgium, who held the Congo Free State as his personal possession

Conrad's *Heart of Darkness* captures the brutality of the European quest for ivory along the Congo River in 1890.[19]

Leopold II needed a means to maintain control of his newly acquired territory. To this end, in 1885, he created the *Force publique*, his private military/police force. As officers, he recruited Belgians and other Europeans, as well as mercenaries, all white; the soldiers were a mix of Congolese conscripts, West African adventurers, and mercenaries, all Black. By 1900, the *Force publique* would grow to 17,000,[20] consuming over half of Leopold II's annual investment in the Congo.[21] During Leopold II's reign, the *Force publique* became synonymous with brutality: flogging men with the *chicotte* – a bull whip made of hippopotamus hide, raping local women, burning entire villages that resisted their orders, and cutting off the limbs of those who failed to perform. The arrows and spears of the Congolese villagers to resist Leopold II's plundering of the Congo were no match for the weapons of the *Force publique*.

By the end of the 1880s, Leopold II had exhausted most of his personal wealth in administering his colony, and he looked to the Belgian government to borrow vast sums of money to continue the Congo operation.[22] As part of this arrangement, in 1889 and 1891 Leopold's agents adopted a policy of economic liberalism: it claimed ownership over all lands not directly cultivated by Africans, and it assigned public property to private firms that could amass great sums of capital for the development of the Congo Free State.[23]

The 1890s saw the international rush for rubber. Goodyear invented the process to vulcanize rubber in the mid-century, and in 1889 John Dunlop of England produced the first commercially successful tire for bicycles. The central African forests were among the most plentiful sources of wildly growing rubber, and Leopold II's agents set about accumulating large quantities through horrific means, especially in the provinces of Kasaï, Equateur, and Bandundu. Because the local population had no monetary currency with which to pay taxes, in 1892 Leopold instead instigated a non-monetary tax on African males to collect wild products and bring them to state agents.[24] The *Force publique* would descend on a village, terrorize its inhabitants, and capture the women who were held hostage until men produced their quota of rubber. As the more accessible rubber vines began to dry up, men were forced to penetrate deeper into the forests to meet their monthly quotas. The soaring price of rubber on the international market only stoked Leopold II's greed to extract even more from the victims of his treachery. Men who failed to deliver on their rubber quota could lose a hand or foot.[25]

Yet Leopold II's plunder of the Congo was stymied by the fact that the Congo River was unnavigable in three locations, thus hindering the transport of goods from the Interior downriver to the mouth of the Congo. Livingstone Falls – some 190 miles (300 km) inland – was particularly problematic, as it blocked river transport between Leopoldville and the mouth of the river. For years, humans had been forced to carry cargo through the tropical landscape along the river, which proved inefficient and often fatal. To this end, Leopold commissioned the construction of a 227-mile (366 km) railroad between Boma and Leopoldville between 1890–98. The working conditions were deplorable; medical and sanitary

faculties were insufficient. At the height of construction, some 150 workers a month died of smallpox, dysentery, beriberi, or exhaustion. By the time the first locomotive arrived in Leopoldville in 1898, 1,932 people – 1,800 Africans and 132 Europeans – had lost their lives.[26]

The effects of Leopold II's avarice on the population were catastrophic. The routine of daily life – hunting, fishing, agriculture – was destroyed by the necessity to meet the rubber quotas. Men were far away in the forest and women were often hostage, leaving few to perform the tasks necessary for their survival. Thousands died of starvation or disease. Others fled deep into the forest to avoid being captured, only to perish from lack of adequate food and shelter. With such disruption of society, the birth rate dropped. Tens of thousands lost their lives in failed rebellions against the injustices inflicted upon them.[27]

Initially, Leopold II had little concern over healthcare. In 1888, health represented only 2.2% of the regular budget and by 1906, it had dropped to 1.9%. Only when sleeping sickness began to decimate his potential workforce did he act. Yet it was the railroad companies that built the first hospitals for Blacks to serve native workers stricken with illness while on the job: one in Matadi in 1897, the second in Stanleyville in 1903.[28]

The highly acclaimed bestseller *King Leopold's Ghost* describes in excruciating detail the horrors that King Leopold II inflicted on the Congo Free State in his quest to exploit its natural resources.[29] Although Leopold had pledged to combat the slave trade, he imposed his own form of forced labor on the local population, using the tools of torture, imprisonment, maiming, and terror.

Missionaries arrive to civilize and convert

At roughly the same time that Henry Morton Stanley was ravaging villages along the Congo River on behalf of Leopold II, the Protestant missionaries entered the Congo. They were by no means the first missionaries in the territory. Portuguese Catholic missionaries entered Congo via the mouth of the river in 1491, paving the way for a long period of evangelization that transformed the region into a Christian kingdom. By 1640, the power of the Portuguese waned, with the influx of Dutch, French, and English, and many missionaries departed, though others stayed.[30] In the late 1700s, the Congo became a hotbed for the slave trade. An estimated one-third of the 4 million people captured during the Atlantic slave trade came from Congo, spurred on by the increasing demand for slaves in the US.[31] With the abolition of slavery in the mid-1850s in Europe and in the United States by 1865, the slave trade waned.

Stanley's explorations spurred the imagination of Protestant missionaries in Europe and the United States, who seized the opportunity to bring the teachings of Christianity to the people of the Congo. A Welsh Baptist pastor Alfred Tilly led the first expedition up the Congo River and in 1878 established the first Protestant mission station in Matadi: the Livingstone Inland Mission, a name that paid tribute to the pioneering missionary who had opened Africa to the world.

Initially, Leopold II supported the Protestant missionaries in hopes of garnering favor with the British, whose support he needed to lay claim to his new territory. He promised the Protestants freedom of religion, and at first they embraced this alliance. By the time King Leopold II claimed the Congo Free State for his own in 1885, the Protestants had set up five missionary posts between Matadi and Leopoldville. Soon, the Baptist Missionary Society of Britain and the American Foreign Baptist Mission Society would take up this work, encouraging other Christian groups to join in this evangelizing task.[32] Leopoldville became the base of activity for Protestant missionaries, most of whom were Brits, Swedes, and Americans.

When Leopold II took possession of the Congo, the Catholic sects with missions on the ground were French: the *Pères Blancs* in Kivu and the Holy Ghost Fathers (Spiritans) in Boma. The vast area between east and west was largely "open" for missionary activity. This unexplored territory included hundreds of different ethnic groups, each of them with their own customs, social structure, artistic traditions, and language or dialect.[33]

Yet Leopold II wanted the Catholic missionaries leading the important work of bringing Christianity to the Congo to be Belgian. He initially exhorted the Pope to dismiss all French missionaries from the Congo, but to no avail. Nonetheless, in 1886 Pope Leo XIII proclaimed that the territory of the Congo would be reserved for Belgian missionaries. Leopold first went to the Scheuts, a young congregation involved in missionary work in China. Unable to take on another large territory, they passed this work to the Jesuits in Belgium, who initially refused, in part because they were unsympathetic to Leopold's exploitative behavior in the Congo.[34] As Leopold reframed the mission as a moral duty to fight the slave trade and provide religious training and education to the children rescued from slave traders, the Jesuits came around. Leopold sweetened the deal by facilitating their entry in every way possible: giving them large concessions of land and providing transportation for personnel and goods on state steamers.[35] Later, other Belgian orders would join them.

Once Leopold II had enlisted the Belgian missionaries to evangelize his territory, he no longer needed the Protestant missionaries and, in fact, disparaged the growing number of groups that had infiltrated the Congo. Yet in the Berlin Act of 1865, he had pledged to open the Congo to all nationalities. Though he could not expel them, he channeled all state funds for establishing schools through the Belgian Catholic missionaries. It became increasingly difficult for the Protestant missionaries to gain new concessions.[36] Without access to state funding, the Protestants had to depend on donations from churches back in Europe or America.

During the early days, the Protestant missionaries struggled to achieve three tasks: survive, plant the gospel, and nurture Christian converts. Food was often in short supply, disease was rampant, and the new arrivals had yet to learn ways to protect themselves. Missionaries would travel through villages for extended periods ("missionary itinerating") or in pairs of two to preach and teach in villages near the mission center. Africans were perplexed by the motives of these pale humans. They were docile enough, in contrast to the Arab slave traders who had terrorized villages along the Congo River for decades. Yet they were not looking for

ivory. As locals began to realize the specialized skills and ways of the white man, many missions were inundated with requests to send teachers to their villages.[37]

The number of Protestant missionary posts outnumbered those of Catholics until the 1930s.[38] Both made inroads into the local population through schools or education camps, often taking in orphans or children "rescued" from slave traders. They aimed to convert them to the ways of Christianity. The Catholics had separate colonies for boys and girls and provided education to boys only (until nuns or female missionaries began to arrive in the 1930s); the Protestants had co-ed mission outposts and schools.[39] To maintain discipline, the priests and nuns resorted to "harsh, if not horrific, pedagogical tools," including the *chicotte* (whip), chains, and a type of straight jacket.[40]

Both Catholic and Protestant missions grew in size, often becoming villages of their own. The very presence of the missionaries often diminished the authority of the local chiefs, some of whom nonetheless entrusted their sons to these missionary outposts, in hopes that they would learn the "white man's magic." These missionary stations became oases of civilization – where children were well-fed and clothed – in sharp contrast to the helter-skelter village life from which they came.[41]

In retrospect, the missionaries brought greater stability to local villages than existed before their arrival. Crawford (1969) described them as "little plots of order in a vast and hazardous land." These communities were better organized, albeit under the tight control of foreigners. They built larger, more permanent houses, schools, churches, and other structures. With this greater sense of permanence came more attention to hygiene and stable agriculture, both poultry and cattle-raising. Both Catholic and Protestant missions offered training in carpentry, brick-making construction, and elementary mechanics.

The cozy relationship between Leopold II and the Catholic missionaries deepened as the state poured increasing amounts of money into these state subsidies. Yet the protection of the schools came with strings attached: four out of five children completing their studies were expected to enroll in the *Force publique*. Quipped Van Reybrouck in this engrossing account of this period, "the Jesuits fought for Jesus, but also for Leopold."

In the final decade of the Congo Free State, the sleeping sickness that had started to sweep across central Africa in 1900 began to threaten the economic revenue streams in the Congo Free State. To protect his imperial aspirations and mitigate the red rubber controversy, Leopold II invested heavily in measures to counter this epidemic. In 1903 he commissioned a team of experts in tropical disease to visit the CFS.[42] Based on their recommendations, in 1905 the authorities initiated a strict policy of control, effectively establishing a police state that restricted the movement of the local population from their villages. Persons diagnosed with the symptoms were forced to relocate to quarantine camps known as *lazarets* and were forcibly treated with Atoxyl injections (an arsenic-based medication), which were extremely painful and had dangerous side effects.[43] Guards were stationed to prevent patients from escaping in response to the painful treatments, poor conditions, lack of feed, and permanent separation from their families.[44] These serious measures to restrict movement did contribute to combating

the spread of the illness but at a heavy toll on the local population. One fortuitous by-product of the multiple tropical diseases in the Congo was the establishment of the School of Tropical Diseases in 1906 (later renamed the Institute of Tropical Medicine) in Belgium.[45]

The Protestant missionaries were among the first to publicly question the brutal tactics of King Leopold II in extracting ivory, rubber, and other products from "his colony." They prepared a document outlining the litany of grievances: natives being shot for failure to bring in their quota of rubber, natives hands being cut off, burning of villages by state authorities, long terms of forced labor for natives, the chaining of women as hostages to encourage villagers to bring in rubber, excessive taxation of the people (the taxes to be paid in rubber), and the permissiveness of the state toward slave raiding.[46] In retaliation for these accusations, state authorities increasingly blocked Protestant missionaries from gaining new concessions (land) that would allow them to expand their work.

Tolerance runs out for Leopold II's atrocities in the Congo

Initially, Brussels discounted these disparaging reports from the Protestant missionaries as sour grapes for the favored treatment of Catholic missionaries.[47] Yet after Roger Casement, a well-respected British diplomat, released his own report in 1903 on the atrocities occurring in the Free Congo State, the tide began to turn.[48] It became evident that the vast sums that had been paid for monuments, museums, and palaces in Belgium were directly linked to Leopold II's exploitation of the Congo.[49] A 1904–05 investigation by the Belgian International Parliamentary Commission of Inquiry confirmed these inhuman practices, although the report was greatly redacted to omit the most horrific details.[50] Finding it morally reprehensible, the Belgian government used pressure and diplomacy to persuade Leopold II to give up his control over the Congo as a private investment, and instead, the state felt obliged to annex this vast territory as a colony. In 1908, the Free Congo State became the Belgian Congo, under the full control of the Belgian government.

All told, King Leopold II's legacy on the Congo was horrific. Over 10 million Congolese died during his reign. Demographers estimate that the population plummeted from 20 million to 10 million between 1880 and 1920, a staggering drop of 50% due to inhuman forced labor, disease, starvation, and torture.[51] King Leopold's personal wealth was estimated at between $100 and $500 million, making him the richest man in the world and furnishing him with the funds to build in Brussels, Antwerp, and Ostend on a magnificent scale.[52] Although he would die within two years of giving up his colony, Leopold II made over $1.1 billion from his exploits in the Congo, which he hid in foundations, Swiss accounts, shell companies, and properties on the French Riviera.[53] Interestingly, Leopold II was gifted an additional 50 million francs from the Belgian government during the transition as a "mark of gratitude for his great sacrifices made for the Congo."[54]

It would be unjust to end this chapter without mentioning alternative perspectives on King Leopold II's role in history. Whereas most accounts describe the

atrocities that he perpetrated on the population of the Congo Free State, some have come to his defense. One line of reasoning is that his exploits were no worse than others of his time; he was an "ordinary businessman of the XIX century."[55] Yabili compares Leopold II's actions to those contemporary acts of abuse: Chinese bosses beating Congolese workers in the copper mines, and the government allowing civil servants to work without pay for months at a time. He adds that colonization-bashing is fashionable; indignation and denunciation, requests for reparation all sell well. And that colonialism and racism are neither an invention of Leopold II or a Belgian exclusivity.[56] Plasman writes that Leopold II was driven less by desire for personal enrichment than for creating a Belgian that was "*plus grande, plus forte, et plus belle*" (larger, stronger, and more beautiful). To this end, he dedicated vast amounts of his private fortune to his enterprise in Congo. Without a male heir, King Leopold II sought to link the benefits that his royal position had afforded him to the grandeur of Belgium.[57] With the riches from the Congo, he was able to build Brussels into a city of magnificent buildings, monuments, and parks, on full display to any visitor today.

King Leopold II died in 1909, possibly from cancer; his funeral procession was booed by a large crowd as it passed to his final burial site in Laeken, signaling the disapproval of his rule by the Belgians. The Belgian people had little love for their king and rather favored his successor, Albert I. King Leopold II died with no male heir, and thus the riches he accrued during his reign of terror on the Congo were returned to the Belgian government, with no lawyers present to suggest that the money should have been returned to the Congolese.[58]

King Leopold II had never set foot in the Congo.

Notes

1 Stanley, Henry Morton. *How I Found Livingstone: Travels, Adventures, and Discoveries in Central Africa; Including Four Months' Residence with Dr. Livingstone*. London: Sampson Low, Marston, Searle, & Rivington, 1890, p 331
2 Jeal, Tim. *Stanley: The Impossible Life of Africa's Greatest Explorer*. New Haven, CT: Yale University Press, 2007, p 185
3 Baumeister, Roy F., and John Tierney. *Willpower: Rediscovering the Greatest Human Strength*. New York: Penguin, 2011, p 144
4 Stanley, Henry Morton. *Through the Dark Continent: Or, The Sources of the Nile, Around the Great Lakes of Equatorial Africa, and Down the Livingstone River to the Atlantic Ocean*. 7th ed. London: Sampson Low, Marston, Searle, & Rivington, 1889, p 535
5 Van Reybrouck, David. 2014. *Congo: The Epic History of a People*. London: Fourth Estate, p 35
6 Jeal, 2007, p 234
7 Forbath, Peter. *The River Congo: The Discovery, Exploration and Exploitation of the World's Most Dramatic River*. New York, NY: Harper & Row, 1991, p 328
8 Viaene, Vincent. "King Leopold's Imperialism and the Origins of the Belgian Colonial Party, 1860–1905." *The Journal of Modern History* 80, no. 4 (2008): 741–90. https://doi.org/10.1086/591110, p 756
9 Op de Beeck, Johan. "Leopold II: Episode 6." *Leopold II*, October 21, 2020. Podcast, MP3 audio, 1:44:29, https://klara.be/lees/leopold-ii-aflevering-6

10 Dunn, Kevin C. "Inventing the Congo: Henry Morton Stanley, Leopold II, and the 'Red Rubber' Scandal." In *Imagining the Congo: The International Relations of Identity*, edited by Kevin C. Dunn, 21–59. New York: Palgrave Macmillan US, 2003. https://doi.org/10.1057/9781403979261_2, p 23
11 Hochschild, Adam. "Leopold II." Encyclopedia Britannica, December 13, 2022. https://www.britannica.com/biography/Leopold-II-king-of-Belgium; Hochschild, Adam. *King Leopold's Ghost: A Story of Greed, Terror, and Heroism in Colonial Africa*. New York, USA: HarperCollins, 1998, p 170–71
12 Stanley, 1889; Op de Beeck, 2020
13 Ewans, Martin. *European Atrocity, African Catastrophe: Leopold II, the Congo Free State and Its Aftermath*. London: RoutledgeCurzon, 2002, p 17
14 Van Reybrouck, 2014, p 59
15 Van Zuylen, Pierre. *L'échiquier congolais, ou, Le secret du roi*. Ch. Dessart, 1959, p 859; Stengers, Jean. "L'impérialisme colonial de la fin du XIXème siècle: mythe ou réalité." Edited by Ronald Robinson and John Gallagher. *The Journal of African History* 3, no. 3 (1962): 469–91, p. 490
16 Fetter, Bruce Sigmond. "Elisabethville and Lubumbashi: The Segmentary Growth of a Colonial City,1910–1945." Ph.D., The University of Wisconsin – Madison, 1968. https://www.proquest.com/docview/302380736/citation/4296BDBB08554708PQ/1, p 4
17 Hochschild, Adam. "From Rubber to Cobalt: The Cursed Wealth of the Democratic Republic of Congo." *TLS. Times Literary Supplement*, no. 6123 (August 7, 2020): p 7–9
18 Van Reybrouck, 2014, p 88
19 Conrad, Joseph. *Heart of Darkness*. New York, NY: Tribeca Books, 2011
20 Van Reybrouck, 2014, p 77
21 Hochschild, 1998, p 123
22 "Belgian King Establishes Congo Free State." *National Geographic Society*, May 20, 2022. https://education.nationalgeographic.org/resource/belgian-king-establishes-congo-free-state/
23 Fetter, 1968, p 6
24 Kisangani, Emizet François. *The Belgian Congo as a Developmental State: Revisiting Colonialism*. New York: Routledge, 2022, p 53
25 Van Reybrouck, 2014, p 88
26 Hochschild, 1998, p 171
27 "Belgian King Establishes Congo Free State." 2022
28 Au, Sokhieng, and Anne Cornet. *Medicine and Colonialism. Medical Histories of Belgium*. Manchester University Press, 2021. https://www.manchesteropenhive.com/display/9781526151070/9781526151070.00009.xml, p 108
29 Hochschild, 1998
30 Kisangani, Emizet François. *Historical Dictionary of the Democratic Republic of the Congo*. 4th ed. London: Rowman & Littlefield, 2016, p xxxii
31 Van Reybrouck, 2014, p 23
32 Crawford, John Richard. "Protestant Missions in Congo, 1878–1969." *Librairie Evangelique de Congo*. Kinshasa, Zaïre, 1969, p 2
33 Van Reybrouck, 2014, p 13
34 Kafarhire, Murhula Toussaint. "Jesuit–Protestant Encounters in Colonial Congo in the Late Nineteenth Century: Perceptions, Prejudices, and the Competition for African Souls." In *Encounters between Jesuits and Protestants in Africa*, Vol. 13. Jesuit Studies. Boston, MA: Brill, 2018. https://www.jstor.org/stable/10.1163/j.ctvbqs62t, p. 207
35 Kafarhire, 2018, p 202
36 Crawford, 1969, p 8
37 Crawford, 1969, p 5
38 Guirkinger, Catherine, and Paola Villar. *Pro-birth policies, missions and fertility: historical evidence from Congo*. No. 2204. Namur, University of Namur, Development Finance and Public Policies, 2022, p 16

39 Guirkinger and Villar, 2022, p 26
40 Depaepe, Marc, and Annette Lembagusala Kikumbi. 2018. "Educating Girls in Congo: An Unsolved Pedagogical Paradox since Colonial Times?" *Policy Futures in Education* 16 (8): 936–52. https://doi.org/10.1177/1478210318767450, p 938
41 Crawford, 1969, p 6
42 Headrick, Daniel R. "Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940." *PLOS Neglected Tropical Diseases* 8, no. 4 (April 24, 2014): e2772. https://doi.org/10.1371/journal.pntd.0002772, p 3
43 Lyons, Maryinez. *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940*. 1st ed. Cambridge: Cambridge University Press, 1992. https://doi.org/10.1017/CBO9780511583704, p 109
44 Bivens, Dana Lauren. "African Sleeping Sickness in British Uganda and Belgian Congo, 1900–1910: Ecology, Colonialism, and Tropical Medicine." MA, Virginia Commonwealth University, 2015, p 79
45 Mertens, Myriam, and Guillaume Lachenal. "The History of 'Belgian' Tropical Medicine from a Cross-Border Perspective." *Revue Belge de Philologie et d'Histoire* 90, no. 4 (2012): 1249–71. https://doi.org/10.3406/rbph.2012.8285, p 1255
46 Slade, Ruth. *King Leopold's Congo: Aspects of the Development of Race Relations in the Congo Independent State*. London: Oxford University Press, 1962. https://www.jstor.org/stable/179627, p 179–81
47 Van Reybrouck, 2014, p 96
48 Casement, Roger. *The Eyes of Another Race: Roger Casement's Congo Report and 1903 Diary*. Dublin, Ireland: University College Dublin Press, 2003
49 Rankin, Jennifer. "Belgium Faces up to Postwar 'Apartheid' in Congolese Colony." *The Observer*, December 9, 2018, sec. World news. https://www.theguardian.com/world/2018/dec/09/belgium-addresses-postwar-apartheid-in-colonial-congo
50 Lozano, Felipe Román. "The Native Voices During the Rubber Boom, a Comparative Analysis." *A contrario* 30, no. 1 (2020): 53–71. https://doi.org/10.3917/aco.201.0053, p 59
51 Hochschild, 2022
52 Denzil. "The Royal Greenhouses of Laeken, Brussels." *Discovering Belgium* (blog), March 12, 2018. https://www.discoveringbelgium.com/the-royal-greenhouses-of-laeken-beauty-and-the-beast/
53 Hochschild, 1998, p 277
54 Dunn, Kevin C. "Inventing the Congo: Henry Morton Stanley, Leopold II, and the 'Red Rubber' Scandal." In *Imagining the Congo: The International Relations of Identity*, edited by Kevin C. Dunn, 21–59. New York: Palgrave Macmillan US, 2003. https://doi.org/10.1057/9781403979261_2, p 59
55 Dr. Miatudila Malonga, personal communication, September 13, 2023
56 Yabili, Marcel. *The Greatest Fake News of All Time: Leopold II, The Genius and Builder King of Lumumba*. Paris: AFNIL, 2021, p 22–24, 49, 56
57 Plasman, Pierre. *Léopold II Potentat congolais: L'action royale face à la violence coloniale*. 1st edition. Bruxelles: Éditions Racine, 2017, p 227
58 Hochschild, 1998, p 266–77

2 The Belgian Congo (1908–60)

The Colonial administration embarks on developing the Belgian Congo

In November 1908, the Belgian parliament reluctantly assumed control of the Congo Free State, renaming its new colony the Belgian Congo. It was to be legally separate from Belgium and financially self-sufficient.[1]

The Belgian government immediately created a "Ministry of Colonies" – a grandiose name for a country with a single colony – to administer the Belgian Congo.[2] Its vision was one of capitalist development with minimal state interference. The private sector would take the lead in developing the country, in return for generous land concessions and lenient taxation from the colonial administration. The prevailing sentiment in Brussels reeked of paternalism: "the people of the Belgian Congo should be taken care of, because they are the most primitive people on earth."[3]

The first Minister of the Colonies, Jules Renkin, set about to replace the reckless and self-serving practices of Leopold II with a colonial bureaucracy to ensure the rule of law, protection of property, and the rights of owners over the proceeds of production.[4] The day-to-day administration of the Belgian Congo would fall to a governor-general, appointed in Brussels and posted to Boma, the colonial capital near the mouth of the Congo River. The colonial administration consisted of civil servants imported from Belgium to bring law and order to the sprawling territory, which was divided into four provinces: Congo-Kasaï, Equateur, Orientale, and Katanga.

The new administration brought stability and predictability to state affairs, which proved crucial to drawing investment to the Congo. Yet the business model was far from altruistic as concerned the local population, nor did the power balance between Europeans and Congolese change from Leopold II's time. The "colonial trinity" consisting of the government, Catholic Church, and private enterprise would maintain control over the Congo for more than 50 years of colonization.

To jumpstart the country toward a model of capitalist development, the Ministry of Colonies created a strong alliance with the private sector. With the large expanses of native lands usurped during Leopold II's rule, the government granted concessions to private companies in mining, agriculture, and transportation.

DOI: 10.4324/9781032718897-3

The *Union minière Haut Katanga* (UMHK), created in 1906, was strategically positioned to take advantage of the copper ore recently discovered in the region around Elizabethville (modern-day Lubumbashi). Also established in 1906 was the *Compagnie du chemin de fer du Bas-Congo au Katanga*, for the purpose of transporting mineral exports from the landlocked province of Katanga to the mouth of the Congo River, a thousand miles cross-country. In 1911 the *Huileries du Congo belge* (HCB), a subsidiary of Lever Brothers, received a concession of 750,000 acres of forest in Bandundu to produce palm oil (and later soap). Many other companies benefited from similar arrangements. The government did not tax these companies but rather received a mandatory share of the profits.[5]

The *Force publique* remained in place as a mechanism of control over the population, albeit with some reorganization. Increasingly the white and Black mercenaries that constituted the *Force publique* under Leopold II were replaced respectively by Belgian officers and Congolese soldiers. Separate detachments were stationed across the territory, primarily for local policing.[6]

Initially, the colonial administration replaced the widely reviled practice of rubber quotas with taxes payable through other commodities: manioc, copal, palm oil, or chickens.[7] Over time they began requiring payment of taxes with money, which served a dual purpose: it generated the finances needed to provide public goods for the country, and it forced the native population to accept jobs remunerated with currency.[8] Local chieftains – by then integrated into the colonial administration at the lowest rung – had the unpopular job of delivering up workers and collecting taxes. Since colonization, they had lost much of their traditional power and influence.

Whereas this arrangement benefited the burgeoning industries in need of laborers, especially in the remote and sparsely populated area of Katanga, it caused great suffering to those forced into providing this manpower. Men lived in hastily constructed camps, far from their families, where food was scarce, snakes and insects were prevalent, and disease was rampant.[9] The meager wages they received were hardly just compensation for the back-breaking work they provided. Meanwhile, this compulsory migration left the rural areas bereft of young able-bodied men to sustain subsistence farming on which the population depended for survival. If the Belgians envisioned lifting the native population from a "backward African existence," these policies had just the opposite effect. The disparity between prosperous economic hubs and increasingly impoverished rural areas took root in the early days of the Belgian Congo.

An early priority of colonial authorities: discouraging polygamy

In the early 1900s, polygamy[10] was commonplace in sub-Saharan Africa.[11] Yet if Catholics and Protestants were united on one issue, it was their abhorrence of the practice.

The Catholic Church – in its privileged partnership with the colonial administration – pressured authorities to address the practice of polygamy. The

colonial charter, drawn up in 1908, promised steps toward the eventual abandonment of polygamy.[12] The Belgians viewed this action as part of their humanitarian vision of development that would bring civilizing practices to the native population. They objected to polygamy as moral depravity; moreover, they argued that it lowered fertility.

There is little evidence that the colonial authorities understood one of the intrinsic values of polygamy: to improve the survival chances of the most recently born baby. The tradition of birth spacing was deeply embedded in traditional African society for the benefit of both mother and baby.[13] The mother of the newborn tried to avoid a repeat pregnancy for at least two years, allowing the baby to breastfeed rather than being prematurely weaned to make way for the next baby. In some instances, the mother would return to her natal village for this extended period. In others, her mother or mother-in-law would move in to prevent any sexual contact with the husband. This practice, known as prolonged postpartum abstinence, worked to the extent that men had access to other wives to satisfy their sexual needs.[14]

The colonial powers realized the futility of outright banning the deeply embedded practice of polygamy. Rather, starting in 1910 they passed a law to discourage the practice by taxing men for the second to thirteenth wife. Men were expected to select one wife, "putting away" all others, an action that the Catholic missionaries viewed as liberating these women from the "slavery" of a polygamous marriage. The term *femme libre* (free woman) was intended to refer to their liberation from slavery, but in the absence of alternative means to support themselves and their children, in some circles it came to denote a woman who turned to prostitution. How else could a woman support herself without a husband? Starting in 1909, the authorities required the registration of *femmes libres* and administered regular gynecological examinations for sexually transmitted diseases; those infected were put in quarantine. By the time the colonial administration realized that it had acted too precipitously in breaking up polygamous unions, the damage was done. Many *femmes libres* would make their way to urban areas.[15]

The Belgian authorities maintained a certain respect for "tradition," so long as it did not conflict with their own priorities. They viewed the Congolese as belonging to one of two camps: those embracing progress (*évolution)* versus those still entrenched in tradition. In a 1914 circular on the topic of polygamy, colonial agents were instructed to distinguish between those natives who were already mixed into the life of whites and those living under the empire of custom. The practice of polygamy was to be strictly forbidden to all those in the first cultural category.[16]

At the time, little was made of the morally nebulous but openly practiced arrangement whereby European men took on a *ménagère* ("housekeeper") to attend to their domestic and sexual needs, though the practice would come under fire in the 1920s.[17]

Box 2.1 Polygamy and matriarchal vs patriarchal societies

The church's efforts to liberate women from the "slavery" of being in a polygamous union inadvertently created an additional burden for the wife who was retained. Men wanted lots of children to demonstrate their strength and virility, which was far easier to achieve with multiple wives. When the man was forced to select a single wife, she alone bore the burden of producing this large number of children. Refusing to have a large family was considered unpatriotic.

The lines of inheritance differed between matriarchal versus patriarchal societies. In a matriliny, ancestral descent was traced through maternal instead of paternal lines. The assets of a family – property, belongings, and children – were passed down through the females in the family. Men gained their power through their role as brother or uncle, not as husband or father. As such, for a man, it was not his wife but the sister who needed to have a lot of children for the assets to remain in his ancestral line.

Dr. Jules-Pierre Miatudila Malonga, who would become a pioneer in the family planning movement, recounts the situation of his maternal grandfather. Alfonse had seven wives and some 25 children. In 1924, he became a Catholic, which meant he could keep only one wife. He chose to retain the one wife who had failed to bear any children because he did not want to "*faire plaisir*" to another man (father children who would enrich another man). For his assets to remain in his own bloodline, he needed a daughter. On the sly, he sought out the wife who had given him four sons but no daughters. Although he had cast her out, he pleaded with her to try once more. To his great satisfaction, she concurred. Nine months later she gave birth to a girl, who was Miatudila's mother.

The Belgian Congo supplies the global market during World War I

Just as rubber had replaced ivory as the most valued export in the late 1890s, so copper ore would eclipse rubber when rubber prices dipped on the global market between 1912–14. By 1917, copper represented 52% of the export revenue for the Congo.[18]

This shift toward mineral exports would accelerate with the outbreak of World War I in 1914. As the demand for minerals, rubber, and agricultural products spiked, the Belgian Congo was well positioned to respond to the needs of the Allied forces for these commodities.[19] The revenues generated during this period further helped to enrich the large private enterprises that were, in turn, fueling the development of the capitalist state.

Yet the spike in demand for these goods required manpower to deliver them. The colonial authorities reverted to, and intensified, forced labor practices, establishing the obligation of 60 days per year service to the state.[20] Ironically, it was men in polygamous marriages that were more likely to meet the quota, presumably because

their multiple wives were available to till the fields.[21] This observation did little to endear the practice to the colonial authorities.

World War I also marked the return of the sleeping sickness epidemic, which peaked as the authorities forced Congolese men back into the forests infected by tsetse flies in search of rubber. Those who failed to meet their quotas were conscripted into labor brigades or used as porters, which caused further spread of the disease. Infection rates varied by province from 10–29% of the population.[22]

Congolese soldiers recruited from the *Force publique* were drawn into the conflict of the European powers when Germany mounted an invasion of East Africa. They also fought in Rhodesia and Cameroon. Local soldiers were credited with defending the borders of the country and tales of these successful military exploits were the source of local pride. Yet the Congolese were never recognized or compensated for their sacrifices in supporting the war effort.[23]

Demographic panic percolates in the 1920s

Concerns about population decline emerged while the Congo was still under King Leopold II's control. But in the wake of World War I, they resurfaced. Maintaining a robust native workforce was critical to the Belgian's model of capitalist development. Thus, reports of population decline in the Congo were cause for alarm in Brussels.

In neighboring France, the government was also coping with population decline following the devastating military losses of World War I. To this end, in 1920 the French passed a law that outlawed abortion, the sale of contraceptives, and contraceptive propaganda, punishable by fines and imprisonment. The text prohibited the circulation of any kind of book, writing, print, poster, drawing, image, or advertisement "describing or offering to reveal" methods preventing pregnancy. Following the lead of the French, in 1923 the Belgian government passed its own law forbidding the advertisement of contraception, which applied to both Belgium and the colony. Decades later, with the advent of family planning programs, the Belgian law became known under the umbrella term of "the Law of 1920."

The decline in population in the Congo could be traced to two sources: the colonial occupation and indigenous practices. Much has been written about the four decades of exploitation, forced labor, tropical disease, and malnutrition that took a devastating toll on the Congolese population, much of it during Leopold II's reign. An estimated ten million people – approximately half of the population of Congo – died between 1880 and 1920.[24]

The second source of population decline was the indigenous practice of prolonged breastfeeding for up to two to three years, accompanied by postpartum abstinence. This practice prevailed across much of tropical Africa, rooted in the deep-seated belief that sexual relations while the mother was still breastfeeding could be fatal to the baby. The colonial government blamed polygamy for prolonged postpartum abstinence since the practice gave men access to their other wives while a lactating mother was sexually unavailable to him. It was one of the two reasons for the 1910 tax on polygamy (the other was its affront to morality.)

Yet by the 1920s, colonial authorities more directly targeted the practices of lengthy breastfeeding and prolonged postpartum abstinence. The colonials were on a "crusade to combat the prejudices that separate the spouses."[25]

Nancy Rose Hunt's engaging article on *Le bébé en brousse* (Baby in the Bush, 1988) captures the flurry of interventions directed to Congolese women through maternal and infant programs and facilities. The earliest infant welfare stations began in 1912 under the high patronage of the Belgian queen,[26] with the intent of reducing infant mortality, but also of combating the "superstition forbidding postpartum sexual relations."[27] The state provided subsidies to the Catholic Church in support of female missionaries taking on this work. European women also formed organizations to educate local women in health and hygiene practices. The motives of such programs were only partially to benefit the health of mothers and babies. As one of the female leaders of this movement wrote, "Without black labor, our colony would never be able to send to Europe the wealth buried in its soil."[28]

Demographers studying the phenomenon of prolonged breastfeeding and postpartum abstinence confirmed with data what the colonial government had feared: that these two practices did in fact inhibit human fertility in the Congo. Equally notable, the interventions to educate Congolese mothers about the "model behaviors of the European woman" produced little change in these traditional practices, especially in rural areas.[29] Far more effective at eroding these practices were the forces of urbanization that came into play after World War II.[30]

Box 2.2 Incentivizing large families

In a tradition dating back to around 1870, a Belgian couple lucky enough to have seven sons without any break in the succession received special favor from the royal family: the King became the godfather of the seventh son. Similarly, the Queen was named godmother of the seventh of seven consecutively born daughters. Records tracking these births indicated 50–60 such occurrences per year through World War I, after which the numbers began to trail off over time to near zero by 1980.[31]

The tradition also extended to the Belgian Congo. What Congolese wouldn't want the honor of having the King or Queen as godparent to their child? In a society where men already aspired to large families, it was but one more incentive to procreation.

The Great Works program stimulates development in the Congo

During the 1920s, the Belgian Congo flourished economically. The revenue from the wartime sales of minerals provided capital for further investing in businesses. With loans from the Belgian government (that were never repaid), the colonial administration began a *Programme de grands travaux* (Great Works) that vastly improved infrastructure, education, and healthcare.[32]

The fledgling private sector greatly needed infrastructure – railroads, waterways, bridges, and roads – to transport its products from the interior of the country to the global market. The mining region in particular was landlocked in a remote area 1,000 miles from the mouth of the Congo River. The construction of railroads and improvements in waterways created the *Voie national* (National Way), a transportation corridor that stretched from Katanga to the Atlantic Ocean. The development of roads also facilitated the transport of agricultural products, making foodstuffs more plentiful in different areas of the Congo.

A second component of the Great Works program was education. In response to the economic needs of the growing private sector, in 1925 the colonial administration initiated a massive program of primary and post-primary education, with hefty subsidies for Catholic schools. Four types of schools existed for the masses: independent Protestant-run schools, Catholic Mission schools, state schools (with teaching from religious personnel or native teachers), and post-primary "professional" or normal (teacher-training) schools. The post-primary schools were much fewer in number and trained locals to become midwives, medical assistants, mechanics, clerks, and foresters. One scholar of the period estimated that only three to seven percent of the native population "had been reached by educational influences."[33]

The colonial mindset was to treat Africans as children.[34] The authorities considered them as being unsuited to acquiring theoretical knowledge, lazy by nature, and slaves to their passions. The paternalism of this era is well captured by Mottoulle (1946): "The colonizer must never lose sight of the fact that Negroes have the souls of children, souls that mold themselves to the methods of the educator."[35]

For all children, the curriculum emphasized discipline, order, and submission. Almost all primary care education was entrusted to the Catholic missionaries, and almost all of their efforts were to educate boys. Whereas boys were taught French, girls were taught only in Congolese languages.[36]A few special schools for girls focused on moral instruction, the maintenance of discipline, rules of hygiene, and housekeeping (washing, sweeping, cooking, and sewing). The goal was to create a pious, submissive housewife, raised in the Christian faith.[37] There were few education opportunities for girls post-primary; one of the few channels for an alternative career to homemaking was to become a nun.[38] The prevailing prejudices of the day – the mental inferiority of women, their unstable nature, their adherence to native customs – hindered girls' education.[39] The nun's words to a local schoolgirl reflect the prevailing views of the day: "What! You a Black woman, working in an office? Never will there be a day when a Black woman works in an office!"[40]

Many girls dropped out after three years of primary school. This was enough schooling to allow them to take their first communion in the Catholic Church. Moreover, by then most were reaching puberty and would be more valuable helping their mothers in the home.

The education for girls differed between Catholic and Protestant schools. As nuns began to arrive in larger numbers in the 1930s, they took over the training of girls.[41] Catholic schools followed a state-mandated curriculum for girls that aimed to raise morality standards, promote "Christian marriage," and teach

appropriate home-keeping practices.[42] Protestant schools also oriented young women toward their future role as wives but provided a better education and stronger female role models. Women had been part of Protestant missionary work from the start, whereas Catholic nuns arrived much later.

Whereas the Catholic missionaries were subsidized by the colonial government, the Protestant missionaries had to rely on financial support from their home churches to build schools and hospitals. In return, they refused to adhere to the official curriculum of the state. Rather, they educated primary school children as well as teachers and nurses in post-primary programs. Yet graduates of the Protestant schools faced a major challenge; their degrees were not recognized by the state. They were barred from employment in the colonial administration and most industries, with one exception: Unilever, the British company that specialized in producing palm oil. For this reason, many Congolese sent their children to Catholic schools.

The educational strategy in the Belgian Congo proved effective. By the 1930s, 13% of children aged 6–14 attended school, which was among the highest rates in tropical Africa (though these figures mainly reflected boys attending school rather than girls).[43] A sliver of the population also managed to get a few years of post-primary education, either from the Catholic Church (in carpentry, mechanics, bricklaying, accounting, or lower-level administration) or from professional schools that targeted technical skills in manufacturing, mining, and transportation.[44]

Yet this rush to educate locals did not establish a pathway for them to go on to university or obtain higher education in technology or medicine. The Belgians had no appetite for creating a cadre of well-educated Congolese elites who might challenge the existing hierarchy of power. The prevalent sentiment was: "*pas d'élites, pas d'ennuies.*" (No elites, no troubles.)[45]

The Great Works program also made impressive strides in developing a health-care network, which would eventually become the best in tropical Africa. At the time of annexation, the colonial administration was already working to combat sleeping sickness through prohibitions against travel within the country and forced quarantining of suspected patients to isolation camps. All of the 135 territories comprising the Congo had at least one medico-surgical center, maternity ward, and prenatal and infant welfare advice center.[46]

Private enterprises and the missionaries were instrumental in improving health-care across the Congo. Private companies recognized the need for a healthy workforce to work in the mines, plantations, and factories. At the encouragement of the colonial officials, private companies built and staffed health clinics to provide medical care to their European employees and Congolese workers. The Catholic Church received additional state subsidies to establish hospitals and clinics that would provide care to the population in and around the Catholic missionary stations.

******

During the 1920s and 1930s, many men left their village homes for the newly emerging urban centers, motivated both by push and pull factors. They were

escaping the drudgery and deprivation of the rural areas where chieftains and powerful elders married all the young women. They were lured by the attraction of a better life: improved housing, clothing, and food. Around 1923, the mining towns in Katanga allowed men to bring their wives and children, with the ulterior motive of increasing motivation to work, impeding prostitution and alcoholism, stimulating monogamy, and promoting tranquility of camp life.[47]

In 1923, the capital city was moved from Boma to Leopoldville by royal decree. Public works engineers from Boma based their designs on the best European city planning practices, creating an administrative district "reflecting the grandeur of an imperial power." In 1928, an equestrian statue of King Leopold II was inaugurated in front of the proposed governor's residence, in the apparent hope of rehabilitating the image tarnished by the red rubber campaign during his reign.[48]

In sharp contrast to the trading posts of the past, new urban settlements grew up, with hotels, banks, theaters, department stores, and hospitals. Local factories manufactured sugar, cotton, cloth, soap, and mineral waters. Garages sprung up and daily papers circulated. The central boulevard was lined with trees and maintained impeccably. High-rise buildings and a cathedral spoke to the European influence.[49] Yet these amenities were available only in the urban areas; 99% of the population still lived in villages.

Despite the enormous advances made in developing industry in the Belgian Congo in the 1920s, the local population paid an extreme price. In response to the rapid growth of mines, agriculture farms, and industry, large numbers of Congolese men were forced to move from their villages to these emerging areas of economic activity. Often, they lived in crowded camps under inhumane conditions in return for paltry wages. Others were forced into labor on the construction of railroads; thousands died from disease or accidents between the 1890s and 1930s.[50] In the absence of able-bodied men, those who remained – the elderly, women, and children – struggled to maintain the subsistence agriculture on which the communities depended, further contributing to malnutrition and impoverishment. The gap between the colonizer and the colonized grew, as postcolonial state managers transferred most Congolese wealth to private accounts abroad.[51]

The Depression of the 1930s reaches the Belgian Congo

The crash of the financial markets in 1929 directly impacted the Belgian Congo, by now a significant player in the global economy. By 1929–30, the Congo was on the edge of a deep depression. The mining sector was the first to suffer the negative effects, with dramatic reductions in the production of copper, tin, and cobalt. In Katanga, three-quarters of the European workers and 47,000 Black workers were laid off between 1930–31.[52] Several years later, agricultural prices plummeted. The large companies that had flourished during the 1920s realized that the model of exploiting the local population for labor and raw materials was not sustainable.[53]

In a scramble to salvage the economy, the colonial administration tightened its grip, with what historians have labeled the Authoritarian Policy of the 1930s.[54] It

extended credit to the largest companies and plantations, expanded the monopoly of large trading companies, and vastly reduced the cost of transportation for export crops.[55] Although the colony was supposed to be financially separate from Belgium, the economic straits required it to depend increasingly on Brussels to remain solvent. It tied the fate of the colony to Belgium in ways that diminished its claim to autonomy.

The actions of the colonial administration in the 1930s further disadvantaged the rural populations. In 1931, it applied "compulsory acreages" across the entire Belgian Congo, including to the 100,000 industrial workers who were returned to their villages during the same period.[56] In 1933, it shifted the burden of building and maintaining local roads to the Congolese. In 1935, the colonial administration initiated a system of indigenous peasantry program (*paysannat*), intended to improve the living conditions of the rural population. It required Congolese to feed their raw materials – cotton, palm oil, rice – to European processing industries. The results proved more beneficial to the European owners than the local population. In the 1930s, the authorities further drove the divide between urban and rural sectors, by defining legal territorial spaces as urban townships (*centres extra-coutumiers*) versus tribal lands.[57]

Pierre Ryckmans took over as governor-general in 1934. With a firm hand, he succeeded in balancing the budget, increasing exports, and stimulating the economy. By 1936 the economic situation began rapidly improving. Ryckmans also increased subsidies to the Catholic missionaries to expand schooling.[58] Yet his philosophy of governance was reflected in the title of his 1948 book, *Dominer pour servir* (dominate to serve).

The colonial administration had rejected the idea of modernizing the rural areas: it would take too long, cost too much, and be too risky to the power dynamics in the Congo. Instead, it had created a "modern, industrial, capitalist, white sector" versus a rural, traditional, Black population with little access to economic opportunity. Congolese were outlawed from starting their own businesses and receiving credit.[59] By the end of the Depression, the economic and social conditions of the rural area were so difficult that the problem of the administration was no longer one of getting enough workers to leave the villages but, rather, one of holding in check the rural exodus.[60]

The 1930s did see improvements in two areas: healthcare and skills training for Congolese workers. In the early 1930s, the Belgian Royal family established a fund for native medical assistance (FOREAMI) to extend healthcare to rural areas and built more than 120 medical centers that served 3,200 communities.[61] The colonial administration set up a health surveillance system to track the leading diseases of the day (e.g., sleeping sickness, malaria, leprosy, and venereal disease).

The private sector had directly experienced the negative effects of labor shortages when Africans from other countries were sent home and white workers became too expensive during the Depression of the 1930s. As a result, the colonial administration and private industry awakened to the need to develop professional education and training for Black workers.[62]

******

As if the native population had not suffered enough during the years of the Depression, one final fate awaited them: an epidemic of "venereal disease" (in the vernacular of the time) that by the late 1930s created pockets of sterility across the colony. The mass migration of men away from their families and toward urban areas had contributed to marital instability and a relaxation of sexual controls, a perfect recipe for the spread of sexually transmitted diseases[63] (most likely syphilis, gonorrhea, and chlamydia).[64] Others would blame prolonged postpartum abstinence for driving men to seek out prostitutes.[65]

The regions in northern Congo (former Orientale and Equateur provinces) afflicted with infertility formed part of a larger "sterility belt" that spanned Central Africa from Cameroon to southern Chad and including the Central African Republic.[66] In Congo, the epidemic peaked between the late 1930s and 1945.[67] Hunt's *A Nervous State: Violence, Remedies, and Reverie in Colonial Congo* describes the urgency of intervention – from medical surveillance to unique traditional practices designed to help women and men to have children.[68]

The demographic data on childbearing revealed the cruel effects of this epidemic. By the 1950s among women aged 35–44, roughly 40% of those in Tshuapa and Equateur districts in Equateur province and almost 45% of those in Bas-Uélé, Haut-Uélé in Orientale province were childless.[69] In a country with near-universal marriage and childbearing, sterility was embarrassing or dishonorable.[70] Childlessness was almost never by choice.

In response to this scourge, the colonial health service launched vigorous campaigns to treat and control the epidemic in areas where the problem was particularly acute.[71] The main weapon of attack was penicillin,[72] although the improved medical facilities of the day also contributed to bringing the problem under control. By the late 1950s, the problem was largely curtailed.

The Congo supports the Allied forces in World War II

After Germany invaded Belgium in May 1940, the machinery of production in the Belgian Congo shifted to support them.[73] In contrast to the Depression years when Brussels supported the Congo, the tables turned with the Congo financing the Belgian government in exile in London for four years. During this period, it operated far more autonomously than previously.

Ryckmans, still governor-general (until 1946) brought the Congo into the war effort on the side of the Allied forces. Congolese soldiers fought against the Italians in Ethiopia, which returned Haile Selassie to the throne.[74] The Congo also supplied agricultural products to feed the armies. To do so, the administration reinstated and increased compulsory labor for men in rural areas from 60 to 120 days.[75] Under his watch, the Congo increased its production of gold and tin to help the Allied forces. It was uranium from the Congo that was used during the Manhattan Project to create the first atomic bomb.[76]

World War II had stimulated the economy of the Belgian Congo. By 1945, Congo was the second most industrialized country in sub-Saharan Africa after South Africa.[77] And for once, at the end of the war Ryckmans called for improved social policies for the Congolese in view of their contribution to the war effort.[78]

Despite the efforts of the Belgians to maintain a happy though tightly controlled native populace, the seeds of protest had begun to take root. At the end of the war, goods became scarce and prices rose, leading to social unrest. Veterans from the war had witnessed firsthand the superior treatment of soldiers in other countries.[79] Although the ten-year period from 1945–55 was free of the outward signs of discontent – rebellions and strikes – the growing desire for equality and recognition from the white elite power structure could not be suppressed forever.

The postwar boom and the Ten-year Plan creates a Congolese middle-class

Flush with revenues from mineral and agricultural exports during World War II, the Congo was ready to embrace development with an eye to improving conditions not only for Europeans but also for the Congolese. Sustained economic growth contributed to diversification. The Congo exported more than twenty cash crops, more than nine refined minerals, and a range of manufactured products. By the 1950s, agricultural exports were as lucrative as mineral exports.[80]

Developed in 1949 and implemented the following year, the Ten-year Plan aimed to improve housing, energy, rural development, and infrastructure in the Congo. It greatly enhanced the standard of living for the average Congolese in urban areas or employed by one of the large private companies (in mining or agriculture). Whereas virtually no Congolese middle-class existed before the war, in the late 1940s and 1950s class structure changed dramatically.[81]

Thanks to the construction of housing with electricity and running water in the *centres extra-coutumiers*, a Congolese middle-class began to emerge, most notably in Leopoldville, Elizabethville, and Stanleyville. Men who had the opportunity to study (as far as the system would allow) prided themselves on being the *évolués* (the evolved). They patterned their lifestyle on that of the Europeans; they educated their children to speak French; and they kept house to a new standard; knives and forks were *de rigueur*.

Evolués fashioned themselves as mediators between the Belgian authorities and the native "*sauvages*,"[82] and they requested a special status in return. In 1948, the Belgian government created a *carte de mérite civique* (civic merit card). Only educated Congolese with no criminal record who rejected polygamy and traditional religion were eligible.[83] Yet many *évolués* found these privileges too limited, so in 1952, the government issued a *carte d'immatriculation* (registration card), which gave a select few Congolese equal legal status to Europeans.[84] They were able to send their sons to European schools.

The mining industry took the lead in creating a highly improved standard of living for their workers. For decades, worker camps had surrounded the mining sites. Yet in the 1950s, the large companies upgraded them to "mini-welfare states" for their workers and their families, providing cradle-to-grave services: housing, schools, hospitals, social workers, recreational amenities, and retirement plans. While these generous benefits also helped the companies to reap huge profits while minimizing labor costs, they did create a new standard that other

industries would emulate. By the late 1950s, much of the urban Congolese population enjoyed social benefits like those in Belgium.[85]

Reforms in education also contributed to progress in the 1950s, while further separating the elites from the masses. Education remained entirely in the hands of the missionaries.[86] By 1948 Protestant missionaries also became eligible for state subsidies for education. In 1954, the Belgians opened the first university, Lovanium, a branch of the Catholic University of Louvain, on the outskirts of Leopoldville. Four years later, a law school was added.[87]

The colonial administration developed the best healthcare infrastructure in sub-Saharan Africa,[88] with approximately 3,000 hospitals, clinics, and dispensaries and 99 specialized health facilities distributed nationwide. As of 1948, the state provided subsidies to both Catholic and Protestant missionaries to support facilities, which blanketed the country. Almost all territories had a Catholic post, and 80% had a Protestant post.[89] Private enterprises provided healthcare for the families of their workforces. White physicians – recruited from Belgium, elsewhere in Europe, and the United States (mostly missionaries) – cared for patients in many hospitals and clinics. The level of care in European-centered facilities was sufficiently high that whites obtained care in the Congo rather than returning to Belgium.[90]

Prior to independence, public health expenditures represented nine to ten percent of the regular national budget. The colonial administration had built an extensive system of medical training institutions: two medical schools, a nursing school, and 134 other public health training schools for medical assistants, male nurses, sanitarians, nurse midwives, and dentists.[91] Yet in this entire medical system, there was not a single Congolese physician. (The first two Congolese graduates of the medical school would receive their degrees only after independence.)

Even the *Force publique* showed improvements in the wake of World War II: better discipline, regular pay, and weekly food allowances. As such, the men in uniform were less likely to resort to looting local farmers for food.[92]

By the late 1950s, the Belgian Congo was known as the "jewel of Africa." The Ten-year Plan had borne fruit. Real wage increases skyrocketed to an annual average rate of 8.7% in the 1950s, with workers experiencing a doubling of their wages.[93] Unions were allowed for the first time after the war. Between 1954–57, the Congolese school population increased by more than one-half (although secondary schooling remained limited).[94] The Congo boasted over 3,000 health facilities countrywide. In 1953, Congolese were allowed to buy and sell property for the first time. Clubs and associations of Congolese sprouted across cities, totaling over 300 by 1956.[95] In 1957, elections were held for local majors in Leopoldville, Stanleyville, and Elizabethville.[96] In 1957–58, political parties were allowed to form.[97] Yet tensions were brewing in the "model colony."

Resentment grows among the Congolese

Economic disparities and social divisions persisted. The salary gap between the European and Congolese was staggering. In the late 1940s, the average salary of a European was 65 times higher than for a skilled Congolese doing comparable

Figure 2.1 Boulevard Albert 1er, downtown Leopoldville, in 1950
Photo credit: Michel HUET/Gamma-Rapho via Getty Images

work. By 1954, the gap narrowed to 40 times higher, and in 1958 to "only" 33 times higher.[98] The Congolese constituted 99% of the population, but their wages represented only 25% of the gross national product.[99]

Congolese chafed at the restrictions that prevented them from obtaining a university-level education, which they sought as a stepping stone to political leadership or an executive position in a private company.[100] A limited number of Congolese (men, no women) were sent to study humanities or the social sciences in Belgian universities, but the colonial authorities barred them from pursuing medicine, engineering, chemistry, or physics. Rather, even the *évolués* were limited to the widely disparaged role of *auxiliaire* (auxiliary or assistant), which allowed them to assume increasingly important jobs as technicians or middle-level managers but never become the boss. This policy fanned the flames of desire for independence.[101]

The Belgians had created a special status for *évolués* to recognize their advancement in education and lifestyle with the *carte civile* and *carte d'immatriculation*. Yet few achieved this level of distinction. By 1951, only 395 Congolese had received the civil merit card, of whom only 12 (3%) were women.[102] By 1957, the number had risen to 1,557 people, still a tiny fraction of the Congolese population.[103] Still fewer had been awarded a registration card: 217 by

1958.[104] Hard as many *évolués* had worked to attain this coveted status, it would fall out of political fashion as impatience for independence grew. "Sooner or later, yearning turns to distaste, yes, even to hostility."[105]

In the *centres extra-coutumiers*, housing was *de facto* strictly segregated by race. In Leopoldville, only whites could live in the city center (the neighborhood of Gombe today). Black people were relegated to the *cités indigènes* (indigenous neighborhoods); the term "*la cité*" remains in use to describe the miles of sprawling neighborhoods outside Gombe. Hospitals, cafés, theaters, department stores, even cemeteries were segregated by race. Black people could not leave their homes between nine p.m. and four a.m. Many white women did not circulate among the Congolese and might only know their "boy" and chauffeur.[106] This residential segregation lessened in the 1950s but the Congolese remained second-class citizens in their own homeland.[107]

As Jennifer Rankin summed it up, "Segregation was total. For white people, it was a world of free healthcare, tennis in the afternoon, black-tie balls, and grenadine cocktails in the evening. For the Black population [*presumably not the évolués*], it was a subsistence diet of cassava root that rarely, if ever, included meat. Only white people could be army generals, engineers, or doctors, while adult Black men were referred to as 'boy.'"[108]

Until 1953, no *indigène* (native person) was allowed to own land. Rather, they had to request housing from the *Service de population noire* (Service for the Black Population) and to report any change of residence. This same government service provided the *laissez-passer* (a pass) to go into the European section outside the customary hours. In contrast to the *évolués*, families of more modest means found themselves living in difficult conditions, often with two families crowded into a house meant for one.[109]

Gender inequality – a modern term for an age-old phenomenon – was rampant in the Belgian Congo, but it was not a source of social unrest at the time. Rather, the male domination that characterized all aspects of colonialism remained the modus operandi for the colony. Educational opportunities for girls – while increasing – were a fraction of what boys enjoyed. In 1949, only one in ten schoolchildren were girls. This increased to 18% by 1954–55, then to 28% by 1958–59. Girls in urban areas were twice as likely to attend school as their rural counterparts.[110] Boys were taught in French, girls in the local languages.[111] Later, the elite schools worked to teach girls at least rudimentary French, to prepare them for marriage to an *évolué*. Yet not all *évolués* wanted educated wives, who might be less submissive and obedient.[112]

Within marriage, the same gender inequality reigned. Based on the accounts of Haitian anthropologist Suzanne Comhaire-Sylvain, as of the mid-1940s, men considered themselves far superior to their wives, who were largely uneducated and illiterate; they would only discuss important matters with other men. The husbands decided if their wives would be permitted to work. It would be unthinkable to ask their wife for advice or confide in her on a personal matter. Rather, the wife's role was to serve him, give him pleasure, and produce his children. Consequently, the woman was marginalized, even in her own household. She lived in constant fear of being replaced by a mistress (*concubine*). Worst yet, if

the husband died, his family would inherit everything the couple owned, down to the clothes on her back.[113]

By the time of independence, the most educationally advanced Congolese female was a senior in an academic high school. There were several hundred students attending the two (recently created) universities in the Congo, and roughly 800 cumulative secondary school graduates; yet, none of them were girls. The Congo had one of the highest rates of school enrollment for boys but one of the lowest for girls in the Global South.[114]

In 1955, urban residents and rural dwellers inhabited two different worlds. The majority of the Congolese population still resided in rural areas, characterized by subsistence farming and low productivity.[115] Whereas urban dwellers and skilled workers near the mines benefited from improved wages and housing, the boom from World War II had only a modest effect on rural wages.[116] The *paysannats indigènes* – designed to improve conditions in rural areas – had failed to deliver. In the rural areas, conditions were miserable, malnutrition was widespread, and even hunting became increasingly futile. Rural dwellers responded by fleeing en masse to urban areas in hopes of a better life.[117]

Modernization brings changing social mores

In an article that brings to light the reproductive health issues of the time better than any other, Hunt (1991) reflects: "I cannot be the first to notice that where women most often appear in the colonial record is where moral panic surfaced, settled and festered."[118]

In 1930, the colonial government passed a new law taxing "women theoretically living alone" (*femmes théoriquement vivant seules*).[119] Targeting a perceived source of immorality, this law applied to women who were divorced, widowed, or single, whatever their livelihood. Exemptions were made for old age, illness, and having more than two minor children. This umbrella label covered young, unmarried girls still living with their parents, but the true target were the *femmes libres*, presumed to be living off sexual liaisons of some sort.[120] As a pamphlet from that era explained, "A woman free of all conjugal or pseudo conjugal ties becomes simple food for prostitution."[121] Their very presence in the cities challenged the colonial idea of Christian matrimony that the Catholic Church had promoted in its civilizing mission in the Congo. Once again, the colonial administration found itself in the morally ambiguous position of collecting revenue while taxing moral depravity. An estimated 20% of the tax revenue collected in Stanleyville came from this source.[122]

Since the time of annexation, colonial authorities had considered polygamy the bane of morality in the Belgian Congo. After its earlier attempts to discourage the practice through taxation, the colonial administration passed a law in 1950 to outright ban polygamy by refusing to legally recognize any polygamous marriages contracted after January 1, 1951. Those already in a polygamous union were not expected to "put away" their additional wives, but they were prohibited from moving into the *centres extra-coutumiers* (urban and industrial areas outside of customary rule).[123]

If this new law curtailed some polygamous unions, it created a new phenomenon of camouflaged polygamy. Congolese men in urban areas took on an additional wife, either as a sign of affluence or in emulation of some Europeans' debauchery.[124] Some claimed that the law of 1950 was aimed at rooting out *les femmes supplementaires* (extra wives), but it simply sent camouflaged polygamy underground.

In 1945, men outnumbered women almost two to one in Leopoldville, which further complicated the process of finding a mate. Most women married within their tribe. In urban areas, the groom or his family was expected to provide a furnished lodging for his bride to inhabit, and the family of the groom would pay a dowry to the family of the bride, which was higher if she had been raised in Kinshasa.[125] Whereas many young girls prided themselves on fetching a high price for their families, others (especially after independence) resisted the idea of being "sold" into marriage. With the dowry came the expectation that the bride would repay it to the groom's family by producing a large number of children.

Most women legally depended on a male: father, brother, husband, uncle, etc. They were not issued a separate identification card but rather simply listed on the roster of the head of household. The small number of women who did work were able to get an ID and work card. Surveillance of this category of women was far less stringent than for the growing number of unmarried women in urban areas, which greatly concerned colonial authorities.[126]

With urbanization, the traditional mores that governed sexual behavior eroded. In particular, the practice of prolonged breastfeeding accompanied by postpartum abstinence waned. The *évolués* who eschewed polygamy and sex with *femmes libres* sought a more rapid return to sex after their wives gave birth. Women wanted to keep their husbands close to home. European women touted the benefits of powdered milk or other substitutes for breastmilk,[127] although the practice of breastfeeding remained near-universal. In surveys conducted four decades later among women of reproductive age, one still found the category of *lits séparés* (separate beds) as one method of pregnancy prevention.

The accounts of Comhaire-Sylvain suggest that premarital sex was condoned, at least in some circumstances. Girls still living with their parents would cook for their future husbands and have sex with him if he so desired. If this arrangement did not produce a pregnancy, the relationship was likely to be terminated. If the girl demonstrated her fertility by becoming pregnant, the relationship then moved toward a regular marriage.[128]

In urban centers, women continued to play their role as housewives, often summoned from the village to join a man who had migrated to the city in marriage. Yet by the end of the 1940s, a small number of women began to migrate from rural areas to Kinshasa on their own, in search of opportunities or freedom. They took up small trade; many sold foodstuffs at the local markets: manioc roots, manioc bread, palm oil, indigenous beverages, and dried fish. A small number of women preferred the freedom that came with being a *femme libre*, the mistress (*concubine*) of a man able to provide her with gifts of clothes or jewelry.

As the cities began to develop, they gained a new *élan*. Women dressed in colorful *pagnes* (pieces of fabric with bold prints, which were made into a shirt,

blouse, and matching head scarf), a custom introduced by the nuns at the missions. A dozen different hairstyles burst onto the fashion scene, some taking up to three hours to create.[129] Women contributed to shaping a new modern African lifestyle, and a handful even broke through to attain prestigious positions.[130]

The fever of independence grips Congolese leaders

As of 1950, Belgium had no vision of moving toward independence in the Congo. Rather, they prided themselves on having a "model colony," which seemed free of the tensions experienced in other African colonies. When King Baudouin criss-crossed the country in 1955, he received a warm reception from Black and white people alike, wherever he went. It was hard to imagine the trouble that brewed just beneath the surface.[131]

Then, as Van Reybrouck describes "… suddenly, it went like lightning. In 1955, not a single native organization dreamed of an independent Congo. Five years later that political autonomy was a fact."[132]

Realizing the inevitability of change, a Belgian professor, A A J (Jef) van Bilsen, produced a blueprint for independence. His plan called for independence after 30 years, the time needed to create an educated elite to run the country. Published in 1955, the "Thirty Year Plan for the Political Emancipation of Belgian Africa" (*Un plan de trente ans pour l'émancipation politique de l'Afrique belge*) was initially received favorably among a small circle of Belgians and Congolese.[133] Yet a year later, it was translated to French and began to circulate more widely through the streets of Kinshasa. One of the new young leaders, Joseph Kasavubu, decried it as too timid, too slow.[134]

In the late 1950s, the *évolués* became increasingly disenchanted with their second-class citizenship in the Congo. Despite progress in wages, housing, education, and legal status (for a few), they sought economic parity and social acceptance as equals from the European elite. A drop in the price of raw materials on the international market in 1956 triggered a loss of jobs and increased crowding in the cities, as the unemployed were forced to move in with relatives. Bars began to pop up, and prostitution was on the rise, further contributing to urban unrest.[135]

Belgian officials sensed that times were changing but hoped to appease the local population with additional concessions. In 1957, municipal elections were held on a trial basis in three urban centers; only males were eligible to vote.[136] There was talk of a move toward a Belgian-Congolese society that would be more equitable, with greater opportunities for advancement.[137] By now, the Congolese were skeptical.

The year of great turbulence was 1958.[138] Several events occurred in quick succession that made a mockery of Professor van Bilsen's 30-year plan for independence.

In 1958, the Belgian government invited 300 Congolese including large groups of soldiers to attend the Brussels World Fair, giving them a front-row seat to observe the enviable European way of life and allowing Congolese from different

parts of the country to mingle. They discovered a land in which Africans were welcome in restaurants, cafés, and movie theaters.[139] Shortly thereafter, across the river from Kinshasa in Brazzaville, French President Charles de Gaulle spoke of autonomy for France's colonies. In December 1958 the All-Africa People's Conference was held in the newly independent Ghana, stirring the emotions of Patrice Lumumba and other Congolese leaders who attended. Within a month, the charismatic Lumumba was back in Kinshasa, calling for independence from colonial imperialism for the Congo as a whole.[140] The Belgians were growing increasingly apprehensive of this charismatic, outspoken leader who showed no signs of kowtowing to Brussels.

On January 4, 1959, fistfights broke out after a soccer game in Kinshasa and thousands joined the melee, which turned violently against the white population. Cries for independence rang out; rioting and looting targeted all things Belgian. By late afternoon bedlam spread across the entire *cité;* the army – greatly outnumbered by protesters – resorted to teargas and gunfire to control the mob. Forty-seven Congolese lost their lives.[141] For safe measure, Lumumba was jailed.[142]

This level of unrest sent shock waves through both Belgium and the Congo. The Belgian government continued to be noncommittal on a date for independence. Yet wishing to avoid further bloodshed, on January 13, 1959, the Belgian King Baudouin went on the radio to announce to the world that Belgium would work toward full independence of the Congo "without delay, but also without irresponsible rashness."[143]

In preparation for elections and independence, new political parties proliferated in Congo, often along ethnic lines that allowed these new leaders to reach large audiences with a common affiliation.[144] The riots of January 4 landed Kasavubu in prison for several months, but it only heightened the populace's support for him as their future leader. His stance was radical and anti-colonial. Moise Tshombe also emerged as a potent leader and spokesperson for the Katangan tribes, with a far more friendly stance toward the concept of a harmonious Belgian-Congolese community. Lumumba wanted a radical separation from Belgium but a unified Congo.[145] Discussions among different parties over the ideal date for independence only stirred the desire for an immediate rupture with Belgium, whether or not the Congo was prepared.

Desperate to calm the situation, the Belgians called for elections in late 1959, but they were boycotted by the major political parties that doubted the sincerity of Belgium to grant them independence. Backed into a corner, Belgium invited a Congolese delegation to a Round Table in Brussels to discuss independence.

On January 6, 1960, the Round Table Conference began in Brussels with some 60 Belgians and 90 Congolese delegates, including Kasavubu and Tshombe. Lumumba – by then in jail – was released to join the delegation in Brussels. The Belgians still envisioned a period of preparation to ensure a smoother transition to independence, perhaps by the mid-1960s. Despite differences on other issues, the Congolese delegation was united in its defiance against further delays. Lumumba pressed for a specific date. Rapid and unconditional independence became a goal in itself.[146]

With the situation on the ground becoming more violent by the day, Belgium wanted to avoid outright warfare over independence as had occurred in Algeria. Moreover, the United Nations by now looked unfavorably upon European countries resisting independence for their colonies. Rather than fight a losing battle, the Belgians hastily agreed to elections in May and independence on June 30, 1960. The political powers drew up a "pseudo constitution" based entirely on the Belgian political model, with no adaptation to the unique circumstances of the Congo.[147] African Jazz – a premier Congolese band – composed a song that would soon ring out across the Congo: "*Indépendance Cha-Cha*."

The top Congolese leaders aspiring to power returned from Brussels to campaign vigorously ahead of the May elections. They could not sacrifice any time away from the Congo to participate in the second Round Table in Belgium, held in March-May 1960. Rather, a second-tier team of young party members assisted by a few Congolese who had studied in Belgium represented Congo at these negotiations. They were no match for skilled and seasoned Belgians there to safeguard their business interests in the Congo. One astute tactic by the Belgians was to allow Congo-based companies to register their businesses in Belgium, thus ensuring them continued protection under Belgian law, even in the event of nationalization. Similarly, the portion of shares in these companies reserved for the Belgian government would not transfer to the new Congolese government but remain in the hands of a new (still nebulously defined) Belgian-Congolese development company.[148] As a consequence, large portions of the mineral wealth of the Congo would continue to flow to Belgium for years to come.

One of the participants of the second Round Table was Joseph Mobutu (representing Lumumba), who later acknowledged that the group's collective lack of training in macro-economics allowed them to be bamboozled in these negotiations.[149]

Three days before independence, the Belgian parliament – with the ill-advised endorsement of the Congolese – disbanded the organization that controlled UMHK, the most profitable company in Congo. This move ensured that the new Congolese government could not meddle in the affairs of UMHK. Although Congo remained a part owner, it would receive far less of the profits than the Belgians.[150] In short, the political power in the new country would revert to Congolese leaders, but much of its wealth would remain in Belgium.

Several political factions vied for power in the May 1960 elections prior to independence. Politicians made rash promises to the masses: that they would become rich overnight, that repressive laws would be abolished, and that employment and taxes would disappear. Voting occurred along ethnic lines, with three men garnering the most votes – Lumumba (representing the northwest and central parts of the country), Kasavubu (the western part), and Tshombe (the far south) – but no one had an absolute majority. Members of Parliament were elected at the national level and to other offices in the provinces. A week before independence, a compromise was reached: Kasavubu would become President, Lumumba Prime Minister. Tshombe – whose region of Katanga represented the major wealth of the country – came away with little to show, a grievance that would come back to haunt the new country.[151]

On June 30, 1960, King Baudouin proclaimed national independence for the Belgian Congo. The country had a total of 16 European-trained university graduates and 600 trained Congolese priests. The *Force publique* did not have a single Black officer, nor was there a single native doctor, lawyer, agronomist, or economist to govern this new country.[152]

Notes

1 Kisangani, Emizet François. *The Belgian Congo as a Developmental State: Revisiting Colonialism*. New York: Routledge, 2022, p 9
2 Van Reybrouck, David. 2014. *Congo: The Epic History of a People*. London: Fourth Estate, p 105
3 Kisangani, Emizet François. *Historical Dictionary of the Democratic Republic of the Congo*. 4th ed. London: Rowman & Littlefield, 2016, p 63
4 Kisangani, 2016, p 5
5 Gann, L. H., and Peter Duignan. *Colonialism in Africa 1870–1960: Volume 4*. London: CUP Archive, 1969, p 82; Van Reybrouck, p 120
6 Abbott, Peter. 2002. *Armies in East Africa 1914–18*. First Edition. Oxford: Osprey Publishing, p 10
7 Van Reybrouck, 2014, p 128
8 Kisangani, 2016, p 154
9 Van Reybrouck, 2016, p 122
10 Following the lead of Hunt (1991, p 471), this book uses the term polygamy rather than polygyny, in keeping with francophone colonial usage.
11 Fenske, James. "African Polygamy: Past and Present." *Journal of Development Economics* 117 (November 1, 2015): 58–73. https://doi.org/10.1016/j.jdeveco.2015.06.005, p 1
12 Hunt, Nancy Rose. "Noise over Camouflaged Polygamy, Colonial Morality Taxation, and a Woman-Naming Crisis in Belgian Africa." *The Journal of African History* 32, no. 3 (1991): 471–94, p 472
13 Walle, Etienne van de, and Francine van de Walle. "Postpartum Sexual Abstinence in Tropical Africa." *Population Studies Center*, African Demography Working Paper Series, no. 17 (January 1989): 15, p 15
14 Caldwell, J. C., and P. Caldwell. "The Demographic Evidence for the Incidence and Cause of Abnormally Low Fertility in Tropical Africa." *World Health Statistics Quarterly. Rapport trimestriel de statistiques sanitaires mondiales* 36, no. 1 (1983): 2–34, p 16
15 Hunt, 1991, p 471–94
16 Hunt, 1991, p 473
17 Hunt, Nancy Rose. "'Le bébé en brousse' European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo." *The International Journal of African Historical Studies* 21, no. 3 (1988): 401–32. https://doi.org/10.2307/219448, p 411
18 Kisangani, 2022, p 9
19 Van Reybrouck, 2014, p 137
20 Soriano, Víctor Fernández. "'Travail et Progrès': Obligatory 'Educational' Labour in the Belgian Congo, 1933–60." *Journal of Contemporary History* 53, no. 2 (2018): 292–314, p 305
21 Hunt, 1991, p 478
22 Headrick, Daniel R. "Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940." *PLOS Neglected Tropical Diseases* 8, no. 4 (April 24, 2014): e2772. https://doi.org/10.1371/journal.pntd.0002772, p 5

23 Kisangani, 2022, p 68; Van Reybrouck, 2014, p 202
24 Hochschild, Adam. *King Leopold's Ghost: A Story of Greed, Terror, and Heroism in Colonial Africa*. New York: HarperCollins, 1998, p 233
25 Hunt, 1988, p 410
26 Mme. van der Kerken. "Les oeuvres sociales et humanitaires au Congo belge," in *Congres colonial national*, Ve session, 1941, no. 15, p 8
27 Congres Colonial National, 1920, 102–104; Leo Lejeune, "L'enfance noire," *Bulletin de l'Union des femmes coloniales*, 15, 88 (February 1938), p 10–11
28 Mme van den Perre. "A la Ligue pour la protection de l'enfance noire," *Notre colonie*, 7, 103 (February 1926), p 44
29 Lauro, Amandine. "Women in the Democratic Republic of Congo." In *Oxford Research Encyclopedia of African History*, Oxford: Oxford University Press, 2020. https://doi.org/10.1093/acrefore/9780190277734.013.544, p 9; Hunt, 1991, p 428
30 Romaniuk, Anatole. "Persistence of High Fertility in Tropical Africa: The Case of the Democratic Republic of the Congo." *Population and Development Review* 37, no. 1 (2011): 1–28. https://doi.org/10.1111/j.1728-4457.2011.00388.x, p 5
31 The Belgian Monarchy, "Expressions of Interest". https://www.monarchie.be
32 Kisangani, 2022, p 6
33 Faris, Ellsworth. "Native Education in the Belgian Congo." *The Journal of Negro Education* 3, no. 1 (1934): 123–30. https://doi.org/10.2307/2292146, p 127
34 Kisangani, 2022, p 20
35 Mottoulle, Léopold. *Politique sociale de l'Union minière du Haut-Katanga pour sa main-d'œuvre indigène et ses résultats au cours de vingt années d'application*. Vol. 14. G. van Campenhout, 1946, p 52
36 Lauro, 2020, p 7
37 Depaepe, Marc, and Annette Lembagusala Kikumbi. "Educating Girls in Congo: An Unsolved Pedagogical Paradox since Colonial Times?" *Policy Futures in Education* 16, no. 8 (November 2018): 936–52. https://doi.org/10.1177/1478210318767450, p 939
38 Lauro, 2020, p 7
39 Depaepe and Kikumbi, 2018, p 939
40 Vinck, Honoré, Jan Briffaerts, Frederik Herman, and Marc Depaepe. "Expériences scolaires au Congo belge: Étude exploratoire." *Annales Aequatoria* 27 (2006): 5–101, p 62–63
41 Guirkinger, Catherine, and Paola Villar. *Pro-birth policies, missions and fertility: historical evidence from Congo*. No. 2204. Namur:University of Namur, Development Finance and Public Policies, 2022, p 16
42 Guirkinger and Villar, 2022, p 9
43 Kisangani, 2022, p 9; Depaepe and Kikumbi, 2018, p 4; Yates, Barbara A. "Colonialism, Education, and Work: Sex Differentiation in Colonial Zaïre." In *Women And Work In Africa*. Boulder, CO: Routledge, 1982, p 142
44 Kisangani, 2022, p 116–18
45 Emoungu, Paul-Albert. "Schooling and Economic Development Revisited: The Case of Zaïre." *The Journal of Negro Education* 56, no. 3 (1987): 282–98. https://doi.org/10.2307/2295224, p 293
46 Kisangani, 2022, p 18
47 Van Reybrouck, 2014, p 164, 171
48 Lagae, Johan. "Colonial Encounters and Conflicting Memories: Shared Colonial Heritage in the Former Belgian Congo." *The Journal of Architecture* 9, no. 2 (June 2004): 173–97. https://doi.org/10.1080/1360236042000230161, p 181
49 Timberg and Halperin, 2012, p 61
50 Kisangani, 2016, p 449
51 Kisangani, 2022, p 17
52 Jewsiewicki, B. "The Great Depression and the Making of the Colonial Economic System in the Belgian Congo." *African Economic History*, no. 4 (1977): 153–76. https://doi.org/10.2307/3601245, p 155–60

53 Moulaert, George. *Problèmes coloniaux d'hier et d'aujourd'hui: pages oubliées: "38 années d'activité coloniale."* L'Édition universelle, 1939; Van der Kerken, Georges. *La crise économique en Afrique belge: situation actuelle et perspectives d'avenir*. Emile Bruylant, 1931
54 Jewsiewicki, 1977, p 155; Kisangani, 2022, p 163
55 Jewsiewicki, 1977, p 158–60
56 Jewsiewicki, 1977, p 160; Palmer, Robin H., and Neil Parsons. *The Roots of Rural Poverty in Central and Southern Africa*. Berkeley, CA: University of California Press, 1977, p 333
57 Hunt, 1991, p 482; Sousa, João Dinis, Philip J. Havik, and Anne-Mieke Vandamme. "Sexually Transmitted Infections, Their Treatment and Urban Change in Colonial Leopoldville, 1910–1960." *Medical History* 65, no. 2 (2021): 178–96. https://doi.org/10.1017/mdh.2021.11, p 191
58 Kisangani, 2022, p 541
59 Jewsiewicki, 1977, p 162
60 Jewsiewicki, 1977, p 171; "Problèmes de l'après-guerre", Archives régionales du Shaba, Lubumbashi and Archives nationales, Kinshasa; Kamwanya, Kalala. "The Present Exploitation of Agricultural Sector and the Integral Development Process in Zaïre." *African Study Monographs* 14, no. 3 (1992): 133–51, p 144
61 Kisangani, 2022, p 121
62 Jewsiewicki, 1977, p 164
63 Romaniuk, 1980, p 294
64 Sousa, Havik, and Vandamme, 2021, p 186; Timberg, Craig, and Daniel Halperin. *Tinderbox: How the West Sparked the AIDS Epidemic and How the World Can Finally Overcome It*. New York: Penguin, 2012, p 58
65 Caldwell, J. C., and P. Caldwell. "The Demographic Evidence for the Incidence and Cause of Abnormally Low Fertility in Tropical Africa." *World Health Statistics Quarterly. Rapport trimestriel de statistiques sanitaires mondiales* 36, no. 1 (1983): 2–34, p 16–17; Romaniuk, A. "Increase in Natural Fertility during the Early Stages of Modernization: Evidence from an African Case Study, Zaïre." *Population Studies* 34, no. 2 (July 1980): 293–310. https://doi.org/10.1080/00324728.1980.10410391, p 294
66 Retel-Laurentin, Ann. 1974. "Sub-Fertility in Black Africa-The Case of the Nzakara in Central African Republic." *Subfertility and Infertility in Africa*, p 71; Frank, Odile. "Infertility in Sub-Saharan Africa: Estimates and Implications." *Population and Development Review* 9, no. 1 (1983): 137–44. https://doi.org/10.2307/1972901, p 138
67 Romaniuk, 1980, p 298
68 Hunt, Nancy Rose. *A Nervous State: Violence, Remedies, and Reverie in Colonial Congo*. Durham, NC: Duke University Press, 2016, p 141
69 Shapiro, David, and B. Oleko Tambashe. "Fertility in the Democratic Republic of the Congo." *Population Research Institute, Pennsylvania State University*, 2001, p 16
70 Romaniuk, 1980, p 299
71 Romaniuk, 1980, p 296, 304
72 Caldwell and Caldwell, 1988, p 29
73 Kisangani, 2022, p 73
74 Van Reybrouck, 2014, p 185
75 Kisangani, 2022, p 83
76 Kisangani, 2016, p 541
77 Van Reybrouck, 2014, p 191
78 Kisangani, 2022, p 74
79 Van Reybrouck, 2014, p 191, 200
80 Kisangani, 2022, p 12
81 Kisangani, 2022, p 84
82 Willame, Jean-Claude. *Patrimonialism and Political Change in the Congo*. Stanford, CA: Stanford University Press, 1972, p 25

83 Young, Crawford. *Politics in Congo: Decolonization and independence*. Vol. 2313. Princeton, NJ: Princeton University Press, 2015, p 93
84 Van Reybrouck, 2014, p 219
85 Kisangani, 2022, p 20, 84
86 Comhaire-Sylvain, Suzanne. *Femmes de Kinshasa, hier et aujourd'hui*. Paris: Mouton, 1968, p 16
87 Van Reybrouck, 2014, p 218
88 Pépin, Jacques. *The Origins of AIDS*. Cambridge, UK: Cambridge University Press, 2011, p 200–32
89 Guirkinger and Villar, 2022, p 16
90 Kisangani, 2022, p 10
91 Lashman, Karen. "Syncrisis: The Dynamics of Health." Washington, DC: US Department of Health, Education and Welfare, Office of International Health, 1975, p 85, 137
92 Gann, Lewis H. *The Rulers of Belgian Africa, 1884–1914*. Princeton, NJ: Princeton University Press, 2015, p 79
93 Kisangani, 2022, p 12
94 Depaepe, Marc, and Denise Angotako Mawanzo. "Colonial Education in the Belgian Congo." In *Encyclopédie d'histoire Numérique de l'Europe*, 2022. https://ehne.fr/en/encyclopedia/themes/education-teaching-and-professional-training/education-in-a-colonial-environment/colonial-education-in-belgian-congo
95 Willame, 1972, p 26
96 Van Reybrouck, 2014, p 2
97 Kisangani, 2022, p 84
98 Joye, Pierre, and Rosine Lewin. *Les trusts au Congo*. Brussels, Belgium: Société populaire d'éditions, 1961, p 190
99 Kisangani, 2022, p 19
100 Kisangani, 2022, p 77
101 Lashman and Daly, 1975, p 154
102 Depaepe and Kikumbi, 2018, p 943
103 Geenen, Kristien. "Categorizing colonial patients: segregated medical care, space and decolonization in a Congolese city, 1931–62." *Africa* 89, no. 1 (2019): 100–124, p. 114; Gondola, Ch Didier. *Tropical Cowboys: Westerns, Violence, and Masculinity in Kinshasa*. Bloomington, IN: Indiana University Press, 2016, p 44
104 Van Reybrouck, 2014, p 219; Young, 2015, p 84
105 Van Reybrouck, 2014, p 219
106 Comhaire-Sylvain, 1968, p 51
107 Tunamsifu, Shirambere Philippe. "The Colonial Legacy and Transitional Justice in the Democratic Republic of the Congo." *African Journal on Conflict Resolution* 22, no. 2 (2022): 85–110, p 89–93
108 Rankin, Jennifer. "Belgium Faces up to Postwar 'Apartheid' in Congolese Colony." *The Observer*, December 9, 2018, sec. World news. https://www.theguardian.com/world/2018/dec/09/belgium-addresses-postwar-apartheid-in-colonial-congo
109 Comhaire-Sylvain, 1968, p 15, 21
110 Depaepe and Kikumbi, 2018, p 942
111 Lauro, 2020, p 7
112 Depaepe and Kikumbi, 2018, p 942
113 Comhaire-Sylvain, 1968, p 41
114 Yates, 1982, p 127, 142
115 Nzongola-Ntalaja, Georges. *The Congo from Leopold to Kabila: A People's History*. London: Bloomsbury Publishing, 2002, p 73
116 Kisangani, 2022, p 149
117 Van Reybrouck, 2014, p 206–08
118 Hunt, 1991, p 471

119 Timberg and Halperin, 2012, p 59; Hunt, 1991, p 484
120 Lauro, p 12
121 Hunt, 1991, p 476
122 Hunt, 1991, p 489
123 Hunt, 1991, p 476
124 Hunt, 1991, p 480
125 Comhaire-Sylvain, 1968, p 25
126 Comhaire-Sylvain, 1968, p 14–15
127 Hunt, 1988, p 405
128 Comhaire-Sylvain, 1968, p 23–24
129 Comhaire-Sylvain, 1969, p 23
130 Gondola, Ch Didier. "Unies pour le meilleur et pour le pire. Femmes africaines et villes coloniales: une histoire du métissage." *Clio. Femmes, Genre, Histoire*, no. 6 (November 1, 1997). https://doi.org/10.4000/clio.377, p 6
131 Van Reybrouck, 2014, p 224–27
132 Van Reybrouck, 2014, p 227
133 Van Reybrouck, p 229
134 Van Reybrouck, 2014, p 233; Labrique, Jean. *Congo politique*. Leopoldville: Éditions de l'Avenir, 1957, p 271
135 Van Reybrouck, 2014, p 234–35
136 Lauro, 2020, p 14
137 Kisangani, 2016, page xxxiv
138 Van Reybrouck, 2014, p 239
139 Van Reybrouck, 2014, p 239
140 Kisangani, 2016, p xxxiv
141 Van Reybrouck, 2014, p 249–50
142 Gerard, Emmanuel, and Bruce Kuklick. *Death in the Congo: Murdering Patrice Lumumba*. Cambridge, MA: Harvard University Press, 2015, p 16
143 Baudouin I, Roi Des Belges, and Maurice Van Hemelrijck. Congo: allocution du roi Baudouin. Brussels, Belgium; Paris, France: RTL 1959. Audio file
144 Van Reybrouck, 2014, p 252–33; Caprasse, Pierre. *Leaders africains en milieu urbain, Elizabethville*. Centre d'étude des problèmes sociaux indigènes, 1959, p 137–41
145 Van Reybrouck, 2014, p 253
146 Van Reybrouck, 2014, p 254
147 Kisangani, 2016, p 85
148 Merlier, Michel. *Le Congo de la colonisation belge à l'indépendance*. Paris: Maspero, 1962, p 292
149 Seko, Mobutu Sese, and Jean-Louis Remilleux. *Dignity for Africa*. Paris: A. Michel, 1989, p 46
150 Joye and Lewin, 1961, p 290–95
151 Van Reybrouck, 2014, p 260–65
152 Van Reybrouck, 2014, p 266

3 The First Decade Post-Independence (1960–69)

Indépendance, cha…cha…

On June 30, 1960, King Baudouin declared independence for the Belgian Congo before the two chambers of parliament in the Palais de la Nation. After King Baudouin's discourse, President Kasavubu followed with a respectful, conciliatory speech. Although not scheduled to speak, Lumumba rose to give his own words of farewell to the Belgian colonizers. His vitriolic speech listed the many indignities suffered under Belgian rule: the humiliating slavery, the grueling labor, the pilfering of the nation's raw materials, the rampant discrimination against the Black man, even the insult of being addressed by whites with "*tu*," never "*vous*."[1] Even some of his own followers felt he had overstepped the line. The Belgians and the American President reacted in unison: Lumumba needed to go.

Finally, the Congolese were free. The local population emptied into the streets in raucous celebration of this day. Beer flowed freely amid parades, dancing, and fireworks. Many assumed with this transfer of power, they would inherit the lifestyle of the Belgians, live in their villas, drive expensive cars, and receive astronomically high salaries.[2]

The first five years post-independence became known as the First Republic (1960–65), during which time the country went by the name of the Republic of Congo.

If the Congolese had succeeded in liberating themselves from Belgian rule, now the leaders faced the daunting task of governing this vast territory and managing the unrealistic expectations of its citizens. At the helm were the two leaders with opposing visions: President Kasavubu, whose ABAKO (*Alliance des Ba-Kongo*) party favored a federation of the Congo's provinces, and Prime Minister Lumumba, whose MNC (*Mouvement National Congolais)* sought a unified state. These leaders would never resolve their differences.[3]

1960–65: *la crise congolaise*

The joyous independence celebrations quickly soured. Within a week, the country descended into political and economic chaos that would last for the next five years. Van Reybrouck divided this tumultuous period into three acts.[4] The first lasted for

DOI: 10.4324/9781032718897-4

seven months, ending with Lumumba's death on January 17, 1961. The second took place from 1961 to 1963, and revolved around the Katangan secession. The third, occurring from 1964–65, began with a rebellion in the east and ended with a military coup on November 24, 1965, which brought Joseph-Désiré Mobutu to power.

The charismatic Lumumba creates enemies at home and abroad

The crack in the armor began with the *Force publique*, consisting of 1,000 European officers who still controlled a force of 25,000 Congolese. Even before independence, the Congolese had outlined their grievances and their demands: for greater authority, higher salaries, and an end to discrimination within the ranks.[5]

Four days after independence, some of the Congolese soldiers disobeyed orders from their superiors. To establish discipline, the chief commander, a Belgian named Emile Janssens, lectured the assembled troops at the Thysville military base on their continued responsibility to serve the country. He underscored his point by writing across the chalkboard: "before independence = after independence." His message was that Belgian officers would remain in control.[6] The Congolese troops – outraged by this proclamation that dashed their hopes for change – revolted. The mutiny spread to other bases, and violence soon swept across the country.[7] Lumumba quickly acted to quell the revolt. He promised every soldier a promotion to the next highest rank. When that failed, he replaced the commander chief Emile Janssens with a Congolese, Victor Lundula, and appointed Joseph Mobutu as his chief of staff. And he renamed the *Force publique* the *Armée Nationale Congolaise* (ANC).

The violence triggered by the mutiny – first against the white officers at the military camp, then against white people in general – reflected the pent-up grievances against the colonizers. Europeans feared for their lives – with reason. The greatest panic among the European community was the threat of sexual violence toward their women.[8]

The Belgians reached their breaking point. Without permission from Kasavubu or Lumumba, Belgium sent its paratroopers to Elizabethville, where five Europeans had been killed. They justified their actions in the name of protecting their citizens. On the same day – July 11, 1961 – Moïse Tshombe declared the independence of Katanga, an action supported by Belgium which had a vested interest in this mineral-rich area. This act effectively stripped the new nation of its most valuable source of revenue.[9] Outraged at the presence of the Belgian military, on July 12, Kasavubu and Lumumba called on the United Nations to send in peacekeeping troops and demanded the removal of Belgian troops. (The troops would not depart until late August.)

Within weeks, over 30,000 Europeans were evacuated.[10] In total, 10,000 civil servants, 13,000 private sector workers, and 8000 plantation owners fled the Congo.[11] The new Republic of Congo experienced a crippling exodus of experienced and technically skilled managers essential to operating government, business, and agricultural enterprises.[12]

The economy would suffer a similar decline. There was no local know-how to operate the export-oriented industry; only the mining sector remained relatively stable. Unemployment skyrocketed. People working for Belgian-owned enterprises were out of a job, as were those who worked as domestics for Europeans. With months, poverty began its insidious creep into many corners of the country.

The Western powers had a great deal at stake with this new nation, lest it fall under the influence of the Soviet Union. With the threat of the Katanga secession, the UN agreed to send in peacekeeping forces (UNOC, *Opération des Nations unies au Congo*) but would not allow them to be used to fight the secessionists in Katanga. Lumumba – displeased with the limited response of the UN – turned to the Soviet Union on July 14 with a request for assistance. Khrushchev was only too happy to oblige. On July 15, the first UN Peacekeeping troops touched down in Congo.

Although supportive of the UN efforts, US President Dwight Eisenhower was increasingly worried that the Congo could fall under Russian influence. For their part, the Belgians had painted Lumumba as an anti-white communist. On July 27, 1961, Lumumba with his entourage made a hastily scheduled visit to the United States, where he spoke at the UN. His demagogic rambling and unrealistic demands made a poor impression on his audience. He again asked both the US and the UN for support in fighting the Belgian-backed Katangan secession. President Eisenhower was frustrated with his impulsive political maneuvering; the UN was losing patience; and President Kasavubu had grown weary of his authoritarian actions.[13] When Lumumba's demands were refused, he turned to Moscow. Furious, President Eisenhower approved plans for his assassination. The Republic of Congo was not yet two months old, but the *crise congolais* (Congo crisis), as it became known, was in full force.[14]

When Lumumba succeeded in obtaining the assistance from Moscow that the West had refused him, the sides were forming. A pro-Western group of allies – including Kasavubu's chief of staff in the army, Joseph Mobutu – began to strategize the ouster of Lumumba. Meanwhile, on August 8, the diamond-rich province of Kasaï also seceded, which would soon result in additional violent deaths, this time of women and children as well.[15]

Although many suspected the CIA of disposing of Lumumba, his own rivals were responsible for his demise. On September 5, 1961, President Kasavubu – increasingly dismayed by Lumumba's power-grabbing and the growing threat of civil war – dismissed him, along with other members of his government, which was within his legal prerogative. In return, in his role as prime minister, Lumumba dismissed Kasavubu. In an attempt to calm the situation, Army Chief of Staff Joseph Mobutu "neutralized" the government on September 14, 1961, with the support of the CIA.[16] This act further strengthened Mobutu's ties with the Western nations.[17] Kasavubu stayed on but Lumumba was placed under house arrest.

In the months that followed, tensions escalated. Lumumba was detained in Leopoldville but escaped in the dark of night in a caravan headed to Stanleyville. The ANC intercepted him, took him into custody, and flew him to Elizabethville on January 17, 1961. Within hours, he would be executed by firing squad in a

remote area outside the city, his grisly death witnessed by Moïse Tshombe. Later his body would be sawed into pieces and dissolved in sulfuric acid. As the world learned of his demise, countries worldwide expressed outrage at the violent death of the spokesman for independence. In death, he became a martyr for the world's oppressed.[18]

Tshombe spearheads the Katangan secession

The second phase of the *crise congolaise* – the Katangan secession – began on July 11, 1960, and ended on January 14, 1963.[19]

The state of Katanga stood apart from the rest of the Congo, which was battling to survive the economic and political vicissitudes of its new statehood. With the *Union minière Haut Katanga* (Haut Katanga Mining Union, UMHK) in full operation, the taxes it generated went not to Leopoldville but to support the state of Katanga. Tshombe had never accepted the model of a complete break with Belgium but preferred a system whereby Belgian advisers provided training to Congolese who would gradually assume positions of power. The Belgian expat community remained alive and well, with the white population occupying their privileged positions in the social hierarchy.[20]

The UN was against the secession of Katanga; rather, it preferred to see a united Congo with a centralized government in Leopoldville. After a half-year of diplomatic discourse went nowhere, the UN decided to use force instead, in hopes of disbanding the local army and driving out foreign mercenaries. The initial offensive starting in August 1961 was ineffective in securing its desired objective but succeeded in terrorizing the local population with murders, bombings, and rapes.[21]

By mid-September 1961, Secretary-General of the UN Dag Hammarskjöld decided to take matters into his own hands. He flew to the region to meet Moïse Tshombe, in hopes of negotiating an end to the Katanga secession. During this fateful mission, his plane crashed in neighboring Zambia on September 18, 1961, killing all 15 passengers aboard. To this day, the circumstances of the crash remain a source of controversy.

U Thant took over from Hammarskjöld, determined to bring an end to Katangan secession. After a year of fruitless diplomacy and negotiations, the UN and President John Kennedy launched Operation Grandslam in late December 1962.[22] By January 14, 1963, Moïse Tshombe declared an end to Katanga secession. He fled to exile to Spain, returning to Congo a year later. He would eventually die under house arrest in Algeria in 1969.[23]

Kasavubu quells the Simba rebellion in the East

With Lumumba dead and Tshombe in exile, the third phase of the *crise congolaise* began. Kasavubu now governed the entire Congo, with support from both Belgium and the United States. A new constitution would define the rules for administering the country. In addition to dividing the country from six large provinces into 21 mini-provinces, the constitution gave the president far greater

powers than before. But Kasavubu would be confronted with new problems. A rebellion from January–May 1964, instigated by a Mao-leaning Lumumba-inspired leftist, challenged his authority. The same year, a band of greatly feared young rebels known as the Simba conquered eastern Congo, then Stanleyville, laying mayhem to those in their path. In September 1964, they declared the formation of the *Republique populaire du Congo* and controlled a third of the Congo.[24]

Kasavubu worried that Tshombe might come back from exile and join the rebels, meaning that two-thirds of the country would be out of his control. Tshombe did return – in 1964 – but to side with Kasavubu, his archnemesis for over two years. Preferring to have Tshombe on his side rather than against him, Kasavubu named Tshombe as prime minister. With support from Belgium and the United States, and participation from Congolese troops and mercenaries from abroad, the Congolese forces were able to defeat the Simba rebels in Stanleyville in November 1964, but not without a hundred people killed during the operation and countless retaliatory murders by the Simbas afterward. Soon thereafter, Kasavubu had to contend with the arrival of Che Guevara, intent on supporting the local revolutionaries in their fight against the Western-supported leaders in Leopoldville. The effort petered out after seven months.[25]

Tshombe's return to the fold not only secured the victory against the Simbas; he also proved an adept negotiator with the Belgians. His popularity surged, and in parliamentary elections held in March 1965, Tshombe won by a landslide. Kasavubu could not tolerate this growing threat to his own power, and in October 1965 he dismissed him as prime minister, just as he had dismissed Lumumba five years earlier, but the parliament refused to endorse the replacement.[26] With the government in disarray, Mobutu convened the country's military leadership to his home and declared himself the new head of state. He had successfully staged a bloodless coup. He renamed one of the main boulevards in the capital city to commemorate this day: *24 novembre*.

Through all the twists and turns of political intrigue in the preceding five years, an estimated 100,000 Congolese were killed.[27]

Five years of freefall post-independence

The economy spirals downward

The political anarchy that characterized the early days after independence caused the economy to nosedive. The Congolese had already signed away to the Belgians a major part of the country's assets: the wealth from the mines in Katanga. After the mutiny among the military led to widespread violence targeting whites, many of the European civil servants who had previously run the government took flight, along with business directors, industry managers, and technicians.[28] Agricultural production – of bananas, maize, manioc rice, coffee, cotton, and palm oil – plummeted.[29] Many plantations and factories owned by expats shut down and sent home their workers. Fields lay fallow as unharvested crops were left to rot. Trains ceased to run on time.[30] Unemployment soared. Families doubled up on

housing. Those with a job tried to feed not only their own children but those of the extended family.[31]

Meanwhile, the newly elected legislators voted themselves pay raises and health benefits, often at levels higher than their colonial counterparts had received, with little concern for the state's financial solvency or the welfare of the population.[32] The system was set up to pay their salaries first, and thus they rarely experienced the phenomenon that started after independence and has continued to the present day: of government employees receiving their salaries months late or not at all.

Although the Belgians had run a tight ship with minimum financial mismanagement or corruption, independence and the anarchy that followed provided an environment ripe for its resurgence. As Comhaire-Sylvain recounts: "Corruption was rampant. No aspect of society was indemnified from it. Once a man becomes minister, within the first month, even before being paid, he adds a floor to his house and opens the bar in the *cité*. Look for yourself. It's a lot worse than before."[33]

The end of Belgian rule did not bring an end to racial discrimination. Congolese now held the political reins to the country but Belgians and other Westerners still occupied positions of power in churches, schools, mines, and hospitals.[34] Congolese were free to use hotels, restaurants, and stores, but the small humiliations of inferior treatment by other patrons or the staff themselves endured. The same existed for Black school children now attending schools with white children.[35]

The leadership of the country – constantly embroiled in political and ethnic conflicts – had little time to invest in the mundane issues of ensuring the wellbeing of its population.

Neglect of healthcare takes its toll

At the time of independence, Congo had the best healthcare system in sub-Saharan Africa.[36] It inherited a network consisting of some 3,000 hospitals (including over 300 for the local population), clinics and dispensaries, and 99 specialized health facilities. The colonial administration had previously financed healthcare and education through subsidies to the Catholic and Protestant missionaries, and the new administration continued the practice. The Catholic Church took advantage of its own internal organization and privileged position during the colonial era to ride out the volatility post-independence and even expanded its activities at a time when the government was in near paralysis.[37]

With the flight of Europeans post-independence, many of the highly trained professionals – doctors, nurses, administrators – left the country for good. With their departure, numerous health training schools closed.[38] The vast majority of Protestant missionaries also evacuated, following the orders of their embassies. Some would return within weeks or months, others never did.[39] One account estimated that between 1960–67 the majority of health facilities were either completely destroyed or severely damaged.[40]

As time passed, government subsidies to Catholic and Protestant missionaries – the primary support for health and education facilities – had begun to dwindle. Belgian-trained Congolese auxiliary personnel stepped in to fill the gap for

emergency and curative health services, but massive inputs from overseas were needed to avoid a complete breakdown of the system.[41] The percentage of the national budget spent on health plummeted from 11% in the 1950s to 2% in the 1960s.[42] Protestant missionaries found themselves once again depending on churches back in the United States or Europe to sustain their operations.[43] By the end of the decade, the healthcare network was a motley assortment of facilities.[44]

Ironically, after years of policies that favored urban over rural populations, the tables now turned. The large majority of missionaries were located in rural areas, leaving the urban areas to contend with the health problems of the growing numbers of migrants to the city.[45]

Maternal and child mortality showed little improvement post-independence and possibly increased.[46] Diseases that had been brought under control pre-independence were again claiming the lives of Congolese citizens: sleeping sickness, tuberculosis, and river blindness.[47] The public health campaigns of the 1940s and 1950s had largely curtailed the epidemic of sterility, and fertility rates began to increase.[48] However, as the cities grew and sex workers sought to make a living, the prevalence of sexually transmitted infections (STIs) again rose.[49]

One of the most insidious diseases was lurking out of sight. Epidemiologists have traced the origins of the human immunodeficiency virus (HIV) to a remote area in Cameroon, where they believe it passed from monkeys to hunters around 1900.[50] It then made slow progress down the Sangha River to the Congo River, arriving in Leopoldville by 1920.[51] The earliest sample of HIV in blood was found in a man living in Leopoldville in 1959.[52] With the sharp economic decline that occurred soon after independence – what one researcher dubbed the "pauperization" of Leopoldville – sex workers had to increase the number of clients to as many as 1,000 a year, amplifying the spread of the virus.[53]

The quality of education declines

At the time of independence, most Congolese schoolchildren were enrolled in church-affiliated, state-financed schools;[54] only one-third of these children were girls.[55] During the 1960s, the Catholic Church solidified its position in the country in three ways. Many expatriate Catholic missionaries stayed in the country, allowing for a gradual transition in personnel. The Church maintained its ties to the political leadership of the country, many of whom recognized the social and political prestige of Catholic schooling. The two were linked in all matters relating to health and education post-independence, including in the eyes of the population.[56]

Paradoxically, the Congo experienced both an expansion and deterioration of the educational system in the 1960s. Primary education grew by almost 5% annually and secondary education by 19% annually,[57] benefiting in the late 1960s from greater economic and political stability than earlier in the decade.

Yet the quality of education suffered for multiple reasons. Even before independence, some teachers had left their posts in favor of jobs in administration or politics and were replaced by far less qualified individuals. At the time of independence, primary and secondary education was largely in the hands of the

missionaries – Catholic and (to a lesser extent) Protestant – although a few state schools operated in Kinshasa. The open hostility toward many Western teachers in the weeks following independence sent them packing. The Catholic missionaries were somewhat protected since most of the political elites in Congo had been educated by them and thought twice about turning on them.[58] Classes were too large (often 50–60 students); two or three students shared a bench meant for one. Teacher pay was low and slow to arrive, triggering strikes among the disgruntled. The ongoing political chaos during the First Republic both distracted the attention of the country's leaders from the educational needs of the children, and the general malaise of this period spilled over into the classroom.[59]

Girls remained poorly served by the education system. While they were making some progress in terms of enrollment at the primary, secondary, and even at university level, the ghost of past discrimination followed them through the system. With low rates of primary education for girls, few were prepared or eligible to enter secondary schools; few had been taught to speak French. The trend was even more dramatic for entry into university. As of 1965, of 1,000 university students enrolled, less than one percent were female, and an even lower percentage were Congolese female.[60]

In 1964 the government formalized its agreement with the missionaries regarding education. It would maintain nominal control over the education sector, develop the administrative network that would cover various church groups, and oversee curriculum design. In exchange, the Catholic and Protestant churches would receive state funding for operations and control over school personnel.[61]

1965–69: Mobutu assumes control

If the Congo had been in a state of perpetual chaos marked by political infighting since independence, it pivoted toward a starkly different reality on November 24, 1965, when Joseph Mobutu staged a bloodless coup in Kinshasa. It marked the start of the Second Republic, with a new word added to the name of the country: the "Democratic Republic of Congo."

Joseph-Désiré Mobutu was born on October 14, 1930, in the province of Equateur. His father, Alberic Bemany, was a cook and servant to a Belgian judge; his mother, Marie-Madeleine Yemo, was a hotel maid. The wife of the Belgian judge noticed Joseph's quick mind and taught him to read and write in French. Later in 1948, he would enter secondary school with the Christian Brothers in Coquilhatville (present-day Mbandaka), from which he would be expelled a year later – the result of stowing away on a ship heading for Leopoldville. His punishment for this prank was seven years of service in the colonial army.[62]

The army proved to be a good fit for Mobutu, who steadily rose through the ranks. In 1956, he worked as a journalist, publishing articles under the pseudonym "de Banzy." Before independence, he had risen to become a sergeant-general, the highest rank allowed for Africans. After independence, Lumumba named him Chief of Staff for the Army. In this role, he established himself as an exemplary Congolese officer, restoring calm to the mutinous troops following Lumumba's

Independence Day speech.[63] When, in 1960, President Kasavubu deposed Lumumba as prime minister and ousted his commander-in-chief of the National Congolese Army (ANC), Mobutu took virtual control.

After the 1965 coup, Mobutu lost no time in centralizing all authority in the presidency, ruling the country through a series of presidential decrees. Wishing to rid himself of vestiges of colonialism and annoyed by the continuing dominance of Europeans and other non-African customs and values, he introduced the concept of *authenticité*. In May 1966, he Africanized the names of the major cities: Leopoldville became Kinshasa, Elisabethville became Lubumbashi, and Stanleyville became Kisangani.[64]

In the name of unifying the country, in 1967 Mobutu established one national political party – *le Mouvement populaire de la revolution* (MPR), in which all Zairians were members from birth.[65] The party and the state became one and the same. He banned other political parties and dissolved the bi-cameral parliament. He alone was responsible for the laws of the country and the judicial system. Only the Catholic Church remained outside his domain of control.[66] Lest there be any question about his absolute power, six months into office he orchestrated a public hanging in broad daylight of four rivals, as tens of thousands of onlookers took in the spectacle in disbelief and horror.[67]

The citizens of the country – weary from the constant strikes, mutinies, assassinations, and other atrocities – initially accepted the idea of a new start for their country, or at least they resigned themselves to it. The new president seemed serious about putting his country back on a more productive track. Mobutu used the country's economic problems to justify his takeover.[68]

However, he failed to win over one group of holdouts: students at Lovanium University who bridled at his authoritarian rule. Students demonstrated on June 4, 1969, to protest poor living conditions and delays in their stipends. Mobutu sent his troops to encircle the campus, but violence nonetheless erupted. Over 100 deaths resulted, and Mobutu closed the school. An opposition group formed, taking the name, and the date would live on in remembrance of the lives lost during this clash with Mobutu's forces.[69]

In addition to steadying the political situation, Mobutu ushered in a decade of economic prosperity. In 1967, Mobutu prepared a stabilization plan with the help of the IMF, intended to restore the confidence of international investors. In the name of economic reform, he devalued the currency and introduced a new currency, the "zaïre" (z). The reform proved successful, causing inflation to fall and the economic growth rate to increase from a negative growth rate in 1967 to eight percent in 1968.[70]

Several other events strengthened the economy. In 1967, Mobutu nationalized the UMHK, paying its stakeholders and renaming it Gécamines, which would directly channel revenues to the national coffers. With the Vietnam War escalating in Asia, the price of copper spiked, providing Mobutu with the money needed to bankroll his new country.[71] He funded new infrastructure projects and brought running water and electricity to additional neighborhoods in Kinshasa.[72] New construction projects, such as a Shaba dam, provided employment and promised electrification to broad swaths of the rural area.

For the first eight years of Mobutu's administration, the country enjoyed solid growth, thanks to favorable terms of trade, restoration of private sector confidence, and sound macroeconomic management.[73] This "golden decade of Independent Congo" (1965–75) would come screeching to a halt in the mid-1970s, but while it lasted, many Congolese experienced improved economic circumstances for the first time in their lives.[74]

Those who applauded this turn toward political stability could not have imagined the price that the populace of the Congo would pay later in the 37 years of Mobutu's reign. In the decades that followed, it would become evident that cruel despotic European rule of the Belgian Congo had been replaced by cruel despotic African rule.[75]

The sex ratio improves with urbanization

The large-scale migration from rural to urban areas continued unabated in the decade post-independence. With the lifting of restrictions on movement following independence, young men and women flocked to the cities in search of better opportunities. Most found the conditions far superior to their rural existence, though the flagging economy in the early years post-independence left many searching for work and housing. Already, the 1959 administrative census had documented the problem of "squatting." Despite skyrocketing rents and scarcity of water in the *cité*, [76] the forces of modernization were in full swing.

As part of his vision to modernize the country, Mobutu talked of wanting to improve the status of women. He recognized that during the colonial period, women – especially rural women – had only limited opportunities. In the mid-1960s, he recruited women as parachutists into the Congolese army.[77] The new constitution finally granted women the right to suffrage in 1967. He welcomed women's organizations into his new party, the MPR, while banning organizations operating outside the MPR. He made substantial investment in girls' education. His catchy slogan paid lip service to a more egalitarian society: *Hommes nouveaux/femmes nouvelles: émancipation* (New men/new women: emancipation).[78]

By 1965, the sex ratio had improved in Leopoldville, with the number of women now close to equal to the number of men. Women were more likely to work than they had pre-independence. Economic necessity overcame the fears of many husbands to have their wives employed outside the home. Among married women, one in five sold agricultural products in the local markets, a job that did not require formal education. Among salaried women, the most common job was teaching (though men still outnumbered women three to one in that profession). A few women found work as clerks in stores or office workers in business or government. Opportunities also existed for nannies or "*boyesses*" (the curious term for women who now did the same work as "boys" in the colonial era).[79]

The anthropologist Comhaire-Sylvain, who lived and worked in Leopoldville in the 1960s, documented the evolution post-independence in the image of women in the Congo. The wife now felt she could "explain herself" if berated by her husband. He was more likely to go out in public with her and less apt to beat her.

Especially if educated, the woman could have a say in the children's education.[80] Yet attitudes toward women's inferiority prevailed. Husbands often managed the family budget, unwilling to delegate this task to their less educated wives. Many wanted their women to maintain an "African profile" (of submission) and not take on the European lifestyle. Even if boys and girls had the same education, boys were expected to go further than girls in their professional lives.

Societal norms favor large families

The Congo was similar to the vast number of developing countries in the 1960s where most couples desired a large family: six children on average in most Latin American and Asian nations, and seven children on average in sub-Saharan Africa. Infant mortality was still high, and couples opted to produce "supplemental children" as an insurance policy against the death of one or more offspring.[81] Also important, children represented a safety net in old age.[82] In 1960, close to 80% of the Congolese population lived in rural areas, where children were needed to harvest the fields and help with the chores. In urban areas, the *évolués* considered the ideal number of children to be five.[83]

Whatever other changes might be taking place in the country, the desire for many children remained strongly ingrained in Bantu traditions. The purpose of marriage was to produce children.[84] The Western notion of delaying the first birth to allow the couple to adjust to their new marital circumstances was totally foreign. Women who did not conceive within a year of marriage drew the scorn of their community, especially the husband's family. Children were considered the family's wealth, as reflected by the oft-heard phrase "*les enfants sont notre richesse,*" even in the most impoverished circumstances.

Traditional African societies – and Congo was no exception – favored birth spacing (much to the consternation of the colonial authorities in the Belgian Congo, discussed earlier).[85] Because African women often started childbearing at an early age and continued well into their 40s, they would give birth to a large number of children, despite the longer intervals between births.[86]

In the context of societal pressure for large families, the scourge of sterility was particularly cruel. By the 1950s, STIs (including syphilis, gonorrhea, and chlamydia) were largely under control, thanks to penicillin delivered through massive public health campaigns that blanketed the country. Yet even in the early 1960s, the effects of the epidemic of sterility were evident among older, childless women.[87] A 1963 study showed that one in five women in Congo who had attained menopause or were 45 years of age and older had never had a live birth.[88] Might the sterility epidemic have scarred the national psyche to the extent that in contemporary DRC, fear of infertility remains deeply ingrained?

In most of the developing world in 1960, fertility levels had been high and stable for a decade, suggesting little deliberate effort to reduce fertility through contraception or abortion.[89] (The contraceptive pill was only introduced in the United States in 1960.) Existing methods at the time included condoms, withdrawal, and diaphragms (the latter virtually unknown outside of the United States and Europe).

Yet abortion was practiced – if only in exceptional cases – in traditional Congolese tribes. The extracts of bark, diverse plants and roots were used to induce abortion. More violent methods included placing pressure on the abdomen or introducing sharp instruments. A woman would opt to abort to avoid the birth of adulterously conceived children, if she had experienced difficult pregnancies in the past, or wanted vengeance on her family or husband (especially in patrilineal tribes, where children conceived in marriage belonged to the husband's clan).[90] In such circumstances, women banded together to keep these abortions secret.

Reflections on the 1960s

At the risk of oversimplification, the first five years after independence – the First Republic – were perpetual chaos: a dizzying array of mutinies, riots, secessions, military interventions, abduction, and torture. Lumumba's pivot toward Moscow in 1961 had brought Africa – and more specifically Congo – into the increasingly acrid Cold War that would continue for more than two decades. The second half of the decade – starting with Mobutu's bloodless coup in 1965 – brought the country back to political stability and economic prosperity, at the price of Mobutu's tightening authoritarian grip on power.

During the First Republic (1960–65), the country enjoyed four days of peaceful celebration over its newly gained independence before the army mutinied. As violence spread across the country, the Europeans – fearing for their lives – fled the country, taking with them much of the managerial experience and technical know-how that had run the country during the Belgian Congo era. Within two weeks of independence, the mineral-rich province of Katanga announced its plans for secession. UN troops touched down to keep order, and UN secretary-general Dag Hammarskjöld died in a mysterious plane crash on a mission to the region. Lumumba was assassinated within seven months of independence. Political rivals vied for power along strong ethnic fault lines. Unable to achieve an end to the Katangan threat of secession, the UN and the US ended this dispute by military force. The eye of the political storm then moved to the east, where the Simba rebellion challenged the central government until that, too, ended in a military standoff. An estimated 100,000 persons died in these five years.

During the early years post-independence, the political leaders were so entirely consumed with the relentless political intrigues that the assets inherited from the Belgian – superb transport infrastructure, a network of health facilities that spanned the country, and a robust system of primary education – started a downward spiral that would only worsen in subsequent decades. The job of attending to the health of the population fell to the Catholic and Protestant missionaries. Agriculture and manufacturing suffered (less so the mining sector); unemployment shot up. Congolese who had expected that after independence, they would inherit the lifestyle of the departing Europeans, were bitterly disappointed.

The second half of the decade began with the bloodless coup in 1965, marking the start of the Second Republic. Mobutu lost no time in setting a new direction for the country. Having eliminated or exiled his political rivals, he sought to unify

the sharply divided factions under a new political party (the MPR), that he alone would lead. He banned opposition parties and sent members of parliament home. He brought the army under his direct control, providing the officers with perks that further ensured their loyalty. Lest anyone question his power, in 1966 he disposed of four potential rivals in a ghastly public hanging as tens of thousands of citizens looked on. Because Mobutu also sent a message of wanting to resurrect the country from its ruinous beginning, many were willing to accept the tradeoff of political stability for the iron rule that Mobutu had imposed Only the university students held out.

Mobutu had great aspirations for the country. He arranged for the Apollo 11 astronauts to visit Kinshasa – their only stop in Africa – months after their moon-walk. He established major building projects such as the Inga-Shaba dam, which provided employment and promised to bring electricity to villages across the country. Thanks to the Vietnam War, the price of copper was high, and by the end of the decade, the country had rebounded economically.

Urbanization continued at a steady pace with increasing numbers arriving in cities ill-equipped to absorb them. Between 1960 and 1970, the percentage of the population in urban areas had crept up from 22% to 25%. Poorly constructed huts with corrugated iron roofs proliferated in the *cité*, unable to absorb the numbers flooding into the city. By the time of independence, sexually transmitted diseases were largely under control and fertility had begun to increase.

In the midst of political anarchy and economic volatility, one aspect of Congolese life remained unchanged: the desire to have a large number of children. In both urban and rural areas, having many children was a source of social status, for both men and women. These children contributed to the strength of the clan, and they were one's only safety net in old age. Women might hope to receive a new *pagne* (fabric for making an outfit) as thanks for producing another child.

In rural areas, in particular, children were a much-needed source of labor. Even the poorest villager would explain that "children are our wealth," and couples welcomed "all the children that God sends." With the exception of condoms (available in pharmacies for Europeans able to pay the high prices), Congolese had little knowledge of or need for modern contraception. Some traditional means of abortion existed, but they were rarely used. Whereas the practice of birth spacing was firmly ingrained among most Congolese, it served the purpose of improving the survival of each child, not limiting the total number of children.

It is against this backdrop that family planning was introduced into the Congo in the early 1970s.

Notes

1 Van Reybrouck, David. *Congo: The Epic History of a People*. London: Fourth Estate, 2014, p 273; Centre de recherche et d'information socio-politiques (CRISP). "Congo 1959: Documents belges et africains." *Foreign Affairs*, January 1, 1961. https://www.foreignaffairs.com/reviews/capsule-review/1961-01-01/congo-1959-documents-belges-et-africains, p 323; The Guardian. "Marred: M. Lumumba's Offensive Speech in King's Presence," July 1, 1960. World News. https://www.theguardian.com/world/1960/jul/01/congo

2 Van Reybrouck, 2014, p 275
3 Van Reybrouck, 2014, p 242–43
4 Van Reybrouck, 2014, p 282
5 Van Reybrouck, 2014, p 285
6 Namikas, Lise. Battleground Africa: Cold War in the Congo, 1960–1965. 1st edition. Stanford, CA: Stanford University Press, 2013, p 114
7 United States Department of State. "Milestones: 1961–1968 – Office of the Historian." Foreign Service Institute. June 23, 2023. https://history.state.gov/milestones/1961-1968/congo-decolonization, p 2
8 Van Reybrouck, 2014, p 289
9 Nugent, Paul. *Africa Since Independence: A Comparative History*. Houndmills, UK; New York: Palgrave Macmillan, 2004, p 85–97
10 Van Reybrouck, 2014, p 289; Verlinden, Peter. *Weg Uit Congo: Het drama van de kolonialen*. Flanders, Belgium: David's Fund, 2002, p 148–51
11 Van Reybrouck, 2014, p 289
12 Kisangani, Emizet Francois. *Historical Dictionary of the Democratic Republic of the Congo*. 4th ed. London: Rowman & Littlefield, 2016, p 49
13 Kaplan, Irving. *Zaire: A Country Study*. 3rd Edition. Library of Congress, 1979, p 48; Timberg and Halperin, p 66
14 United States Department of State, p 2
15 Kisangani, 2016, p 81
16 Kisangani, 2016, p xxxv
17 United States Department of State, p 2
18 Kisangani, 2016, p 396
19 Van Reybrouck, 2014 p 311
20 Kisangani, 2016, p xxxv
21 Van Reybrouck, 2014, p 315
22 Van Reybrouck, 2014, p 316
23 Kisangani, 2016, p xxxv, 590
24 Van Reybrouck, 2014, p 318–24
25 Van Reybrouck, 2014, p 328
26 Van Reybrouck, 2014, p 329
27 Özsu, Umut. "Organizing Internationally: Georges Abi-Saab, the Congo Crisis and the Decolonization of the United Nations." *European Journal of International Law* 31, no. 2 (September 21, 2020): 601–19. https://doi.org/10.1093/ejil/chaa044, p 617
28 Briscoe, Charles H. "Congo Rescue: 1960." *Veritas* 14, no. 1 (2018): 19, p 8
29 Kisangani, 2016, p 56
30 Van Reybrouck, 2014, p 333
31 Van Reybrouck, 2014, p 329
32 Briscoe, 2018, p 7–8
33 Comhaire-Sylvain, Suzanne. *Femmes de Kinshasa, hier et aujourd'hui*. Paris: Mouton, 1968, p 109
34 Timberg and Halperin, 2012, p 67
35 Comhaire-Sylvain, 1968, p 116–17
36 Kisangani, 2016, p 279
37 Boyle, Patrick M. "Beyond Self-Protection to Prophecy: The Catholic Church and Political Change in Zaïre." *Africa Today* 39, no. 3 (1992): 49–66, p 54
38 Lashman, Karen. "Syncrisis: The Dynamics of Health." Washington, DC: US Department of Health, Education and Welfare, Office of International Health, 1975, p 85
39 Crawford, John Richard. *Protestant Missions in Congo, 1878–1969*. Kinshasa, DRC: Librairie évangélique du Congo, 1969, p 17
40 Lashman, 1975, p 85
41 Lashman, 1975, p 85
42 Kisangani, 2016, p 280

43 Crane, Sophie. *A Legacy Remembered: A Century of Medical Missions*. Kinshasa: Providence House Publishers, 1998, p 290–1
44 Baer, Franklin C. "SANRU: Lessons Learned 1981–1991." Report submitted to USAID/Washington. Harrisonburg, VA, 1992, p 3–5
45 Lashman, 1975, p 85
46 Lashman, 1975, p 47
47 Van Reybrouck, 2014, p 329
48 Romaniuk, Anatole. "Increase in Natural Fertility during the Early Stages of Modernization: Evidence from an African Case Study, Zaïre." *Population Studies* 34, no. 2 (July 1980): 293–310. https://doi.org/10.1080/00324728.1980.10410391, p 295, 299
49 Lashman, 1975, p 51
50 Timberg and Halperin, 2012, p 2
51 Timberg and Halperin, 2012, p 31; Faria, Nuno R., Andrew Rambaut, Marc A. Suchard, Guy Baele, Trevor Bedford, Melissa J. Ward, Andrew J. Tatem, *et al.* "The Early Spread and Epidemic Ignition of HIV-1 in Human Populations." *Science* 346, no. 6205 (October 3, 2014): 56–61. https://doi.org/10.1126/science.1256739, p 57
52 Schoepf, Brooke Grundfest. "'Mobutu's Disease': A Social History of AIDS in Kinshasa." *Review of African Political Economy* 29, no. 93–94 (September 1, 2002): 561–73. https://doi.org/10.1080/03056240208704638, p 561
53 Pépin, Jacques. "The Expansion of HIV-1 in Colonial Leopoldville, 1950s: Driven by STDs or STD Control?" *Sexually Transmitted Infections* 88, no. 4 (June 2012): 307–12. https://doi.org/10.1136/sextrans-2011-050277, p 311
54 Boyle, Patrick M. "Beyond Self-Protection to Prophecy: The Catholic Church and Political Change in Zaïre." *Africa Today* 39, no. 3 (1992): 49–66, p 55
55 Depaepe, Marc, and Annette Lembagusala Kikumbi. "Educating Girls in Congo: An Unsolved Pedagogical Paradox since Colonial Times?" *Policy Futures in Education* 16, no. 8 (November 2018): 936–52. https://doi.org/10.1177/1478210318767450, p 944
56 Boyle, 1992, p 56
57 Kisangani, 2016, p 207
58 Boyle, 1992, p 56
59 Comhaire-Sylvain, 1968, p 234
60 Comhaire-Sylvain, 1968, p 248–49
61 Ekwa, Martin. *Pour une société nouvelle, l'enseignement national: textes et discours, 1960–1970*. Kinshasa: Éditions du BEC, 1971, P 44–47
62 Wrong, Michela. *In the Footsteps of Mr. Kurtz: Living on the Brink of Disaster in Mobutu's Congo*. Reprint edition. New York: Harper Perennial, 2002, p 72–74
63 Monheim, Francis. "Mobutu: Portrait of a Friend." *Africa Report* 12, no. 7 (October 1, 1967): 15–18, p 15–16
64 Kisangani, 2016, p xxxvi, 79
65 Lashman, 1975, p 185
66 Boyle, 1992, p 57
67 Van Reybrouck, 2014, p 336
68 Van Reybrouck, 2014, p 334
69 Kisangani, 2016, p 317
70 Kisangani, 2016, p 15, 306
71 Juif, Dácil, and Ewout Frankema. "From Coercion to Compensation: Institutional Responses to Labour Scarcity in the Central African Copperbelt." *Journal of Institutional Economics* 14, no. 2 (April 2018): 313–43. https://doi.org/10.1017/S1744137416000345, p 319–20
72 Van Reybrouck, 2014, p 345
73 Kiakwama, Gilbert, and Jerome Chevallier. "The Case of the Democratic Republic of Congo." In *Aid and Reform in Africa: Lessons from Ten Case Studies*, 627–43. Washington, DC: World Bank Publications, 2001, p 636
74 Van Reybrouck, 2014, p 335

75 Timberg and Halperin, 2012, p 66
76 Comhaire-Sylvain, 1968, p 67, 72–79
77 Van Reybrouck, 2014, p 340
78 Lauro, 2020, p 16
79 Comhaire-Sylvain, 1968, p 69, 173, 194–99
80 Comhaire-Sylvain, 1968, p 221
81 Bongaarts, John, and John Casterline. "Fertility Transition: Is Sub-Saharan Africa Different?" *Population and Development Review* 38, no. Suppl 1 (February 2013): 153–68. https://doi.org/10.1111/j.1728-4457.2013.00557.x, p 153–55
82 Lashman, 1975, p 7
83 Romaniuk, Anatole. "Persistence of High Fertility in Tropical Africa: The Case of the Democratic Republic of the Congo." *Population and Development Review* 37, no. 1 (2011): 1–28. https://doi.org/10.1111/j.1728-4457.2011.00388.x, p 10, 14; Romaniuk, 1980, p 303
84 Lashman, 1975, p 51
85 Caldwell, John C., I. O. Orubuloye, and Pat Caldwell. "Fertility Decline in Africa: A New Type of Transition?" *Population and Development Review* 18, no. 2 (1992): 211–42. https://doi.org/10.2307/1973678, p 217
86 Bongaarts and Casterline, 2013, p 8
87 Romaniuk, 1980, p 300
88 Lashman, 1975, p 43
89 Bongaarts and Casterline, 2013, p 2
90 Waife, Ronald S. *Traditional methods of birth control in Zaire*. Chestnut Hill, MA: Pathfinder Fund, 1978, p 7–8

Part II

The Fifty Years of Family Planning

4 The 1970s

President Mobutu Authorizes *Naissances Désirables*

The country rides an economic rollercoaster in the 1970s

At the start of the 1970s, President Mobutu was riding high. He had managed to "unify" the country by creating a single political party (the MPR) and centralizing power in himself. He further solidified his position through a presidential election in December 1970, in which he was the only candidate, and voters cast their ballot as a "yes" or "no." The results were nearly unanimous. Of the 10.1 million ballots cast, only 157 were "no" (primarily from the University of Lovanium district). Mobutu received some 30,000 more "yes" votes than there were registered voters.[1]

Thanks in large part to the economic reforms of the late 1960s, the economy was strong and stable. The price of copper on the global market kept the country's balance sheet in the black. Inflation was low. With favorable terms of trade, the country was attracting foreign investment and the economy was growing at an average of 4.4% annually.[2] But, corruption and embezzlement had already crept into the system. As of 1970, an estimated 60% of the national budget had been misappropriated.[3] But the pie was large enough to support the social sector (education and health) while allowing Mobutu his oversized portion of public money.

All would be well if it were not for those pesky university students who refused to embrace Mobutu's vision. On June 4, 1971, students from both the Lovanium and Lubumbashi campuses demonstrated to commemorate the murders of their fellow students in the protests of June 1969. Furious, Mobutu closed the universities and conscripted all students from the Lovanium campus into military service.[4] He then nationalized the three private universities (Kinshasa, Kisangani, and Lubumbashi) and created a single government-controlled entity, *Université nationale du Zaïre*, or UNAZA.[5]

As Mobutu continued to consolidate his power, he worked to stamp out all vestiges of the colonial past. He had already "Africanized" the names of the major cities in 1966. On October 27, 1971, he went one step further in renaming the country the "Republic of Zaïre." Overnight, Congolese became *Zaïrois* (Zairians); the Congo River was now *le fleuve Zaïre*. The European names on streets, bridges, and buildings were renamed in honor of Congolese heroes and leaders.[6]

DOI: 10.4324/9781032718897-6

To further his pursuit of *authenticité*, in May 1972 Mobutu ordered all citizens to stop using their Christian names and adopt new Zairian names instead. He led by example, renaming himself Mobutu Sese Seko Kuku Ngbendu Wa Za Banga (which meant "the all-powerful warrior who, because of his endurance and inflexible will to win, goes from conquest to conquest, leaving fire in his wake"). He banned Western clothing, including ties. Men would now have to wear a Mao-style tunic known as an *abacost*, women traditional *pagnes*.

If the average citizen found this difficult, the Catholic Church was up in arms. Priests could face up to five years imprisonment for baptizing a Zairian child with a European name.[7] In what was the first major break between the government and the Catholic Church, Mobutu had usurped the Catholic Church's control over the University of Lovanium, which they had established less than a decade earlier. The Catholic Church was no longer invited to participate in a governmental grand scheme to integrate all church-supported schools into a single system. Ironically, by the time the government nationalized church-affiliated schools in 1975, the economic situation of the country was so dire that the government was unable to finance its plan, and instead, responsibility for education was handed back to the missionaries.[8]

In November 1973, Mobutu made a bold move that would have devastating repercussions for decades afterward: *Zairianization*. He expropriated over 100 large businesses and countless medium and small enterprises owned by foreigners (mostly of Asian, Arab, and southern European nationalities), making them the property of the state. He then turned them over to his political cronies: ministers, members of the party's political apparatus, and top military officers. Prime targets were businesses in agriculture, trade, and transport. Little consideration was given to the managerial knowledge and skill needed to maintain the financial profitability of these operations. The agricultural sector was hit particularly hard because the new owners were unable to maintain the transportation, distribution, and marketing infrastructures.[9] In many cases, the new owners sold off the assets and closed down operations. Many expat owners took whatever capital they could recover and fled the country.

Zairianization sent shock waves through the international community, especially foreign investors. Combined with the decreasing price of copper on the global market in 1974, Zairianization marked the beginning of the end of the golden decade of the independent Congo. The GDP declined at a rate of 1.5% per annum through the end of the decade.[10] The practice of printing money and using internal loans for personal gain sparked inflation and created a balance of payments problem.

Realizing the ruinous economic consequences of his Zairianization policy, on December 30, 1974, Mobutu introduced "*rétrocession*," a scheme whereby he returned up to 40% of the expropriated businesses to their rightful owners, a percentage that would increase to 60% within a year.[11] However, investor confidence had reached new lows and the damage was irreversible.

By the mid-1970s, Mobutu was dealing with the perfect storm. World oil prices shot up, while the price of copper dropped. His Zairianization policy had wreaked

havoc on the country's economy, as did the heavy debt incurred by Zaïre for non-viable projects.[12] These events triggered a steady decline that would soon reverberate through the social sectors. By 1973–74, the welfare state established during the Belgian Congo began to crumble. Social benefits for public sector workers vanished and salaries of public servants were delayed.[13] Salary arrears in the public sector became the norm: three to four months in Kinshasa, and up to ten years in rural areas.

In a November 1974 policy speech, Mobutu paid lip service to health as one of four priority areas needed to improve the wellbeing of the population, but funding did not follow. The government did start several health programs in the 1970s – in maternal/child health, endemic disease control, and occupational health – but their coverage was limited, mainly to populations in urban areas. By 1974, the state maintained only 122 health facilities, compared to 3,951 at the time of independence.[14] The distribution of health facilities skewed heavily toward Kinshasa and other regional capitals. Close to three-quarters of the population had no access to the formal healthcare system.[15]

As if to legitimize the corrupt practices he had perfected, in May 1976 in a speech before 70,000 Congolese and millions of radio listeners, President Mobutu passed along the following advice: "If you want to steal, steal a little in a nice way, but if you steal too much to become rich overnight, you will soon be caught."[16] Such was the moral tone that Mobutu set for the country.

The decade would end with Mobutu still maintaining an iron grip on power. One strategy was to constantly reshuffle members of his government, to instill fear and insecurity. Holding down one's job was not based on efficiency or effectiveness, but rather Mobutu's whims. Realizing that their tenure in a government position might be short-lived, officials were incentivized to take what they could quickly, resulting in widespread embezzlement and financial mismanagement. As Kisangani notes, "effectiveness and good conscience were major obstacles to political advancement."

Despite the common knowledge of Mobutu's pilfering habits, he was re-elected president in 1977. His presidency was marked by political skirmishes involving Angola in 1975 and guerilla attacks in Shaba in 1977, resulting in a Pan-African peacekeeping force being established in the region.

If the 1970s began on a high note for President Mobutu – at the zenith of his power and popularity – the economic tides had turned by the mid-1970s. The end of the Vietnam War in 1975 further depressed prices for copper and other minerals from the Congo. After *Zairianization* and *rétrocession*, Mobutu was never able to reconstruct the country he had hoped to build. Yet it was his pilfering of the national treasury that thwarted his dream. Data from the central bank showed that starting in 1972 through the late 1980s, Mobutu spent an average of 35% of the national budget on himself.[17]

The problem of pregnancy-related deaths persists

By the early 1970s, Kinshasa boasted a shiny new hospital. The Belgians had begun construction in 1910 on an outpatient facility in Leopoldville. A decade later they built the first inpatient ward and over the years additional pavilions were

added. By the late 1960s, *l'Hôpital des Congolais* was the major medical facility trying to keep pace with the fast-growing population of Kinshasa. With little financial support from the government and the post-independence departure of many Western physicians and nurses, the *Hôpital des Congolais* was quickly deteriorating.[18] One missionary doctor who had stuck around – challenged rather than repelled by the impossible working conditions he found – was Dr. William Close (father to the actor Glenn Close, who was by then living abroad but would periodically visit her parents in Kinshasa).

In 1968, President Mobutu asked Dr. Close to modernize this 1,500-bed hospital in terms of infrastructure, trained personnel, equipment, and supplies. Close agreed to do so, on the condition that there would be no interference from the ministry of health, trade unions, or political allies. Mobutu kept his word, and for almost a decade, the president would regularly deposit the funds into the account of FOMECO (*Fonds Médical de Coordination*), an NGO created for this purpose. By the early 1970s, the hospital had been transformed into a state-of-the-art facility occupying two city blocks in downtown Kinshasa. Everything was new: nine operating rooms, clinics, hospital wards, walkways, kitchens, offices, even a new sewer, electrical wiring, and switchboard. Mobutu was impressed.[19] Upon the death of his mother on May 18, 1971, President Mobutu renamed the hospital in her honor, *Mama Yemo.* [20]

The university students at Lovanium were still up in arms over Mobutu's repressive tactics. When the president declared four days of mourning for his mother, they were outraged. "Four days for a whore" they claimed, but no tribute was ever paid to the students who had died in the June 1969 clash with the army. Infuriated, Mobutu retaliated by drafting all university students into military service. One of the recruits was Jules-Pierre Malonga Miatudila. On October 27, 1971, the same day that the Democratic Republic was renamed Zaïre, Miatudila and his fellow graduates received their degrees as doctors in medicine, surgery, and obstetrics.[21]

The government "owned" the service of the Congolese medical graduates who were unable to engage in private practice (whereas non-Congolese could). On December 6, 1971, two days after his wedding, Dr. Miatudila went to work in the emergency room at the *Hôpital Mama Yemo* – the public hospital where 200–300 people were seen every day. Although Dr. Miatudila and his classmates had emerged from their training with a fancy title, they had little practical training or experience in surgery or obstetrics. FOMECO, the same NGO charged with renovating Mama Yemo, offered a 15-month internship for these recent graduates as part of its mission to improve medical standards in the country. They received their baptism by fire at a hospital that delivered an average of 140 babies a day (and sometimes as many as 170) and treated at least 20 botched abortions daily.[22]

Faced with the incessant stream of women presenting at Mama Yemo with obstetric complications, Dr. Ferdinand ("Ferd") Pauls, head of the Ob-Gyn service, and his team felt that something had to be done. Dr. William Close, president of FOMECO and Mobutu's private doctor, encouraged them to propose a solution to address this problem.

President Mobutu went over the notes that Dr. Pauls and his team had submitted through Dr. Close, but he faced a very complex situation. Family planning – the obvious solution – was easier said than done. In addition to the societal norms that supported large families, Zaïre was still a French-speaking, strongly Catholic country. The Law of 1920, which the country had inherited from France through Belgium, stood in the *Code des lois* (Code of Laws). One could go to jail for providing contraception. Under no circumstances could they use the term "family planning." The census of 1970, although incomplete, showed a very low density of population, meaning that any effort to curb births would be criticized. At the same time, the rapid population growth was making it increasingly difficult for the government to keep up with the demand for public services: roads, transportation facilities, utilities, schools, hospitals, and dispensaries, not to mention adequate supplies of medicine and food.[23]

Mobutu introduces the concept of *Naissances Désirables*

In December 1972, President Mobutu Sese Seko gave a historic speech in which he introduced the concept of *Naissances Désirables* (desirable births).[24] Consistent with his campaign for authenticity, he presented this concept as aligned with traditional Zairian values. His basic premise was that couples (especially in rural areas) were accustomed to having large families (excessive births) as a response to high levels of infant and child mortality of the past. To assuage the fear of parents that their children might die prematurely, he counseled that the number of actual births should correspond to the number of desired births.[25] Underlying the concept of *Naissances Désirables* was the ability of the couple to have the number of children they wanted, to raise them in good sanitary and social conditions, and to protect the mother. As the leader of a Black African nation, Mobutu rejected the concept of imposing a limitation on the number of births, which would be a detriment to the country. Rather, *Naissances Désirables* would address the multiple problems of maternal deaths, unwanted births, and sterility.[26] The visionary speech made Zaïre the first Francophone sub-Saharan African country to embrace the paradigm of family planning.

On February 14, 1973, President Mobutu signed Presidential Ordinance No. 73/089 for the establishment of the *Conseil national pour la promotion des Naissances Désirables* (CNPPND; National Council for the Promotion of Desirable Births). This ordinance authorized the provision of information and services for the desirable births program. The CNPPND entrusted its field operations to a technical body called the *Comité national des Naissances Désirables* (CNND; National Committee for Desirable Births), which was responsible for conducting programs to promote family planning services.[27] Appointed by Mobutu, Dr. Anatole Sabwa served as the first president of CNND from 1973–79, before leaving to work with IPPF/Nairobi (International Planned Parenthood Foundation), then the United Nations Population Fund (UNFPA) in West Africa.

President Mobutu named a number of illustrious individuals as the first board members of the CNND: Professor Bongoey (an economist from

Figure 4.1 President Mobutu Seso Seko Africanizes his name and authorizes *Naissances Désirables* in 1972

Equateur), Dr. Kalala Tshibangu (an Ob-Gyn from Kasaï), Mr. Kashongwe (a lawyer from Kivu), Mr. Kikasa (a journalist from Katanga), Dr. Miatudila (a physician from Bas Zaïre), Dr. Sabwa (a physician from Kasaï), Mr. Wawa (a demographer from Bandundu), and Dr. Yoka (a physician from Guyana married to a lawyer from Bandundu). The CNND board represented a broad range of disciplines and geographic regions of the country. Although they had not known each other beforehand, they came to form a close-knit group with a common mission who worked well together to set the direction for CNND. Board members were asked to recruit volunteers to promote the concept of *Naissances Désirables* and family planning countrywide.

In 1974, the Population Council and the Ob-Gyn department of Mama Yemo Hospital convened a three-day seminar on the topic of "desirable births" in Kinshasa. Attended by over 100 participants from Zaïre and 14 other (mostly African) countries, it marked the first formal activity in the area of family planning in Francophone Africa.[28]

At the start, CNND had no office. Rather, it conducted business out of Dr. Sabwa's Ob-Gyn clinic at Mama Yemo Hospital. When a patient arrived for a consultation, the CNND personnel scurried out until the patient left. IPPF

supplied CNND with contraceptives and a car that, for security reasons, was parked at the hospital.

The workload began to grow and in 1976 IPPF sent funds to hire three staff and to set up a CNND office near the intersection of Avenue du Commerce and Kasavubu. With Dr. Sabwa's imminent departure, M. Sébastien Mutumbi was hired as team leader. M. Jean-Pierre Misamu was recruited as secretary and logistics manager, and Mme. Mulelebwe Issiki as press officer. In return, IPPF expected timely reports written to its specifications.

Box 4.1 An early convert to family planning

Dr. Miatudila had planned to specialize in internal medicine, more specifically in neurology. One afternoon in 1977, he found himself at the bedside of a 15-year-old girl who was slowly losing her battle to the complications of an induced abortion. He realized that he knew her; they had grown up in the same neighborhood. Unable to control his frustration in the face of this needless death, he shouted at her, "Eve, Eve, *ma petite soeur*, why did you let this happen to you? Why weren't you more careful?"

She replied to him calmly, "It is too late for me, but promise me that you'll work to help other girls avoid this fate."

Instantly, this very young and inexperienced doctor regretted his unprofessional conduct toward this victim of circumstances. Shaken by the incident, he vowed to do as she had asked: dedicate himself to helping others avoid the tragic consequences of unwanted pregnancy. And for more than 50 years, he kept that promise.

By 1977, the range of activity at CNND had grown leaps and bounds: programming, clinical service provision, information-education-communication, public relations, training, contraceptive logistics, finance, and monitoring and evaluation. Dr. Sabwa hired nine new staff: Mwamba Muteba (administrator), Mutumbi Kuku Dia Bunga, Miasmu Kamitondo, Mr. Kazadi Polondo (training), Mme. Kazadi Salwa (clinic), Mulelebwe Issiki, M. Onanga Bongwele (evaluation), Nkosi Mbenga (finance), and Zawadi Mwenge (social assistant).

CNND's first order of business was to identify and create a network of all public and private organizations involved in any aspect of desirable births/family planning countrywide. With this task came other responsibilities: tracking the results of the family planning service delivery in these facilities through service statistics, designing and organizing information-education campaigns for the general public, and advocating for family planning among governmental decision-makers and other authorities.[29] CNND also coordinated relations with national agencies and international organizations, including the Pathfinder Fund, Family Planning International Assistance (FPIA), and the Association for Voluntary Surgical Contraception (AVSC).

With time, CNND also took on responsibility for three additional tasks: ordering, stocking, and distributing contraceptive commodities; training personnel in family planning information and service delivery techniques; and evaluating specific projects.[30] The staff benefited from on-the-job training and technical assistance organized by IPPF/Nairobi, which helped to indoctrinate staff into its procedures and approaches in the areas of management, finance, clinical service provision, communication, evaluation, and training of trainers.

Within a year of CNND's inception, family planning services sprang up in selected locations in Kinshasa. The Ob-Gyn service at Mama Yemo became the mothership for *Naissances Désirables*, with CNND responsible for running the family planning service. Family planning was introduced into two maternal and child health (MCH) facilities that had been established with FOMECO support to lessen the load on Mama Yemo: in Barumbu and Bumbu. The typical session consisted of a talk given by a *motivatrice* (a female educator/counselor) on the concept of desirable births and information on the contraceptive methods available. The client would then have a private consultation, including a physical exam, and the nurse would recommend a method. The majority of clients opted for the injectable (Depo-Provera), followed by the intrauterine device (IUD), pills, and in rare cases tubal ligation. By 1974, the Mama Yemo clinic operated five days a week and handled some 100 new acceptors per month.[31] Since many women aspired to have at least five children, most clients were already mothers several times over.

As part of its advocacy work, CNND launched a series of communication activities through television, radio, and newspaper articles. In addition, in 1976 it organized a scientific conference directed at decision-makers, government officials, staff of international organizations including the United Nations, and members of the scientific community. The CNND members gave talks from the perspective of their respective disciplines.

In 1978, the CNND arranged a meeting with the Attorney General of the Republic, accompanied by Mr. Michel Sozi, the IPPF regional director, to discuss and solicit his support for obtaining legal status for CNND to become an NGO.

Box 4.2 Dr. Miatudila's visit to the archbishop

Even with Mobutu's endorsement of *Naissances Désirables*, many service providers had deep-seated conflicts over their religious beliefs and the expectation that they would provide contraception. They would ask themselves, "Do we promote family planning, or do we let these women die?" In 1978, Dr. Miatudila went to the Archdiocese in Kinshasa where he saw the archbishop. Deeply troubled, he explained to the archbishop, "I am asking for my own sake, not for a public statement." He continued, "I have a problem. I am a Catholic, but I practice family planning. What should I do? Am I sinning every day?"

The Cardinal replied: "*L'église dicte les normes, mais il appartient à chaque individu de voir comment ces normes s'appliquent dans sa vie réelle.*

Tu dois agir selon ta conscience." (The Church dictates norms, but it is up to each individual to see how these norms apply in real life. You must act according to your conscience.) Dr. Miatudila felt a great weight lifted from his shoulders, and he simply replied: *merci beaucoup*. He was then able to share this story with his fellow Catholic doctors, who still had to contend with the controversy around modern "artificial" contraception daily.

AZBEF is born

The establishment of CNND by presidential decree resulted in an interesting dance between CNND and the regional office in Nairobi of the IPPF, the leading family planning agency at the time. After President Mobutu had established the CNND in 1973, the entity had legal status but no money. The CNND had a certain clout that emanated from its support by Mobutu and its status as a parastatal ("it was government," giving it more importance than a non-governmental organization).[32] During these same years, IPPF was looking to identify private organizations in African countries that showed interest in family planning, and the CNND stood out as a pioneer in Francophone Africa. IPPF offered full financial support, but only if they became an NGO. Therein lay the rub.

For several years, IPPF closed its eyes to the legal status of CNND while encouraging the organization to quickly become a full-pledged NGO. CNND played both sides as long as they could. To IPPF, they were an NGO; within Zaïre, they were a parastatal. During those years, CNND remained an "associate" rather than an "affiliate" of IPPF and had no rights to vote, but they could attend the IPPF Africa region meetings.

Finally, in 1977 the *Association Zaïroise pour le Bien-Être Familial* (AZBEF; the Zaïre Association for Family Well-being) was established to placate IPPF and benefit from its financial support.[33] Its mission changed little from the days of CNND, although it lost its privileges of stocking its contraceptives and parking its vehicle at Mama Yemo Hospital. Some members bristled at the change in name from CNND to AZBEF and continued to use the original name, leading to the practice of using the two interchangeably.

In 1979, Dr. Miatudila was elected by the AZBEF membership as president, assisted by an administrator, Mr. Tharcisse Mwamba. When the latter left for West Africa, the post briefly remained vacant until the board of directors suggested that Dr. Miatudila take over the position. It was to his advantage since the administrator earned a salary, but the president, being a volunteer, did not. Miatudila was the only *Zairois* to both preside over the committee of volunteers and then serve as administrator to the staff.

By the end of the 1970s, AZBEF was the beacon of hope for family planning in Zaïre, with a staff of well-trained, motivated individuals who believed in this pioneering work. It received funding from several international sources – Pathfinder, FPIA – in addition to IPPF.

Yet, as anticipated, AZBEF as an NGO became less powerful than it had been as a parastatal, when it operated as a true family planning champion. At the insistence of the IPPF, AZBEF opened its doors to a large number of "volunteer members," many of whom did not share the mission of the organization; rather, they smelled money from an international donor. The original CNND committee had been criticized as a *club des amis* (club of friends), despite the fact that the members represented different regions of the country. By contrast, AZBEF fell into the quagmire of tribalism (cronyism based on one's tribe). The IPPF regional office remained oblivious to the importance of multi-tribal representation to an organization like AZBEF in Zaïre.

The Protestant missionaries become family planning pioneers

By the 1970s, the Protestant and Catholic facilities were an established part of the healthcare landscape in Zaïre. Churches operated well over half the health facilities in the country. The exact figures differ by source, but one 1974 estimate gave the following breakdown: Protestant (52%), Catholic (31%), government (13%), and others (4%). The funding for the Protestant hospitals came largely from churches in the United States or Canada. Since all universities and almost all secondary schools were restricted to males, almost all healthcare providers in the 1970s were male.[34]

At the start of the decade, some 60 Protestant mission groups worked together under a long-established umbrella organization, the *Eglise du Christ au Zaïre* (ECZ), based in Kinshasa, under the leadership of a Congolese Protestant minister Jean Bokeleale. The stated purpose was to bring unity over ideological and ethnic divisions, though the ECZ proved useful in representing the large number of Protestant missionaries living in remote regions of the country.[35] By the mid-1970s, 18 of these Protestant missions were the largest healthcare providers in the country, with 437 health facilities and 14 health manpower training schools in Zaïre.[36]

Most of the doctors and teaching nurses at Protestant-run hospitals – largely expats – were already knowledgeable about contraception. Moreover, they were acutely aware of the suffering of women in the rural population who ended up at their hospitals: high parity mothers who were desperate to avoid their 10th, 12th, or even 14th pregnancy, women rendered sterile by an unsafe abortion, and adolescent girls who developed fistulas from prolonged labor (leaving them to drip urine and feces for the rest of their lives, causing their total ostracization by society).

When President Mobutu delivered his historic speech on *Naissances Désirables* in 1972, the ECZ embraced the policy as a means of saving women's lives and improving their health. Soon the ECZ would be playing a pioneering role in family planning in Zaïre by introducing contraception into existing MCH services. By the mid-1970s, they began to work with health centers and church outposts in the Interior (including many of the "antennae clinics" affiliated with CNND).[37]

The Medical Office of the ECZ was headed by Mr. Nlaba Nsona, a nurse by training, whose primary responsibility was getting incoming missionaries accredited to work in the 80 ECZ hospitals in Zaïre. There was a rigorous process in place whereby the government reviewed and approved the credentials of doctors

and nurses wishing to work in Zaïre, followed by additional in-country training. Nearing retirement age and with his wall displaying all his accreditations, he gladly passed anything related to family planning to the Galloways.

The Reverend Ralph and Florence (Bonnie) Galloway were well into their 50s when they first arrived in Kinshasa in 1972. The Galloways learned first-hand from their previous stint in Cameroon of the devastating consequences for young girls and boys from untreated sexually transmitted infections, and they had been sent to Zaïre specifically to work in family life education and reproductive health. Soon after their arrival, President Mobutu gave his discourse authorizing *Naissances Désirables*, which quieted any internal opposition within ECZ to family planning promotion. They began by incorporating family planning education and service provision into the MCH clinics located at 19 churches throughout Kinshasa, but before long they extended the reach of their work to church groups throughout the country.[38]

The Galloways brought numerous skills that they put into the service of promoting family planning. Ralph, an ordained Presbyterian minister and fluent in French, would routinely preach when he visited different locations. Soon he became known as the "pastor with condoms in his pockets." Florence, a registered nurse with a masters of public health (MPH) degree, had honed her skills in imparting sex education during their previous tour in Cameroon. She became a tireless trainer of nurses and midwives in contraceptive counseling and service delivery. Together, they organized and administered the shipments of contraceptives and equipment to church health outposts in the Interior. At a time when most working in health and development were young professionals, the Galloways cut an imposing image with their snow-white hair. Ralph always seemed to be carrying his briefcase and had a smile ready for anyone he met. Florence came across as "no nonsense" with her perfect posture and slim frame, but she communicated a genuine desire to bring relief to the women and girls she visited. Their soft-spoken, unassuming manner belied the powerful impact they had on promoting family planning in its infancy in Zaïre.

The church-related health programs benefited from an asset that set them apart from any other government or private entities then and now: the Mission Aviation Fellowship (MAF). Conveniently headquartered within the ECZ compound in Kinshasa, MAF regularly flew small planes from Kinshasa into remote church outposts carrying personnel, medical equipment and supplies, and contraceptive commodities. With the Galloways managing this flow of supplies, the ECZ minimized the problems so common to family planning service delivery at that time: stockouts, lack of equipment, and inadequate supervision.

Because of the Galloways' connections with the US, they were effective in attracting additional resources to support their work at a time when funding for international family planning was readily available but few sub-Saharan African countries were vying to obtain it. In 1973, Pathfinder financed the printing of family planning brochures in Zaïre. By 1976, the ECZ was obtaining contraceptives from the US Agency for International Development (USAID), the major supplier at the time for the entire developing world. The Galloways brokered numerous

Figure 4.2 Mme. Jeanne Bokeleale greeting Florence and Ralph Galloway

opportunities for *Zairoïs* to receive training in the United States and elsewhere.[39] In 1978, they began working with Jhpiego (an affiliate of Johns Hopkins University in Baltimore, MD) to train Zairian doctors in performing tubal ligation using laparoscopy, a procedure which until then was used primarily in hospitals for diagnosing infertility resulting from fallopian tube blockage. They sent nurses to Downstate Medical Center in New York to learn counseling and service provision, and they recruited women leaders from the ECZ to attend the three-week women in management training program offered by CEDPA in Washington DC. Later, the laparoscopy training would be moved to Tunis and Rabat to avoid the language barrier for French-speaking trainees. Many of the physicians who received this training would become leaders in family planning.

In 1976, ECZ received funding from the Pathfinder Fund to set up a network of family planning clinics in three regions of Zaïre: Shaba, East Kasaï, and West Kasaï.[40] To learn more about traditional methods of pregnancy prevention and assess the availability of family planning service delivery, a team from the ECZ, composed of Citoyen ("Mr.") Lahema Lata Dihongu, Ralph and Florence Galloway visited these regions between May 1976 and January 1977. The Pathpapers, written by R. Waife (1978), drew on the reports of this team to provide invaluable insights into the traditional practices and attitudes of rural population on the eve of the introduction of modern contraception into these areas.

Consistent with descriptions by Romaniuk on the widespread use of postpartum abstinence, polygamy, and breastfeeding as means of birth spacing in the 1940s and 1950s,[41] the ECZ team found evidence that these practices persisted into the 1970s in the three regions they visited. Conditions that justified preventing a pregnancy included high parity (over eight children), difficult labor, or anger between the spouses. Methods of preventing pregnancy included:

Virginity: part of the wedding ceremony was to determine if the girl was a virgin. If yes, the husband would give a goat to the bride's mother "to honor the woman who had preserved her daughter's virtue." If not, the family might search for the man involved and force him to marry the girl.

Withdrawal: coitus interruptus was regularly practiced, with some exceptions. Among the Baluba tribe, there was a strict religious belief that a man's sperm contained the soul of a new person, making coitus interruptus a mortal sin.

Contraceptive potions, poultices: various roots, barks, herbs, and berries could be crushed, boiled, pounded, and mixed and then swallowed, rubbed, or inserted.

Rites: In West Kasaï, 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. If the elders of the family wanted to prevent another pregnancy for a woman who had experienced a difficult pregnancy or to punish the girl for marrying against the will of the family, they could place curses of sterility on her.

Abortion: Abortion was performed in some traditional societies of these regions without much controversy. Reasons for abortion were disagreements or lack of love between the husband and wife; when the husband had abandoned the wife; or when the woman wanted to end an extramarital pregnancy.[42]

In short, the ECZ team found a long-standing recognition that too many children born too quickly was not good for infant or maternal health. Although there was no firm documentation of the effectiveness of polygamy and abstinence during breastfeeding, they uncovered clear evidence of a precedent for behaviors aimed at regulating fertility and spacing children. Subsequent family planning promotion often used this argument, in a country with deep-seated respect for ancestors.

At the time of their visit in 1976–77, the ECZ team found that existing family planning services were scattered, inadequately staffed, and undersupplied. Although oral pills, condoms, injectables, and IUDs were available in some locations, the choice of methods in a given facility depended on what came through the pipeline that month.

The ECZ team came to realize that the introduction of new ways could be very disruptive to local norms, given that modern contraception had no roots in social conduct. With these new methods, couples could avoid pregnancy without reverting to polygamy and postpartum abstinence. There was no longer a justification for the double standard, whereby the woman abstained but the husband did not. Women no longer accepted being relegated to a mat on the floor to achieve "separate beds." Men felt a loss of control over the sexuality of their wives. Wives objected to their husbands' infidelity. This abrupt cultural upheaval was a recipe for jealousy and marital discord. However, because these new methods were often used incorrectly, pregnancies ensued. In such cases, "modern" contraception proved less effective than prolonged abstinence. Much work remained to be done.[43]

Box 4.3 Vanga: a family planning pioneer

Vanga, located in the province of Bandundu (now Kwilu), was among the first Protestant sites to introduce *Naissances Désirables* into its maternal and child health services.

Dr. Dan Fountain and his wife Miriam (a nurse) arrived as missionaries in 1961 at the 100-bed Vanga Evangelical Hospital, serving 250,000 people. There was no electricity, water, or phone. In his inspirational book *Health for All: the Vanga Story*, Dr. Fountain recounts how he faced this challenge by first training local personnel in integrated medicine, which later became known worldwide as primary healthcare.[44] He also made small improvements to the physical infrastructure. A five-year grant from Oxfam in 1970 allowed him to experiment with outreach: each month four mobile health teams would visit 150 villages in their catchment area to provide education and primary healthcare. Yet he was still frustrated. The mobile teams could only reach half the population in the catchment area, and even in those villages reached, what

happened for the rest of the month after they left? Dr. Fountain went to work with local communities, encouraging them to build a basic structure that would serve as a health center and train health workers to staff these facilities. He also developed a system for stocking and resupplying medications that would be financially sustainable. Throughout this period, he worked hard to maintain cordial relations with local government officials, even when he did not agree with their approach to managing other facilities in the geographic area. At a meeting with the regional medical officers in 1975, the Minister of Health stunned Dr. Fountain by endorsing the idea that government and private healthcare entities should work together in a single system for the good of the population. Later in the year, a conference held in Mayidi, Bas Zaïre, defined the key concepts that would shape the future of health zone development in Congo.

Although family planning was only one part of the program, Vanga was one of the first church health programs to systematically incorporate family planning into its primary healthcare services. Mme. Alice Adombo was part of this pioneering work. In her role as a maternity nurse (*infirmière accoucheuse*) at the Vanga hospital, in 1975 she was chosen to receive training in family planning at Mama Yemo Hospital in Kinshasa, along with 15 nurses from other church hospitals. As part of the ECZ initiative to get more church personnel trained, she was sent for training at the Downstate Medical Center in New York in 1978. Initially, she put this training into practice at the Vanga hospital. Then, when Vanga initiated its outreach program, Mme. Alice was part of the six-person team, consisting of Dr. Fountain, young doctors in training, and other nurses to take services into the surrounding villages. Family planning was integrated into other MCH care: prenatal visits, child growth monitoring, and immunizations.

As Mme. Alice recounts, villagers worried that using contraception meant never having more children. And for several years, her program received more clients seeking ways to have children than those wanting to space out births. In broaching the sensitive topic, Mme. Alice would share her own experiences. “I used the IUD. Then after 2–3 years, when I wanted to get pregnant, I would have it removed. It has worked for me.” Many of the women cried out in joy that such a thing was possible. After having seven, ten, twelve children, they were eagerly listening. “We don’t want to grow old too early,” a perceived effect of having many children. Husbands admitted that they had been fearful of bringing up the topic with their wives. “Her parents could accuse me of being a bad person.”

When the Vanga team began its outreach work, the levels of illiteracy were high, especially among women. Thus, women tended to prefer Depo-Provera (the three-month injectable) to the pill, which they feared they would not be able to manage daily. The team also counseled women with a large number of children about the option for tubal ligation, advising them that another pregnancy could bring dangerous complications. The surgical procedure remained controversial; not only the woman and her husband had to consent but also their families.

The Vanga outreach team did run into occasional resistance over their promotion of *Naissances Désirables*. "Children are a gift from God," they would hear. The staff worked overtime to address misgivings deeply rooted in cultural beliefs with messaging based on faith and medical experience. They promoted the notion that the effective use of family planning required close cooperation between husband and wife, a concept largely foreign to local beliefs and practices.

Another missionary couple – Richard and Judith Brown – would come to play a key role in family planning in Zaïre, during their three separate postings in the 1970s, 1980s, and 1990s. Some 15–20 years younger than the Galloways, the Browns arrived in Zaïre in 1973, shortly after the Galloways. Through the joint decision of the Presbyterian Church (US) and the *Communauté Presbytérienne du Kasai* (regional church), Dick and Judith were posted to Bulape Hospital (West Kasaï Province) to continue the outreach work of Dr. John K. Miller (who had grown up in Congo, the child of missionary parents; he earned an MD from Tulane and an MPH from Harvard). Bulape, a rural church station, had been operational since 1920, with a hospital, a school, and a church. It offered the perfect setting for the Browns' two young daughters to run free with the local children, within the safety of the station. The Bulape outreach team was already well ahead of most other church-owned hospitals in pushing services from the hospital into the surrounding communities, starting with child immunizations.

The Browns arrived fresh from their training at Harvard: Dick with an MPH (he already had an MD), Judith with a PhD in anthropology. They first trained the local team to conduct a census of the population in the hospital service area. The team numbered houses and recorded the age and sex of members of each household.[45]

They began by focusing primarily on nutrition: why in a province with plenty of food was there such a high level of malnutrition? Through their community surveys, they soon learned that breastfeeding was nearly universal, but mothers stopped breastfeeding when they got pregnant with the next baby, at 21 months on average. They realized the need to educate mothers about birth spacing calculated and the ideal interval between pregnancies to be 27 months, and from their nutrition research, they realized the need for birth spacing. They also encouraged mothers to feed their children several times a day.[46]

Given limited resources, the Browns began to look for funding for family planning. At first, all doors were closed. "No one thought it was worth it to try doing anything in rural Africa," explained Judith Brown. Finally, in 1975 they obtained a small grant from FPIA for what became "Zaïre Project 01." They sought to recruit local women who could read and write in French, as their community educators. Of the two they identified, one had a child but was unmarried, so the church leaders nixed her candidacy. A second was a woman in her mid-50s, married, and an elder in the church, but with no children of her own. Despite early skepticism that a childless woman could speak credibly on

Figure 4.3 Baba Luta and Judith Brown discuss the growth chart of a young child during the Well-Baby Clinic Day near Bulape, Zaire (1975)

birth spacing, Baba Luta quickly integrated with other members of the public health team. At each monthly village clinic, mothers formed a long queue to check in, weigh their babies, and get them vaccinated. At the end of that line was Baba Luta, who talked to each mother about delaying her next pregnancy and how it could help keep this child healthy. She had contraceptives available for those interested. This method of combining birth spacing/family planning with well-baby services proved very effective. A subsequent survey showed that the use of modern contraceptive methods increased from less than 2% to 14.5% within the first year of the project. The Browns concluded that family planning could succeed in rural African society. Acceptors favored spacing their children to be able to nourish the youngest child better, and they were most receptive when methods were given by familiar, respected health workers.[47]

******

Not all Protestants favored family planning. Whereas some church leaders began actively teaching about contraception, others considered it a sin to interfere with the will of God. The Galloways developed a useful strategy when confronted directly with this question. They would turn it back, asking members of the assembled community to offer their own viewpoints. More often than not, the local pastors would come down in favor of family planning, "considering how their ancestors had been very strict about being responsible about spacing pregnancies."[48]

Figure 4.4 Baba Luta talks with a mother about ways to delay her next pregnancy (1976)

Box 4.4 A party guest in New Orleans

In 1976, Bill and Jane Bertrand hosted a party at their New Orleans home for Tulane international graduate students. Jane had already begun her career in international family planning but was focused entirely on Latin America and had never traveled to Africa. She was pleasantly surprised to learn that one of the guests – Dr. Miatudila from Zaïre – was a member of a fledging family planning organization supported by the IPPF. Two years earlier, Dr. William Close had negotiated with USAID to send three young Zairians to study public health at the Tulane University School of Public Health and Tropical Medicine, and Dr. Miatudila was among them. He not only excelled in his academic work but returned to Zaïre with the idea that the country should establish its own School of Public Health. That vision became reality in the mid-1980s, with funding from USAID and technical assistance from Tulane and other universities.

Little did Jane know at the time that she would focus over two decades of her professional career on family planning in Zaïre/DRC, that her party guest would become one of the most consequential figures in family planning in the country, and that he would serve as a senior spokesperson in Tulane's advocacy work in the DRC decades later.

UNFPA opens an office in Kinshasa

The United Nations Population Fund (UNFPA) was created as part of the UN system of agencies in 1967 to oversee population, family planning, and reproductive health, and in 1969 it started funding population programs in developing countries. In 1978, UNFPA established an office in Kinshasa to cover the three neighboring countries of Zaïre, Rwanda, and Burundi. This office operated under the United Nations Development Program (UNDP), with Dr. George Bartet overseeing the work.

Few records exist from that period. However, during the period from 1975–84, UNFPA undertook an extensive program of national censuses, which was the priority activity for most Francophone African countries at the time. Zaïre was no exception, and the preparatory work during the late 1970s paved the way for the 1984 census in Zaïre.

A growing cadre of physicians embrace *Naissances Désirables*

By the late 1970s, several young Zairian doctors were drawn to the alarming problems stemming from unwanted pregnancy and its tragic consequences. These doctors were tapped for training abroad in management and clinical service delivery: by Jhpiego in Baltimore, Maryland, and by AVSC (later renamed EngenderHealth) in Tunisia. Upon return to Zaïre, each doctor received a set of equipment and supplies that allowed him to provide family planning services, including tubal ligation (permanent contraception for women). After multiple cohorts had been trained abroad, additional training took place in-country.

Dr. Nlandu Mangani was the first Congolese physician to travel to Tunisia for this training, recruited by the Galloways. At the large Protestant medical center in Kimpese/IME (*Institut Médical Evangélique de Kimpese*) in the 1970s, he encountered numerous cases of young girls who had aborted. The Church forbade any discussion of contraception with unmarried women since it was widely presumed that contraception would bring down the morals of the country. The IUD was considered an abortifacient. Dr. Mangani found one workaround, which he tried first on his cousin, then offered to others: to prescribe the oral pill for irregular menstrual cycles. Among married couples, it was essential for the husband (and sometimes his family) to authorize the wife's use of any type of contraceptive method.

Upon return from Tunisia in 1979, Dr. Nlandu went on to represent Jhpiego in Zaïre from 1980–82, helping to recruit doctors for training abroad. Priority went to doctors affiliated with large church hospitals (many affiliated with with the Basic Rural Health Project, SANRU): Nyankunde, Kimpese, Kisangani, Karawa/Equateur, as well as physicians from the *Cliniques Universitaires* in Kinshasa. As Dr. Nlandu traveled around the country to recruit doctors for this training, his main problem was that often the "chief" doctor wanted the opportunity to travel abroad but was not necessarily the best suited to receive the training. Dr. Nlandu recounted the case of one district chief medical officer who

retaliated for not being selected by hiding the equipment or removing the necessary parts from the physician who had received the training.

Dr. Gilbert Wembodinga was another in this cohort of young doctors who would pave the way for family planning in Zaïre. When he finished medical school in 1975, the archbishop of the province of Sankuru implored him to return "home" to work. Much to the dismay of the Dean of the Medical School who had loftier ambitions for him, Dr. Wembodinga accepted a job fresh out of medical school to work in the extremely rural health zone in Sankuru. The Indiana Methodists had helped to establish the Lambuth Memorial Hospital in Wembo-Nyama in 1950, but for lack of upkeep, goats and sheep had overrun the facility. The Methodists were looking for someone to help them fundraise back in the US, and Dr. Wembodinga's crash course in English got him the job. Through the missionary network, Dr. Wembodinga was identified as a candidate for training abroad. In 1979 he traveled to Baltimore/Jhpiego for training in family planning management and thereafter to Tunisia for training in laparoscopy using the Yoon ring. When his equipment arrived for performing tubal ligation, his first client for the procedure was his mother-in-law. Asked if he had experienced community opposition to introducing a method "to stop having children," Dr. Wembodinga indicated that he had not; by then, the community had trust in him. "When you have five, eight kids, each pregnancy is a death sentence."

Dr. Alexis Ntabona became interested in the issue of abortion when his supervisor Dr. Tshibangu Kalala asked the audacious question, "Should abortion be legal?" Having received his medical degree in 1975 (the same year as Dr. Wembodinga), Dr. Ntabona was working at the *Cliniques Universitaires de Kinshasa*, which frequently admitted emergency cases of complications from induced abortions. His supervisor encouraged him to study the problem and challenged him to focus his thesis on it. "We need to provide evidence on abortion; it's a question we can't continue to hide." Dr. Ntabona accepted, possibly influenced by the expectation that Dr. Tshibangu would soon be named chief of the department. Dr. Ntabona approached the topic from the least controversial angle possible. He documented the clinical and sociodemographic profile of some 100 women presenting at the hospital with complications of induced abortion. Months before he was to present the findings from his thesis *Aspects socio-démographiques et cliniques des avortements provoqués à Kinshasa*, his thesis supervisor left for a position in Gabon; his replacement was not remotely interested in the topic. With this setback, Dr. Ntabona almost did not finish. Finally, in 1980 he presented his study, which documented the serious complications of abortion, including hemorrhage, peritonitis, and uterine perforation. He also identified a horrific yet frequent complication that resulted when the abortion provider failed to dilate the uterine neck and instead perforated the lower portion of the uterine wall to extract the fetal tissue. The provider would then urge the patient to rush to the hospital, swearing her to secrecy as to his name or address. Those who survived such a trauma developed a large utero-vaginal fistula which caused them to miscarry in future pregnancies. In addition to making an important contribution to the extremely limited literature on abortion complications, Alexis Ntabona was among the group of young doctors who would be pivotal in the evolution of family planning in the subsequent decades.

Box 4.5 Why emphasize permanent contraception in a country still skeptical of birth spacing?

One might question why in the late 1970s family planning resources were channeled into training for permanent contraception, at a time when birth spacing remained controversial, birth limitation was widely condemned, and resupply methods were not yet widely available in the country.

From the Western perspective, tubal ligation was an important part of a full range of contraceptive methods. At the time, voluntary surgical contraception (sterilization) was enjoying tremendous success in Latin America and parts of Asia, leaving some to imagine that Africa would not be far behind. Physicians needed to be able to perform tubal ligation on women for whom another pregnancy would be life-threatening.

From the Zairian perspective, there was mounting pressure to address sterility and childlessness as part of *Naissances Désirables.* Zaïre was squarely located in what had been the "infertility belt" of Central Africa, and President Mobutu had promised that *Naissances Désirables* would include help for couples trying to have children. Physicians who went abroad through AVSC/Jhpiego scholarships were trained to use laparoscopy for performing tubal ligation. Yet upon returning to Zaïre, they found this same equipment useful in diagnosing infertility, tubal blockage being the main cause of most sterility in Zaïre. Dr. Alexis Ntabona, Director of the Infertility Unit with the Department of Ob-Gyn at *Cliniques Universitaires,* recounts that by the early 1980s, Jhpiego/AVSC stopped providing laparotomy equipment, repair parts, and supplies when they realized that local physicians were using these items primarily to diagnose infertility, not perform tubal ligations.

Reflections on the decade of the 1970s

By the end of the 1970s, AZBEF was firmly established as the lead organization for *Naissances Désirables/*family planning in Zaïre. It had 25 core staff, many of whom benefited from training and technical support from the IPPF regional office in Kenya. AZBEF introduced and legitimized the concept of birth spacing across the country through advocacy efforts and information-education-communication activities. Moreover, AZBEF reported some 100 "antennae" clincs nationwide that delivered a range of contraceptives (pills, Depo-Provera, IUDs, condoms, and spermicides), as well as 75 outlets that distributed non-clinical methods only (condoms and spermicides). Of the total, 73% were MOH clinics, 18% ECZ, 2% Catholic, and 7% other.

In Kinshasa, the four main sources of contraception were the AZBEF-run clinic at Mama Yemo, church-supported health centers, pharmacies, and dispensaries of several large private sector companies (e.g., Bralima beer, UTEX textiles, OZACAF for coffee, SEP Zaïre for fuel). These private companies were responsible, by law, for providing health services to their employees and their families. By contrast, access to contraception was far more limited in rural areas, with a few notable

exceptions (Vanga and Bulape). The ECZ had begun to incorporate contraception into existing maternal and child health programs in church-owned hospitals and health centers, but such efforts were still in their infancy. Even in Vanga, with one of the most advanced rural healthcare operations in Zaïre in the 1970s, demand for contraceptive services was low. As Dr. Dan Fountain explained in his book *Health for All: The Vanga Story*, "In spite of major efforts in education, the number of couples making use of these methods remained low … due to the deep-seated desire in the traditional culture to have many children to support the extended family, clan, and tribal structures."[49]

In both urban and rural areas, the demand for contraception remained low because the demand for children remained high. Most couples aspired to have at least five children. Because of high rates of infant and child mortality, couples felt compelled to protect against future loss by having "additional" children. In a country where each generation depends on the next for support as they grow older, children become one's security in old age.[50]

If women in urban areas had limited opportunities for advancement in the formal labor market, rural women had virtually none. Large families were a source of social status for both parents, but especially for women who had few alternative avenues for personal advancement. Children were not only the product of a marriage, but the reason for getting married. If a married woman failed to produce the children that the husband or his family expected, he might seek them from other women or even abandon her altogether. Given the economic dependence of women on their male partners, women risked severe financial hardship for themselves and their children if they were caught using contraception.[51] The few contraceptive users in rural areas tended to have at least five children or to have a medical condition that curtailed further childbearing.[52] Except for the most educated couples in villages, cultural norms severely hindered the spread of contraception.

AZBEF had led the charge for introducing the concept of *Naissances Désirables* to Zaïre and establishing a network of antennae clinics. In an effort to educate the population and create demand, it devoted major resources to its advocacy and information-education-communication activities. But AZBEF fell short in its role of coordinating family planning work at the national level, according to an evaluation conducted in 1982. Communication with the antennae clinics was sporadic. Service statistics – if collected at all – were so unreliable as to be useless in forecasting future needs for contraceptives. And training of service providers – desperately needed for an expanding program – lacked standardization and rigor.[53] By the time this evaluation occurred, USAID had already made its own assessment. It would chart a different course in developing and supporting a national program for family planning service delivery. The results of the evaluation could only have validated USAID's decision to go a different direction in the 1980s.

Notes

1 Lodge, Tom, Denis Kadima, and David Pottie, eds. "Democratic Republic of Congo." Essay. In *Compendium of Elections in Southern Africa*. EISA, Johannesburg, 2002, p 68–70

2 *Zaire: Social Sector Project*. Washington, DC: The World Bank, 1990, p 1
3 Kisangani, Emizet F. *Historical dictionary of the Democratic Republic of the Congo*. Fourth ed. London: Rowman & Littlefield Inc., 2016, p 356
4 Kisangani, 2016, p 571
5 Boyle, Patrick M. "Beyond Self-Protection to Prophecy: The Catholic Church and Political Change in Zaïre." *Africa Today* 39, no. 3, 1992: 49–66. http://www.jstor.org/stable/4186832, p 58
6 Kisangani, 2016, p 460
7 Odom, Thomas P. *Shaba II: The French and Belgian intervention in Zaire in 1978*. Fort Leavenworth, KS: U.S. Army Command and General Staff College, Combat Studies Institute, 1993, p 10
8 Boyle, 1992, p 60–61
9 Kisangani, 2016, p 634–5
10 The World Bank, 1990. p 1
11 Kisangani, 2016, p 635
12 Devarajan, Shantayanan, David R. Dollar, and Torgney Holmgren, eds. "Democratic Republic of the Congo." In Aid and Reform in Africa : Lessons from Ten Case Studies. Washington, DC: World Bank, 2001. https://hdl.handle.net/10986/13894, p 629
13 Kisangani, 2016, p 280–1
14 Kisangani, 2016, p 280
15 Lashman, Karen. "Syncrisis: The dynamics of health." XIV: Zaïre. Washington, DC: US Department of Health, Education and Welfare, Office of International Health, 1975, p 47
16 Kisangani, 2016, p 355
17 Kisangani, 2016, p 356–6
18 Close, William T. *Beyond the Storm: Treating the powerless and the powerful in my Mobutu's Congo/Zaire*. Marbleton, WY: Meadowlark Springs Press, 2007, p 132
19 Close, 2007, p 223
20 Kisangani, 2016, p 630
21 Close, 2007, p 260
22 Close, 2007, p 224, 232, 263
23 Lashman, 1975, p 52
24 Bertrand, Jane, and Judith Brown. "Family Planning Success in Two Cities in Zaïre." The World Bank, Policy Research Working Paper Series, January 1, 1992, p 1
25 Bertrand and Brown, 1992, p 1
26 Lashman, 1975, p 52
27 Lecomte, Jean, and Jay Friedman. "An Assessment of the Goals, Activities, and Performance of the National Committee for Desired Births, Government of Zaïre". USAID, May 12, 1982. https://pdf.usaid.gov/pdf_docs/PNAAL438.pdf, p 5–6
28 Lashman, 1975, p 52
29 Friedman, Jay. "Foreign Trip Report (AID/RSSA), Zaïre: Program Evaluation of the Comité national des naissances désirables-CNND (National Committee for Desired Births)." Prepared by Center of Disease Control for USAID, March 12, 1982. https://pdf.usaid.gov/pdf_docs/PDAAL443.pdf, p 2–3
30 Friedman, 1982, p 2–3
31 Lashman, 1975, p 54
32 Lecomte and Friedman, 1982, p v-vi
33 Bertrand and Brown, 1992, p 3
34 Lashman, 1975, p 87, 124
35 Rich, Jeremy. From "Jean-Perce Makanzu to Makanzu Mavumilusa: An Evangelical Protestant Leader in Mobutu's Congo, 1960–1980." *Journal of Africana Religions*, Vol. 4, No. 1, 2016, p 77
36 Lashman, 1975, p 107
37 Lecomte and Friedman, 1982, p 6; Bertrand and Brown, 1992, p 1

38 Baer, Franklin. "SANRU: Lessons Learned (1981–1991)." Harrisonburg, VA: USAID, 1991. https://pdf.usaid.gov/pdf_docs/PNABM846.pdf, p 71
39 Baer, 1991, p 71
40 Baer, 1991, p 71
41 Romaniuk, Anatole. *La fécondité des populations congolaises.* Paris: Mouton, 1967
42 Waife, RS. "Traditional methods of birth control in Zaïre." Chestnut Hill, MA: Path Papers, No. 4. 1978. p 7–8
43 Waife, 1978, p 9–10
44 Fountain, Daniel E. *Health for all: The Vanga Story.* Pasadena, CA: William Carey Library, 2014.
45 Brown, Judith E, and Richard C Brown. "Characteristics of Contraceptive Acceptors in Rural Zaïre." *Studies in Family Planning* 11, no. 12, 1980, 378–84. https://doi.org/10.2307/1965844, p 378
46 Brown and Brown, 1980, p 381.
47 Brown and Brown, 1980, p 383.
48 Waife, 1978, p 11
49 Fountain, 2014, p 57, 160
50 Lashman, 1975, p 68
51 Lashman, 1975, p 56
52 Waife, 1978, p 4
53 Lecomte and Friedman, 1982, p 19

5 The 1980s

Zaïre Experiences the First Golden Decade for Family Planning

Mobutu presides over an economically volatile decade

Zaïre – home to the largest number of Catholics on the African continent – ushered in the decade of the 1980s with a visit from Pope John Paul II. President Mobutu continued his autocratic rule under the slogan "*un seul guide*" (only one leader). He used repressive tactics to quell the confrontation from opposition parties that were starting to emerge, drawing criticism from the international community. In 1984, he was elected for a third term as president, receiving 99.16% of the vote.[1]

If Mobutu was successful in fending off political opposition, he had a far more formidable threat in the 1980s: the deteriorating macroeconomic condition of the country. In the early 1980s, the public sector was ineffective; the investment climate was uninviting; the external debt had ballooned to 100% of the GDP; and the country had failed to invest in human capital. After previous failed attempts, in 1983–86 the country implemented a reform program – financial stabilization and structural adjustment – that yielded some positive results.[2] It devalued the currency and tightened control on public expenditures, among other measures, gaining short-lived approval from Western powers. Yet the government could not sustain the reform measures, which petered out between 1986 and 1988. These strict reforms economically strangled the average citizen and restricted Mobutu's ability to tap into the national treasury for his personal needs. Although the government maintained some measures of economic control, they were insufficient to negate the true source of the country's economic woes: Mobutu's relentless embezzlement of public funds.[3]

By the 1980s, the population of Zaïre was growing at three percent per year, among the highest rates in sub-Saharan Africa. Approximately 30% of the population was urban.[4] The rapid rate of population growth coupled with the deteriorating economy resulted in a drop in GDP, negatively impacting families already struggling to survive. Some 40–60% of men in urban areas did not have a stable salaried job.[5] The salaries paid to mid-level government employees were a fraction of those paid to high-level civil servants, who in turn earned far less than private sector employees of a similar rank. Government employees became demotivated and increasingly supplemented their earnings with side jobs. Many resorted

DOI: 10.4324/9781032718897-7

entirely to the informal sector. Families with little for themselves had to take on the burden of family members with even less. Very poor families allowed, or encouraged, their daughters into sex work as a survival strategy.[6]

The burgeoning population also increased pressures to provide education, housing, and jobs, which the government was unable to meet. The deteriorating economy created new dynamics within families; husbands had to count increasingly on their wives to contribute to the family income, primarily through the informal sector (selling produce in the market or brewing beer, for example). This gradual shift challenged the time-honored paradigm of the woman within Congolese society and the Catholic Church, leading some to ask, "who wore the trousers."[7] Lest there be any question, the Family Code of 1988 legally recognized the man as head of the household; his wife had to request his permission to work or handle certain legal transactions.[8]

Education – a determining factor in development – continued to decline. The percentage of the government budget spent on education dropped from 24% in 1978 to only 8% in 1989.[9] Given the educational priority given to males since the era of the Belgian Congo, literacy rates were far higher for men (79%) than women (45%) as of 1985.[10] By the close of the decade, the rate of girls' schooling was one of the lowest in sub-Saharan Africa: 63.6% enrollment at the primary level and 13.1% at the secondary level.[11]

The health sector fared no better. By the end of the 1980s, the majority of hospitals had closed, and those that continued to operate instigated the practice of "impounding the ill," to guarantee that they paid for the services received. The Armed Forces regularly patrolled hospitals to make sure that non-paying patients did not escape.[12]

In 1989, the country experienced a short-lived economic improvement, with a temporary increase in copper prices on the global market and a resumption of the stabilization measures. But with a drop in GDP and less foreign investment, the country was in dire economic straits. President Mobutu's insatiable need for money to support his entourage of friends and political sycophants prevented any meaningful control over public expenditures, robbing the country of effective investment in development.[13] Yet the international community was complicit in the deplorable state of the economy; the Western powers had been his major creditors. They had persisted in financing non-viable projects in the 1970s, then failed to provide debt relief in the 1980s when the country was trying to introduce reform.[14]

With the fall of the Berlin Wall in November 1989 and the Cold War drawing to a close, the walls began to close in on President Mobutu. He faced internal protests, Western condemnation of civil rights abuses, and a faltering economy. At the heart of his problems was his unremitting practice of corruption.[15]

Against this backdrop of a volatile economy, declining educational opportunities, and the autocratic rule of President Mobutu in the 1980s, the country would nonetheless experience the first golden decade of family planning.

The nagging concern for the Law of 1920 hangs over *Naissances Désirables*

At the dawn of the 1980s, family planning services peppered the capital city and regions of the Interior. The CNND, now formally AZBEF (The Zaïre Association for Family Welfare but still called CNND by many), was responsible for coordinating the work of all other family planning actors. There were some 100 "antennae" clinics across the country. The family planning clinic at Mama Yemo – the most active in the country – reported 2,500 client visits a month. In the Interior, the Protestant Church hospitals had the most robust family planning services, as they started to expand their facility-based curative services to include outreach services to the health centers and health workers in surrounding communities.[16] Dr. Miatudila, in his role as administrator at AZBEF, collaborated with Professor Ngondo Seraphine, a demographer and AZBEF volunteer, to introduce a course on *Naissances Désirables* at the demography department at *Université de Kinshasa* (UNIKIN) in 1982.

It was now a decade since President Mobutu had endorsed the concept of *Naissances Désirables*. Yet Dr. Miatudila was not entirely comfortable about the potential liability for those working in this new field. He could not overcome a nagging fear about the Law of 1920 – prohibiting the promotion and provision of family planning services – which was still a part of the penal code in Zaïre. In theory, Mobutu's 1973 decree gave Dr. Miatudila and fellow doctors cover from possible recrimination. But what could happen in the case of a change of regime? Officially repealing the Law of 1920 was the only way to prevent the threat of jail for those involved in this controversial new program. In 1982, an AZBEF volunteer – Mr. Maneng Ma Kong – had been elected to parliament and arranged for Dr. Miatudila to make his case before lawmakers.

Box 5.1 Dr. Miatudila and the Law of 1920

When Dr. Miatudila addressed the parliament in 1982, he intended to argue that the Law of 1920 had become obsolete: if a law is repeatedly violated over time with the implicit approval of the authorities, it becomes *caduque* (has lapsed). He cautiously introduced the topic, but before he could complete his argument, one of the parliamentarians began to lash out at the AZBEF colleague who had introduced him to the chamber. "Who invited this lout to speak before such an august body as the parliament? He should be carried off to Makala (the Kinshasa central prison) because what he is saying is blatantly against the law."

To this, Dr. Miatudila answered in a soft voice, "Excuse me, I am only a humble doctor. Where is the law written down?"

The parliamentarian shot back, "In this book of laws," which he hoisted over his head for all to see.

Dr. Miatudila had anticipated this exchange and had brought his own copy of the *Code penal du Congo belge et du Rwanda-Urundi.* "I, too, have a copy of your book of laws. So let me read to you from it." He opened to a

passage and began to read to the assembled members of parliament, "*Il est interdit d'habiter dans le quartier des blancs*." (It is prohibited [for Congolese] to live in the zone inhabited by the whites.) "*Les prisonniers congolais sont tenus de laver les vêtements sales des prisonniers blancs*." (The Congolese prisoners are required to wash the dirty clothes of the white prisoners.)

This book of laws clearly dated to the days of colonial rule, which were abhorrent to the now-independent citizens of Zaïre. In a flash, the atmosphere changed; the parliamentarians began to applaud. With an approving gesture, they added: "You can let him go."

Although Dr. Miatudila avoided being whisked off to Makala, he was unsuccessful at having the Law of 1920 stricken from the books. It would take another 36 years before parliament passed the Public Health Law of 2018 that legalized access to contraception for all people of reproductive age.

If CNND/AZBEF had set the pace for *Naissances Désirables* in Zaïre during the 1970s, the tides turned in the 1980s. AZBEF continued its support of some family planning clinics and in its advocacy and information-education-communication work. Yet in the 1980s, its leadership role would be largely eclipsed by programs funded by the United States Agency for International Development (USAID).

USAID plays a catalytic role

As the leading donor for international family planning at the global level, USAID had prioritized Latin America, Asia, and North Africa in its funding decisions since the

Figure 5.1 A young Dr. Miatudila Malonga as Administrator of AZBEF

inception of the Office of Population in 1965. Programs in these countries – initially controversial – were showing measurable success in terms of contraceptive uptake and fertility declines (albeit modest).[17] Although tempted to continue to reward success in those countries, the leadership of USAID realized the need to begin a gradual shift in funding toward the region with far greater needs – SSA. To this end, the funding levels established by USAID/Washington for selected missions (USAID offices) in SSA increased, as did USAID central funding administered through international NGOs based in the United States to conduct project work in developing countries ("cooperating agencies").[18] As family planning work blossomed in Zaïre in the 1980s, the vast majority of it could be traced back to USAID.

Pivotal to USAID's work in Zaïre in the 1980s was Mr. Richard Thornton, who arrived in Kinshasa in 1979 to serve as USAID/Kinshasa population officer. Within months, two senior members of the Health Office abruptly departed, leaving the relatively inexperienced Thornton in the driver's seat. A young dynamic individual rarely seen without his combat boots, he was no one's typical bureaucrat. He had inherited the Health Systems Development Project in the health zone of Kongolo but was quickly dissatisfied with that project "run by a beltway bandit in Washington, DC" and managed ineptly by the Ministry of Health. He set to work on developing a better model for service delivery.

As Rick Thornton was contemplating what that better model might entail, he received word from Washington that the USAID Office of Population had approved funding for an operations research project to test the community-based distribution of contraceptives in Zaïre. Jane Bertrand of the Tulane School of Public Health and Tropical Medicine visited Kinshasa in 1979 as a consultant to a Tulane nutrition project with CEPLANUT (National Nutrition Planning Center, today PROPLANUT). While at USAID/Washington to pitch a potential project in Brazil (which met with resounding disinterest), she expressed to Dr. Duff Gillespie her amazement that Zaïre had such an underdeveloped family planning program. Her timing was spot-on. Duff, then the head of the research division at the USAID Office of Population, was keen on identifying opportunities to work in sub-Saharan Africa and encouraged her to submit an unsolicited proposal on family planning in Zaïre. On a follow-up visit to the country, she contacted the Galloways to explore what might be done. They recommended she work with Dr. Nlandu Mangani, Médecin Chef de Zone (MCZ, chief district medical officer) in Nsona Mpangu, Bas Zaïre (today called Kongo Central), who had recently returned from a Jhpiego training in tubal ligation. Bertrand submitted her unsolicited proposal to USAID in 1980 and, within months, received USAID/Washington approval for the project (virtually unheard of in today's world of mandated competitive bidding).

Rick Thornton did not mince words. From the start, he was against this new project, even though the funding would be coming from USAID/Washington, not his own budget. "This project is not sustainable," he argued, first to Jane Bertrand and then to his boss, Norman Sweet, then director of USAID/Kinshasa. The counterargument was that this type of project would provide a test of concept: would rural women accept contraception if offered by female providers trusted by the community? Whether to stay in the good graces of USAID/Washington or to

support family planning (a growing priority for USAID as an agency), Norm Sweet overruled Rick Thornton and approved the project. Thornton never held it against Tulane, even though the project represented an additional supervisory responsibility for him.

Unbeknownst to anyone at the time, Thornton would jumpstart the expansion of family planning in the 1980s that few could have imagined. Following closely on the Tulane project PRODEF, Thornton oversaw the design and implementation of two major projects with national reach: the Basic Rural Health (SANRU) project and the *Projet des Services des Naissances Désirables* (PSND, the Project for Services for Desirable Births, often referred to in English as the Family Planning Services Project). As HIV/AIDS surfaced in Zaïre in the mid-1980s, the Zaïre Social Marketing Project became a highly effective mechanism for condom distribution and a model for other countries in sub-Saharan Africa.[19] Later in the decade, a second USAID-funded operations research project – the Kananga Project – tested strategies for promoting family planning in the fifth largest city in the country.[20] These two research projects (PRODEF and Kananga) – though far smaller in scale than SANRU and PSND – provided the first concrete evidence of the potential effectiveness of family planning interventions on increasing modern contraceptive use in Zaïre. As such, they bookended what would become the first golden decade for family planning in Zaïre, under the banner of *Naissances Désirables*.

PRODEF tests the viability of community-based distribution

The story of USAID-funded family planning in Zaïre in the 1980s opens with PRODEF because it was the first to receive official approval from USAID. In the early 1980s, the international family planning community recognized the need to push beyond the delivery of contraceptive services in fixed clinical facilities. It was not practical to reach the large numbers of women in need of contraception through fixed clinics. Instead, numerous countries in Latin America, Asia, and North Africa experimented with two alternative models of service delivery: community-based distribution (CBD) and contraceptive social marketing (CSM). The research division at the USAID Office of Population in Washington, DC had funded multiple studies in developing countries, especially on CBD, to demonstrate the feasibility and acceptability of these mechanisms.[21] Zaïre was to become the next in this line of operations research.

Once again, Ralph and Florence Galloway played a key role in establishing this new project. They recommended that Tulane work with one of the ECZ (*Eglise du Christ au Zaire*) members – CBZO (the *Communauté baptiste de Zaire-Ouest*, or Baptist Community of West Zaïre) – that had a long history of supporting health services in Bas Zaïre.[22] As the province abutting Kinshasa to the west, Bas Zaïre offered an unquestionable advantage: proximity. The Galloways felt that Dr. Nlandu Mangani, MCZ in the rural health zone of Nsona Mpangu, would make an excellent counterpart for this project. The Baptist missionaries had first come to Nsona Mpangu in the mid-1920s and built up a station there, complete with a church, a school, and a three-ward hospital between 1924 and 1928. By 1980, the expat missionaries were long

gone, but the vestiges of better days were still there. Dr. Nlandu and his family of six children lived in one of the remaining brick houses. Two Peace Corps volunteers lived in another. The hospital was solidly built but had suffered from years of neglect. Dr. Nlandu depended on government subsidies and occasional donations of used equipment to keep the operation going, along with the paltry payments received from patients. During one visit of international guests, Dr. Nlandu was called away to attend to a young boy whose torso had been impaled by the branch of a mango tree. The Western visitor held the flashlight as he operated.

Nsona Mpangu proved to be an excellent base of operation for the project. Dr. Nlandu was a beloved figure in a community that relied on the hospital as its sole source of curative treatment and basic surgery. Moreover, he managed the operation with autonomy, in part because of lax oversight from an under-resourced government. In contrast to sites that could only be accessed by plane, Nsona Mpangu was five to six hours from Kinshasa by Jeep: five hours down the well-traveled Highway 1 toward Matadi, then one hour into the bush over deeply rutted dirt roads.

The objective of the project was to improve attitudes toward family planning and increase modern contraceptive use among married women. To improve the generalizability of the findings, it was decided to test the CBD strategy not only in this rural health zone but also in the nearby port city of Matadi, located one and a half hours from Nsona Mpangu by Jeep.[23] Because Dr. Nlandu had no official standing with Matadi, he networked with existing health officials to implement the project there.

After signing a contract with CBZO, Tulane worked with Dr. Nlandu to finalize the design of the project. In a move that was radical for the times, Dr. Nlandu hired a

Figure 5.2 Dr. Nlandu Mangani on the Zaire River

woman – Matondo Mansilu – to serve as his deputy. With no local blueprint on how to set up a CBD program in Zaïre, the team drew inspiration from models that were functioning well in Latin America, where Bertrand had worked for several years. They named their activity PRODEF for *Projet d'éducation familiale* (the Family Education Project). USAID/Washington assigned Ms. Elizabeth (Liz) Maguire, one of its young project officers, to supervise this new project. During one supervisory visit, she and Bertrand took a harrowing five-hour drive between Kinshasa and Matadi, during which the driver of a dilapidated taxi puffed nonstop on his cigarettes while an open gas can rolled around in the trunk. Fortunately, both survived the experience allowing Maguire to go on to become the director of the Office of Population at USAID and later president/CEO of Ipas.

The PRODEF project was implemented in Matadi (an estimated catchment area of 133,000 people) and a rural health zone (consisting of 53 villages with a population of 25,000). The two main activities were reinforcing existing health facilities and conducting outreach. The former involved training nurses in contraceptive service delivery, keeping them supplied with a full range of contraceptives, and collecting statistics on the quantity of contraception distributed.[24]

The outreach in the urban area of Matadi took the form of home visits. The project hired a team of eight salaried workers, identifiable by their pink jackets, to canvass the area in three rounds of home visiting. During these visits, they educated women or couples about family planning and sold three types of contraceptives – pills, condoms, and spermicides – at highly subsidized prices. Women wishing another method or resupply after the three rounds were referred to local health facilities.[25]

Figure 5.3 Matondo Mansilu (left), Dr. Nlandu Mangani (right) with a local colleague in Bas Zaire

Outreach in the rural health zone of Nsona Mpangu also included home visiting by a team of female workers trained for the task.[26] They traveled as a group to the villages in the catchment area, pouring out of the Land Rover with their pink jackets upon arrival at each village. On the first visit, they would explain the project to the village chief, who in turn would convene members of the community to participate in a group education session. The home visitors would then circulate through the community, educating women or couples in their homes. In villages that did not have close access to a health facility, the community would select one woman to establish a CBD "depot" in her home. She received the honorific title of *matrone*, as well as a large red trunk in which to securely store the products she would sell at subsidized prices to her neighbors. To enhance the acceptability of this new program in rural areas, the *matrones* received and sold four medications for children under age five at subsidized prices: antimalarial drugs, de-worming medicines, rehydration salts to treat diarrhea, and aspirin.[27] When the same was proposed for Matadi, officials felt that the sale of these products would threaten existing commercial interests; thus, the urban program offered family planning services only.

The project was designed to test the relative effectiveness of combining the two approaches: the first involved increasing access through health facilities/CBD posts plus outreach, and the second increased access but had no home visiting. The areas assigned to each approach were designated as Zone A and Zone B, respectively, in both Matadi and the rural communities. A before/after survey among married women 15–49 years old was conducted to measure the effectiveness of PRODEF in improving knowledge, influencing attitudes, and, most importantly, increasing modern contraceptive use (known as the modern contraceptive prevalence rate or MCPR). The project also tracked statistics on the quantity of contraception distributed in each location over time.[28]

In the 21 months of project implementation, MCPR increased in both urban and rural areas, with a particularly dramatic rise in the city of Matadi: from 4% of married women using modern contraception in 1981 to 17% in 1984. By comparison, MCPR increased from 3% to 12% in the rural area. Contrary to expectation, Zone A, which had received the added benefit of outreach, did not show significantly higher levels of use than Zone B in either the urban or rural setting.[29] Ken Heise, USAID population officer, was invited to present these findings at the State of the Art meeting for USAID staff in Gettysburg, VA, in 1984, indicating the interest far beyond Zaïre in this test of CBD in a rural area of francophone sub-Saharan Africa.

The PRODEF model of community-based distribution led to a series of spin-offs, as USAID renewed Tulane's contract from 1985–89. The most similar was in the health zone of Sona Bata, some 80 kilometers down Highway 1 from Kinshasa in Bas Zaïre.[30] An American Baptist physician, Dr. Glen Tuttle, had established the hospital there in 1925, and by the mid-1970s the hospital was operated by several missionary physicians from the Netherlands. Dr. Félix Minuku Kinzonzi arrived in 1977 as the first Congolese physician to practice there, and shortly thereafter he was named MCZ of the Sona Bata health zone. It was under his capable leadership that PRODEF/Sona Bata was launched.

The Sona Bata project tested two strategies: providing family planning through 32 CBD workers in one area and through health centers and posts in a second area. The project also had a comparison area in which no new family planning activities were undertaken. Minuku's team worked with the community health committees (CODESA) in each village to identify the CBD worker: a woman who could read and write, was liked by the community, was already involved in community work, and wanted to volunteer. As in Nsona Mpangu, these volunteers received the honorific title of *matrone*. They sold contraceptives and childhood medications, and they referred difficult cases to the hospital. In reflecting on the community's ready acceptance of PRODEF, Dr. Minuku commented that "it would have been difficult if they were only offering family planning." The CBD workers sold a higher volume of contraceptives than the health centers/posts did. Use of modern methods increased from 3% to 8% in the areas that had CBD workers and from 4% to 9% in the areas with health centers/posts. However, it increased a similar amount (from 1% to 6%) in the comparison area, meaning that factors in addition to PRODEF were at work. The strict interpretation of these results is that PRODEF had no effect (the net increase was not significant). Yet MCPR had risen in all three areas, possibly because the effects of PRODEF spilled over into the comparison area.[31]

Would the PRODEF model yield similar results outside of Bas Zaïre, in other areas of the country that differed substantially in ethnic composition, language, and culture? As the national program became operational, Tulane assisted in establishing a PRODEF/Kisangani project in 1986, directed by Dr. Gilbert Wembodinga, who also offered contraceptive services through a clinic in the city. PRODEF/Mbuyi Mayi was scheduled to begin in 1986 in the heart of the diamond mines, with both an urban and rural (*Miabi*) component.[32] Delayed by turnover of the MCZ, in 1988 Dr. Ntumbak Kalala was finally able to initiate project activity. In Kinshasa, PRODEF tested the feasibility of incorporating AIDS prevention activities with family planning in two health zones (Makala and Kikimi). However, hindered by logistical delays and political setbacks, none of these projects benefited from the assessment of effectiveness available from the three sites in Bas Zaïre.[33]

Matadi emerged as the PRODEF success story. During phase two (1985–88) the strategy of using visiting health workers was replaced by establishing 40 CBD posts (sales from the person's home) across the two zones of Matadi. The project also continued to retrain personnel and resupply eight health facilities with contraception. The results of a follow-up study in 1989 showed that modern contraceptive use had continued to increase among married women: from 4% in 1981 to 17% in 1983, and 23% in 1989, the highest reported level anywhere in the country in the 1980s. Whereas the first increase could be traced directly to PRODEF, by the late 1980s, other family planning services became available, undoubtedly contributing to this increase.

Nsona Mpangu and Sona Bata became victims of infighting. At the request of the Ministry of Health, in 1987 Dr. Nlandu Mangani moved from Nsona Mpangu to Kinshasa to assist with the national family planning program. He was replaced

Figure 5.4 Jane and Bill Bertrand in a village in Bas Zaire, 1981

by an MCZ who wanted, but did not get, control over PRODEF. Despite efforts of the PRODEF staff to establish an effective collaboration, the frustrated MCZ undermined their efforts throughout the zone. The findings from the third round of data collection reflected his negative influence. After MCPR had increased from 4% to 12% between 1981–84, it dropped to 8% in 1988.[34]

Sona Bata also experienced problems. After the project closed in 1989, a local conspiracy erupted against Dr. Minuku. Some factions of the community "saw him get rich with the *prime* (bonus) from PRODEF." Others resented that he had received a Land Rover in connection with the project. The pastors at Sona Bata felt that they also should have received something from the PRODEF budget, and the local administrative council began to make life difficult for Dr. Minuku. Discouraged, he asked for and received a transfer to the nearby health zone of Kisantu, where his dedication to family planning was temporarily stymied. The Catholics running the operation at Kisantu wanted nothing to do with family planning.

In total, PRODEF established CBD services in eight health zones during the 1980s, with over 270 CBD workers. It showed convincingly that when contraceptives were made available to the population at low cost through a trusted and convenient mechanism, there was a demand for this service, even in rural settings. PRODEF in Bas Zaïre benefited from the positive relationship that the community already had with the two MCZs, Nlandu Mangani and Félix Minuku. Despite the

prevailing high fertility norms in these communities, PRODEF did not experience any serious opposition, either from community leaders or the Catholic Church. The *matrones* were well accepted, especially since they could provide mothers with highly valued medicines to treat the most common childhood ailments at a subsidized price. The project promoted *Naissances Désirables,* emphasizing birth spacing, not limitation.[35] In two of the eight sites that experienced problems, the conflicts related to money and turf, not to the CBD approach or family planning per se.

In 1989, the USAID project that supported Tulane's operations research work ended. Rick Thornton had been right – the original model for CBD was not sustainable in terms of paying salaries and restocking CBD workers with childhood medications after the project ended. However, PRODEF had succeeded at demonstrating the cultural acceptability of providing contraceptives through existing health facilities and CBD posts, as well as the effectiveness of these strategies in increasing modern contraceptive use.[36] The national program, which began several years after PRODEF, adopted CBD as one of its models of service delivery, and it would have a resurgence several decades later.

SANRU introduces *Naissances Désirables* to rural areas

In his initial role as Population Officer at USAID/Zaïre, Thornton was tasked with developing a major family planning project that would have a nationwide reach. As an agency, USAID used a team-based approach to designing new

Figure 5.5 Tulane research assistants transporting questionnaires, Nsona Mpangu, Bas Zaire, 1981

projects and Zaïre was no exception. Thornton assembled a team of Americans – family planning experts imported for the purpose – and Zairians, who would assess the landscape for service provision and develop a "Project Paper" recommending the design of a new project.[37]

In mid-1981, Thornton leased an aging DC-3 plane and took the design team on a ten-day grand tour of Protestant-run hospitals scattered across the country, selected because they had the most functional family planning services at the time and a landing strip. He kept a close watch on the suitcase he carried, filled with Zairian currency. The team zigzagged across the country to at least eight locations – Mbandaka, Mbuji-Mayi, Kisangani, Bukavu, Goma, and others – speaking to clinic personnel, local chiefs, and women in the communities. This trip provided invaluable insights into the nuts and bolts of delivering contraceptive services in Zaïre. An iconic photo of the group visiting the church hospital in Nyankunde provides the historical record of this adventure.

Beverly BenSalem – at the time a staff member for the Association for Voluntary Surgical Contraception (AVSC), later renamed EngenderHealth – recounts numerous anecdotes from this "magical mystery tour." The plane was intended

Figure 5.6 USAID design team (left to right): kneeling on the ground: Jean-Pierre Muka, and colleague. Standing: Bill Bair, the main pilot, Miatudila Malonga, Rick Thornton, a Zairois union representative, Florence Galloway, Chirwisa Chirhamolekwa, Wilbur Wallace, Beverly BenSalem, the co-pilot, and Ralph Galloway. Seated in plane: Joyce Holfeld

for cargo, with few available seats. Team members – role-playing as flight attendants – distributed bananas to the passengers from the cargo they found aboard. At their first stop in the city of Mbandaka, the Belgian doctor in charge of the operating theater in the local hospital proudly informed them that "this operating table straddles the equator." Given Thornton's hard-driving manner, the team referred to him as "the Thorn."

This trip was not for the faint of heart. In Kananga, the landing strip abutted on a steep cliff. Thornton had paid the fee (bribe) for use of the landing strip. The DC-3 was hurtling down the airstrip approaching lift-off when the crew on the ground frantically gestured to the pilot that he had to return. The plane ground to a halt 20 feet short of the cliff. The problem: the bribe had not been large enough.

Most of those mission stations had been established in the late 1800s or early 1900s with financial assistance from churches in the United States, Canada, and Europe. By 1980, the stations often consisted of a hospital, school, and church, as well as housing for expat missionaries willing to live and work in these remote locations. Because no Congolese were trained as physicians during the colonial period, the church hospitals were staffed primarily by expat doctors and nurses, as well as Congolese nurses and administrative staff. The government of Zaïre (GOZ) provided partial support for these facilities through payment of staff and purchase of equipment and supplies, but churches back home often supplemented the funding. In sharp contrast, the team also visited several government hospitals that were woefully lacking in equipment and supplies. As BenSalem lamented, "often they had nothing."

Organized Western-style around medical services and gender-segregated wards, most church hospitals offered surprisingly good curative care under the circumstances. Yet the surrounding villages were ravaged by health problems common to developing countries in the tropics: malaria, tuberculosis, malnutrition, respiratory diseases, and diarrhea, to name the most common. The long distances and poor modes of transportation deterred many from even trying to reach the hospital for emergency care. Women with obstructed labor would often arrive with such advanced obstetrical complications that the doctors could do little to save them. Children died from preventable conditions.

A few of the church hospitals had begun to experiment with some form of outreach to communities surrounding the hospital. Vanga was at the forefront of such efforts for extending services to these outlying villages, largely through training healthcare workers and encouraging villages to build a health dispensary with some funding from Oxfam.[38] Other hospitals working toward the health zone and community health models included Bwamanda, Katana, Kasongo, Kimpese, Kisantu, and Tshikaji. The design team found that the problems were similar at the different sites, although the expressed needs and approaches differed.

Unquestionably, the church hospitals represented a valuable resource for any future project but it would be important to expand beyond curative treatment for those lucky enough to get to a hospital. Rather, the team discussed how one could develop a system of decentralized health zones that would provide primary healthcare in surrounding villages and involve members of the community in healthcare activities.

Whereas USAID had originally tasked Rick Thornton with developing a nationwide family planning program, the tour to these rural hospitals changed his thinking. In speaking with everyone involved in the delivery of maternal child health services, he and others on the team became acutely aware of the need to address the critical lack of healthcare across the vast rural population of the country. Presumably, his sudden promotion to de facto head of the USAID Office of Health had also broadened his vision and changed his priorities.

The concept behind the health zone model was to establish a decentralized structure for primary healthcare in a geographically defined catchment area. At the time, it was common for multiple entities – Protestant, Catholic, state, and private sector – to operate health facilities in a given geographical area, each with its own administration, supply chain, financial control, and statistical reporting system. The health zone model was designed to bring these different entities into a single, coordinated system, to avoid duplication and improve health outcomes.[39]

The health zone model was first proposed at a 1975 national planning conference organized jointly by the MOH and church health network partners. Elements of the model included the provision of "integrated medicine," later known as primary healthcare; geographically defined decentralized health zones created around functional hospitals; and a joint partnership between the MOH and church health networks to manage activity within the health zones.[40]

The new project would help the government to scale up the health zone concept by developing and supporting 50 health zones: manageable units that could better meet the needs of rural communities, which comprised over two-thirds of the total population at the time. The health zone would consist of a referral hospital, satellite health centers, and community action groups (such as the CODESA).[41]

As USAID worked on the project design, Thornton began to consider what organizations might be best able to implement such a large, ambitious project. The government would be key to its eventual success and sustainability. The GOZ was already working in several aspects of primary healthcare, although through vertical programs housed in different offices in the administrative area of Kinshasa (Gombe): nutrition at CEPLANUT, immunizations at PEV (Expanded Vaccination Program).[42] In discussing this future project with government officials, Thornton explained that it would also have a family planning component. The MOH did not (yet) have a program in family planning, but the minister of health indicated his willingness to work on this topic.

Whereas Thornton considered the government to be essential to the project, he was disinclined to entrust them with managing the finances. Their accounting systems were weak and previous projects had been wrought with financial irregularities. Neither was he impressed with the success of using "imported" institutional contractors, as had been the case for the unsuccessful Health Systems Development Project in Kongolo.

Dr. Miatudila, one of the consultants involved in the development of the project proposal, recommended that USAID select a non-governmental entity experienced in health work. At the time, the Catholic and Protestant churches

owned and/or operated more than half of the health facilities and schools in the country, based on agreements between the government and the churches dating back decades.

Dr. Kaba, then head of the MOH, accepted the advice not to run the financial management of this new project through the government, given the recent disastrous experience of FOMECO (*Fonds médical de coordination*, or the Medical Coordination Fund). This entity had supported Dr. William Close in the successful renovation of the Mama Yemo hospital and training of its staff to provide quality medical care in the early 1970s. Initially, President Mobutu had given Dr. Close total control over the financial management of the hospital. Yet in 1978, Mobutu made demands on Dr. Close: to hire back a doctor whom they had jointly decided to fire after he was caught stealing hospital equipment. Rather than oppose Mobutu, Dr. Close left the country. Mobutu replaced him by this same physician who had stolen from the hospital, thus marking the start of the pilfering of the FOMECO coffers. Based on this experience, Dr. Kaba had no grounds on which to argue that the MOH should administer the funds for this new USAID project.

Dr. Miatudila, who had been educated by Belgian Catholic missionaries, was well placed to approach the Catholic leadership on behalf of USAID to explore its interest in implementing this new project that would span the country. The BDOM (*Bureau diocésain des œuvres médicales*, Office of the Archbishop for Medical Projects) was a well-established entity in Kinshasa with a track record for managing large projects. However, when BDOM learned that this was a primary healthcare project that included family planning, they assumed it was a back-handed effort by the Americans to strongarm them into offering artificial contraception. Also, they bristled at the idea of Americans eroding Belgian supremacy in the Congo. Their response was a categorical "no."

On behalf of USAID, Dr. Miatudila then turned to the ECZ, which had a rather loosely defined network of around 80 hospitals and several hundred dispensaries. The Protestants had no problem in implementing a project with a family planning component. In fact, Ralph and Florence Galloway, Presbyterian missionaries, were already providing some family planning services from ECZ's medical office and had already integrated contraception into the MCH services in multiple health facilities across the country. Bishop Bokeleale, president of ECZ, accepted this offer and the ECZ staff began to work with USAID on finalizing the details of the rural health project.[43]

The search remained open for a project manager. Ralph and Florence Galloway recommended Franklin Baer, a former Mennonite Central Committee volunteer, knowing that he had worked at Vanga for three years (1976–1979) and had helped develop Vanga into a pilot health zone. At that time, Frank was completing a a doctorate of public health at Tulane University. Rick invited Frank to come to Kinshasa for a short-term consultancy to develop a start-up plan for the Basic Rural Health (BRH) project. Thornton was pleased with his work and USAID immediately offered Frank a contract as the BRH project manager.[44]

In the end, USAID entered into separate agreements with the MOH and ECZ; one with ECZ for the financial, administrative, and technical aspects of the

project, the other with the Ministry of Health for coordination, oversight of policies, and technical protocols. The BRH Project agreement was signed in August 1981, with Mr. Nlaba Nsona as ECZ project director. With the arrival of Baer in January 1982, the BRH project very quickly became one of the key health development partners for the MOH and USAID.[45]

The BRH project was, in French, called the *Projet des soins de santé primaires en milieu rural*. Based on a competition to choose a shorter, catchier name, SANRU (*Santé rurale*) emerged as the winner. The objective of SANRU was to establish a self-sustaining, community-supported system of primary healthcare, effectively offering prevention and treatment for the ten most prevalent health problems in 50 rural health zones in Zaïre.[46]

The BRH project aligned well with the emerging MOH five-year health plan (1982–87) that proposed creating 300 health zones. That target was a back-of-the-envelope calculation: an estimated population of 30 million people grouped 100,000 per health zone. That plan also outlined the components and characteristics of a health zone. Fortuitously, around that same time, PEV began training medical doctors to manage immunization activities at the health zone level. The combination of PEV's training along with SANRU support provided trained MCZs to begin a bottom-up creation of health zones around their functioning hospitals. Each health zone proposed its geographic boundaries with respect to existing health facilities and topography of access.[47]

SANRU began with a team of six in four offices of ECZ. Nlaba Nsona was the project director; Dr. Miatudila Malonga, GOZ representative (based at the MOH); and Frank Baer, project manager. Florence and Ralph Galloway served as finance and training coordinators, and M. Dianzola Lufwakasi was administrative secretary.[48] That core team managed the entire project in its first year, then gradually added more staff.

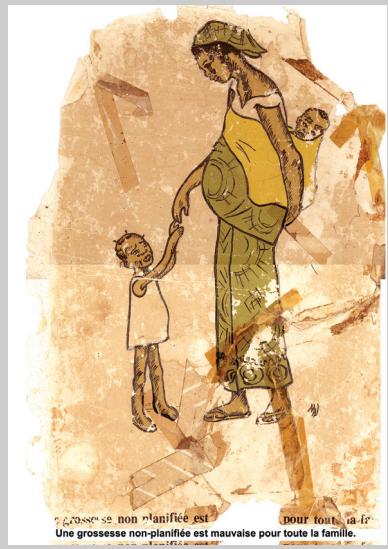
Box 5.2 The origin of the iconic SANRU logo – father with baby

One of the first health education endeavors of SANRU was to print family planning posters. Florence Galloway, the SANRU training coordinator, led this initiative. Florence contacted an artist and fellow Presbyterian missionary, Mildred Washburn, who was based in Kananga. Washburn responded with four colored sketches: 1) a mother breastfeeding her child; 2) a healthy family with mother, father, and child; 3) a pregnant mother with malnourished children; and 4) a father holding a healthy child.

The staff developed a slogan for each picture and printed them as small posters for project-assisted health centers. Those posters were some of the first, and in many cases the only, posters displayed in these health centers. SANRU promoted family planning from the early days of the project.

In 1983, as SANRU prepared for its first conference, a local supplier suggested that SANRU create a special T-shirt for the occasion. The idea was well received, but the only images on hand were from the four family

planning posters. The SANRU staff decided that the "father holding a child" would work well on a T-shirt along with the name SANRU and commissioned the printing of several hundred T-shirts. The T-shirts were a great hit at the conference, although the quality of the printing was not ideal and the



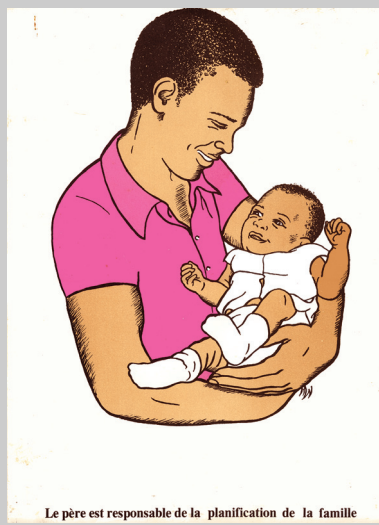


image faded after several washings. Although never intended as the logo for SANRU, the father holding the child was so favorably received that de facto it became the SANRU logo.

In 1982, SANRU lost no time in rolling out support to a first "wave" of 15 Protestant hospitals: Bibanga, Kajiji, Kalonda Ouest, Karawa, Kimpese, Kikonzi,

Loko, Nsona Mpangu, Nyankunde, Oicha, Sona Bata, Tandala, Tshikaji, Vanga, and Wembo-Nyama.[49] Even though the SANRU project documents specified the creation of 50 health zones around 50 Protestant-owned hospitals, the SANRU team, in consultation with Rick Thornton, decided that SANRU should not limit assistance to Protestant hospitals. After selecting the most promising areas for health zone development in Wave 1, in 1983 SANRU directed a second wave of support to 20 health zones that included eight Protestant, five Catholic, and seven state-owned reference hospitals.[50]

Box 5.3 The promising model of Vanga

Vanga, the Baptist mission hospital developed by Dr. Dan Fountain, was pivotal in designing and testing the nascent concept of the health zone.

In 1982, Vanga was among the first wave of health zones to receive support from the SANRU project, which included family planning as one of ten components of primary healthcare. SANRU provided personnel at Vanga with refresher training in family planning and a reliable source of contraceptive commodities from 1982–91 and then again from 2001–05 (under SANRU III). During the 1980s, Vanga became the model health zone under SANRU. It was one of SANRU's preferred destinations for international visitors interested in observing the health zone concept and the role of church hospitals. Although Dan Fountain characterized the demand for contraception as "low" in his book on the Vanga experience, he nonetheless led the way in promoting family planning in rural health zones.

To those familiar with the church hospital system, Vanga became synonymous with quality service delivery to thousands of rural residents in the 1980s. It showed that even in low-resource settings, human ingenuity and dedication to the health mission could overcome financial and cultural barriers.

By 1983, the requests for SANRU assistance outpaced the 50 health zones envisioned by the project. Every day would bring someone new to SANRU seeking assistance. It might be the MCZ of a health zone, a Catholic Sister managing a maternity unit, or a Peace Corps volunteer assigned to work in a SANRU-assisted health zone. SANRU maintained an unofficial policy that no one who was sincerely seeking assistance for their primary healthcare program should leave SANRU offices empty-handed.[51] To that end, the project maintained a large stock of Salter baby scales, "Road to Health" weight charts, and pre-packaged kits with health education books and flipcharts. The kit also included an International Planned Parenthood Federation (IPPF) table-top family planning flipchart to introduce birth spacing in SANRU-supported health zones.

Two years into the project, SANRU had surpassed the original target of 50 health zones. Through combined efforts of SANRU and other projects, 85 functional health zones were operational and recognized by the MOH. Project and

MOH staff saw the need to officially define the boundaries of the health zones to avoid geographic gaps and overlap of activity. After a series of conferences organized by SANRU in collaboration with the MOH and other donors, by the end of 1985, the whole country had been delimitated into 306 health zones.[52]

At the end of 1984, the minister of plan organized a Round Table to discuss health zone development and to plan for future expansion. The meeting defined the manpower needed in a typical health zone, estimated the recurrent costs and financial investment required, and projected the pace for the development of other health zones. Those figures were used as the basis for developing the SANRU II proposal, which aimed to create 100 functional health zones between 1986–90.[53]

In addition to US dollars that USAID allocated to SANRU, the project also had access to counterpart funds, local currency (zaires) generated from the sale of US wheat to Zaïre under the PL 480 Food for Peace program. The Zaïre government received the wheat as a donation but could sell it, depositing the revenue into a counterpart fund (CPF) that in collaboration with USAID was allocated for various development projects.[54] About half of SANRU's funding came in the form of CPF, which was used to cover supervision at the HZ level, spring capping, and various types of training, including family planning.[55] Unbeknownst to most project staff, there was regular haggling within USAID/Zaïre for the allocation of these funds to specific projects, and in this competition SANRU – and later the Zaïre Social Marketing Project – were clear favorites.

The ECZ worked at two levels: from a macro perspective on activities that affected all zones, and with individual health zones. For example, it created awareness of the concept of a health zone, reprinting a document written by the MOH but virtually unknown outside of Kinshasa. It helped to define primary healthcare to include curative, preventive, and promotive healthcare. SANRU also worked directly in establishing or reinforcing the administrative structure and health services delivery in the selected health zones, in collaboration with local officials and hospital leadership at each site.[56]

Because SANRU began its work in Protestant hospitals, all of them accepted family planning as one of the components of their primary healthcare services.[57] As SANRU extended its partnership to Catholic-run hospitals, the reception was predictably different.[58] Several initially refused to include family planning in service delivery. Others sought a compromise arrangement. In a health zone managed from a Catholic hospital, SANRU agreed that Catholic-owned facilities would not be obliged to stock "modern" contraceptive methods, but that they would provide family planning education (using a popular IPPF table-top flipchart) and then refer clients to a health facility that could provide them with products that the Catholic-owned facility did not stock.

Box 5.4 Catholics and contraception

Dr. Armand Utshudi, SANRU project officer at USAID, recalls a trip that he made with Frank Baer to Bandundu in 1983. They presented the new project in broad strokes to the personnel at a Catholic-run hospital. After some

discussion, the nurses and doctors asked them to "give us the contraceptives but don't tell the bishop." The personnel at Catholic facilities could not speak publicly about family planning, but many were amenable to stocking the products for couples interested in using them. In retrospect, Frank Baer wishes he had a camera on hand when nuns left the SANRU warehouse with armloads of contraceptives.

******

In the rural areas, many Catholic Missions felt they had no choice but to toe the line from Rome. However, the priests and nuns who had worked for decades in these rural outposts were not oblivious to the loss of life and grave suffering caused by unwanted pregnancies. Dr. Miatudila tells the story of his visit to a clinic in the town of Walikale in North Kivu, one of the demographically densest regions of the country. He asked a white Polish nun, "What do you do here for family planning," knowing that the Pope – also Polish – had admonished against "non-natural methods." He added, "I know that we Catholics promote natural methods, but what do you do if the husband is uncooperative?"

Obviously, the nun was conflicted. Given Dr. Miatudila's insistence, she led him down the hall to the cellar (*cave*). She opened a drawer, and there was a full array of contraceptive methods. She mentioned that "she wouldn't touch them," but made it clear that her Zairian colleagues were within their rights to do so. As an afterthought, she added, "Rome is so far away."

It is hard to overstate the breadth and depth of activities conducted under SANRU, whose mandate was to improve health service delivery across ten components of health while building the infrastructure for the management of the health zones. SANRU stuck to the basics, providing comprehensive support (*appui global*) to the health system across the six dimensions that were subsequently defined by the World Health Organization as "building blocks": service delivery, health workforce, information systems, essential medical products and technologies, financial systems, and leadership and governance.[59]

By 1987, midway through the SANRU II project (1986–1991), the pace of health zone development plateaued. At that time, approximately 50% of functioning health zones were managed for the MOH by church health networks. New leadership within the MOH triggered a conflict regarding health zones as state-managed entities versus collaboratively managed with church health networks. The GOZ made unilateral decisions to transfer personnel from functioning health zones to regional offices where they were less effective for the work of a project such as SANRU. The constant devaluation of the local currency during the 1980s caused further problems for those managing the health zones.[60] A UNICEF pledge to support 184 health zones with an assistance package similar to that of SANRU never fully materialized.[61] Despite these setbacks, SANRU demonstrated the multiple benefits of the health zone approach.

In 1988, Dr. Duale Sambe became Director of SANRU, replacing Papa Nlaba who was retiring. Dr. Duale had graduated from medical school at UNIKIN in 1979, and through intervention from the leadership of the Protestant Church, he was assigned to work at the Karawa Hospital in his home province of Equateur. He describes the heady experience of serving as the first Zairian doctor at Karawa, shortly after the Alma Ata conference in 1978 that defined public health as the pathway to "Health for All by the Year 2000." Soon after his arrival, he was named MCZ and charged with further developing the health zone model at Karawa. In 1985, he obtained a master's in public health from Tulane, further equipping him with the necessary tools for the job. When he took over as director in 1988, SANRU increased the number of MCZ and provincial health officers sent to receive master's degree in public health training at the Kinshasa School of Public Health (KSPH), thus strengthening their capacity to manage a health zone. The gap between health zones with and without SANRU assistance became increasingly evident, even political. One parliamentarian demanded that SANRU adopt his health zone so he could show his people that he was doing something for them.

What was SANRU's impact on family planning in Zaïre? It is likely that without SANRU, there would have been little to no family planning in rural areas of Zaïre in the 1980s, except for populations served by Protestant hospitals. Thus, the very existence of family planning as part of the package of integrated health services in SANRU health zones helped to legitimize and diffuse the concept of *Naissances Désirables.*

SANRU delivered on its contractual agreement regarding family planning. Consistent with USAID's strong emphasis on family planning in the early 1980s, it was one of the ten components in the integrated package of services to be delivered in each health zone. SANRU trained clinical personnel – largely nurses – in counseling, management of side effects, and contraceptive service delivery; and it attempted to keep facilities stocked with a range of contraceptives (pills, condoms, Depo-Provera, IUDs, spermicides), albeit with occasional stockouts related to supply chain problems. By 1985 SANRU had exceeded the target of establishing 250 family planning services in 38 health zones.[62] The presence of the Galloways – with their fervent interest in family planning – undoubtedly kept family planning on everyone's radar. Ralph and Florence could check that shipments of medications to be delivered by MAF planes to particular health zones included the requisite supply of contraceptives. In contrast to programs that claimed to offer family planning as part of their integrated package of services but had no contraceptives on the shelves, SANRU worked hard to ensure that contraceptives would be available in these rural health zones.

Yet family planning was never a priority in the SANRU project. It was unquestionably – and some would claim understandably – overshadowed by other, more urgent health problems in these rural communities: malaria, tuberculosis, malnutrition, lack of sanitation and clean water, and vaccine-preventable diseases. In rural communities where high fertility norms prevailed, the demand for contraception was low. SANRU responded to the expressed interest of women or couples to use contraception, rather than actively trying to stimulate

greater demand for this service, leading one observer to describe it as a "passive approach." The project was expected to register 1% of women of reproductive age as new acceptors for family planning each year. A 1986 evaluation indicated that it fell well short of this mark, clearing this modest bar in only 11 of the 38 health zones reporting on this indicator. Reasons included the unavailability of Depo-Provera (the popular injectable), irregular supply chains, low acceptance due to cultural and religious inhibitions, and lack of knowledge.[63]

SANRU was one of the most successful health projects in the history of USAID/Zaïre. The 1986 evaluation commended SANRU for its success in strengthening healthcare services among the rural population of Zaïre. Family planning received less priority than other aspects of primary healthcare because there was less demand for it among the rural populations served by the project.[64] Whereas the SANRU project did little to increase contraceptive prevalence at the national level, it made other lasting contributions. It established family planning as part of the "minimum package" of health services. It demonstrated the feasibility of training large numbers of health workers in the provision of family planning service delivery and of resupplying rural health zones with contraceptives, even in remote areas. It served to familiarize the rural populations with the concept of modern contraception for birth spacing, even if relatively few chose to adopt it at the time. SANRU's low-key approach to promoting family planning services resulted in very little opposition to the activities from local officials. Over a decade after SANRU ended (prematurely and abruptly in 1991), the lessons learned in family planning in the 1980s served SANRU and the country well in reestablishing family planning in rural health zones a decade later.

Box 5.5 Protestant mission hospitals: the incubator for future family planning leaders

Coincidence or not?

In all three of the major donor agencies for family planning in the DRC – USAID, UNFPA, and FCDO (Foreign, Commonwealth and Development Office of the United Kingdom) – the top-ranking Congolese family planning advisers got their start in family planning with Protestant missionaries.

Dr. Théophile Nemuandjare calls himself a child of these missionaries. He did his primary and secondary schooling with the 27th Mennonite Church of Zaïre (CMC). Upon graduating from the UNIKIN School of Medicine in 1983, he received a scholarship from the Mennonites to return to work in their community. As a young doctor, from 1983–86, he practiced at the Reference Hospital of Kalonda-West, which served the health zone of Tshikapa in the province of Kasaï Occidental (West Kasaï). This hospital was one of the best in its day. Dr. Dennis Ries had integrated family planning into the package of primary healthcare. Every Thursday was dedicated to family planning: education, counseling, appointment cards, client records, and contraceptive service delivery. There Dr. Théophile learned from his mentors how to organize and manage a family planning service. The methods available were condoms,

diaphragms, spermicidal foam, oral pills, Depo-Provera injections, IUDs, and implants. He also performed tubal ligation for women in need of a permanent method. From there, he became MCZ and hospital director in two different locations – Nyanga (1991–93) and Kamonia (1993–2002) – where he integrated family planning into ongoing service delivery. In 2004 UNFPA/Kinshasa recruited him for its Program on Sexual and Reproductive Health for Adolescents and Young People. Then in 2011, UNFPA named him as the first occupant of a newly designated post: Director of UNFPA's Family Planning Program in the DRC, which he held until 2021.

Dr. Thibaut Mukaba finished medical school in 1990, after which he took an internship in a Protestant hospital in Tshikaji, where Richard and Judith Brown had arrived the same year. At the time, Tshikaji had an active family planning program. It was one of the few sites in Zaïre to offer Norplant (a five-rod contraceptive implant placed in a woman's upper arm, effective for five years). In addition to being exposed to a full array of other health problems, Dr. Mukaba had a front-row seat to the devastating consequences of ill-timed or unwanted pregnancies. Through the family planning clinic, he gained experience in contraceptive service delivery. Under the tutelage of Dr Walter Hull, he learned to perform contraceptive laparoscopy (tubal ligation). He also observed the value of extending services beyond the hospital, through the Kananga Project implemented through the Tshikaji's *Centre d'etudes et recherche* (Center for Study and Research), led by Dr. Judith Brown. And Dr. Mukaba came to understand the power of data when the Kananga Project demonstrated a significant increase in modern contraceptive use, one of the first projects in the country to do so. This early introduction to contraceptive service delivery in an environment that fostered training and applied research would serve him well in his position as a family planning and reproductive health specialist for USAID/Kinshasa from 2006 to the present.

Dr. Albert Mudingayi also received his introduction to family planning in Tshikaji. While in medical school at the University of Lubumbashi in 1989, he worked at IMCK during his vacation breaks back home. He remembered how well organized the service was, both at the clinic in the city of Kananga and at the hospital, located 18 km away at Tshikaji. "They never had stockouts." The promotion of family planning was everywhere. When a woman gave birth, the nurses would counsel her on the benefits of family planning for herself and her baby. Later in 1994–96, Dr. Mudingayi returned to the hospital, including for a six-month internship in Ob-Gyn, where he dealt with the dual problems of high fertility and sterility. Under the direction of Dr. Walter Hull, he completed his education, "what he hadn't learned in medical school." Dr. Hull supervised his first surgeries (Cesarean sections and ectopic pregnancies). He learned to use the laparoscope to diagnose infertility, repair tubal blockages, and on rare occasions perform tubal ligation. "While women were in labor, they screamed that they didn't want any more children. The doctor would advise them, '*Maman*, you need to rest now (from

multiple pregnancies).' But after the mother delivered and saw her baby, when the doctor mentioned that it was time to tie her tubes, she would have changed her mind." From Tshikaji, Dr. Albert transited through the Church of Christ of Congo (ECC), the French NGO *Médecins du Monde*, and UNICEF, before landing a position as health adviser for the British Embassy in 2009. In his current role, Dr. Albert is the top-ranking host-country national for family planning at the British Development Agency, FCDO.

Projet des Services des Naissances Désirables becomes the lead family planning agency

No sooner was the SANRU project signed in August 1981 than Rick Thornton went to work on designing a second project, one that would support family planning service delivery in urban areas of the country. Again, Thornton assembled a design team – this time with three MOH representatives, one AZBEF, five Americans, one pilot, and two mechanics – and organized a two-week tour of nine urban sites across the country to explore the existing landscape for family planning service delivery. The design team combined what they learned on that trip with knowledge of projects in other countries to develop the Project Paper, which outlined objectives and proposed an approach for the new project. It also outlined obstacles that the new project would likely face: a lack of knowledge of modern methods and sources to obtain them; opposition from the medical community based on traditional, religious, and cultural beliefs; inadequate coordination among relevant organizations; inadequate supply chain for contraceptive commodities; and an inadequate number of existing services.[65]

As the project design took shape, USAID needed to identify an organization to manage it. Dr. Miatudila again recommended that USAID partner with an NGO to minimize the risk of deleterious political interferences in the management of the project. But Thornton had decided that the MOH should take the lead on this new project, despite his apprehension over financial mismanagement. The US government was still licking its wounds over the vast amounts of money lost to management issues on the Inga-Shaba construction project, and Thornton did not want similar questions of financial impropriety to derail this project. He also wanted to strengthen the capacity of the MOH to administer healthcare on such a large scale, to ensure sustainability of the effort. The MOH – having been bypassed as the financial lead on the SANRU project – was considerably more interested in obtaining a piece of the action this time. AZBEF would be named as a partner on the new project, but in a secondary role to the MOH.

By now, Thornton had his eye on the person he wanted to direct the new project, Mme. Chirwisa Chirhamolekwa (Flora). She had the right credentials, a demonstrated track record within the MOH, and a no-nonsense approach that would be essential to getting the job done. She would become the face of family planning in Zaïre in the 1980s.

Mme. Chirwisa had been in training for this position all her life. As the oldest of 11 children and first daughter, born in Bukavu – one of the most densely populated areas of the country – she had assisted her mother from an early age with complicated deliveries. Having witnessed the hardships experienced by so many women, she vowed to "help these women avoid all these problems" when she grew up. Educationally, Chirwisa benefited from the transition period following independence, when some schools established by the Belgians (Jesuits) still maintained high standards. She first attended a secondary school operated by Catholic nuns, before entering *Formulac Katana* for clinical training as a medical assistant from 1963–66. She considers it "destiny" that at age 19 she was selected for a WHO scholarship in Senegal, where she studied teacher training and health services administration in Africa from 1968–71. Initially, the secretary general refused to approve her travel for the scholarship, since his sister had been passed over for this; instead, it went to "that young girl from the Interior." But WHO intervened, and Chirwisa was allowed to travel.

After returning to Bukavu, Chirwisa was called to Kinshasa in 1973 to assist in training others in maternal child health and nutrition, since by then most of the Belgians had left but the health services needed to function. Mobutu's motto was that if someone had studied, it was their duty to contribute. She became a *Chef de bureau* for the MOH and was posted at the *Clinique Kinoise* (supported by the Danish), where she began training nurses for the first two years of their university program. To address the manpower shortage, WHO again supported Chirwisa to study at the Université Libre de Bruxelles in Belgium from 1976–80.

Upon her return to Zaïre in 1980, she expected to go back to Bukavu, but the needs of the MOH in Kinshasa were too great; there were not enough doctors in the country. She was named *Chef de la Division de la santé de la mère et de l'enfant* (head of the MCH Division) of the 4th Direction at a time of great turmoil for the MOH. Despite her impressive title, she had no desk, chairs, equipment, or supplies. Still, she was committed to working on the *condition feminine*. She crisscrossed Kinshasa, visiting health centers where she discovered deplorable conditions, with women dying from childbirth or unsafe abortion. Everywhere she went, she took notes to document the horrific state of affairs. She also gathered statistics from other health offices (e.g., PROPLANUT, the Population Statistics Department). "People thought it was normal for women to die, but I knew it wasn't right," Chirwisa explained.

Rather than holding her tongue, Chirwisa took her complaints to the minister of health, Mr. Mozagba Ngbuka, who was well-connected with President Mobutu. Others warned her not to stir up so much trouble; "they could take your degree away." Based on her visits to health centers across the city and on statistics she had collected, she wrote up a proposal to establish 32 MCH centers. She was pleasantly surprised to learn that her proposal had not fallen on deaf ears.

The minister of health sent his black SUV to bring her into his office. During a meeting with his advisers in attendance, Dr. Mozagba revealed that he had lost his first wife in childbirth. "Our country doesn't have the money to establish 32 MCH centers, but we can introduce you to those who can give you an

opportunity to work with women and children – USAID." Soon thereafter she met Rick Thornton. Initially, she was disappointed to learn that USAID only had funding for family planning, not the 32 MCH health centers she wanted, but her colleagues persuaded her to take it anyway.

By the time her proposal had churned through several levels of review at USAID, a new minister of health had been installed. When this potential project with USAID came to his attention, he was vehemently opposed. "It's against the policies of this country." Chirwisa momentarily retreated in search of a copy of Mobutu's 1973 ordinance, which was hardly top-of-mind for most government officials, even those working in health. Given the internal discord over this issue, President Mobutu convened a meeting with the new minister of health, a political adviser, and Mme. Chirwisa. The new minister repeated his opposition: "How can you propose something that will kill children and that the Catholics oppose?" Chirwisa produced a copy of the 1973 decree establishing *Naissances Désirables*. President Mobutu seemed pleased that this concept would be put into action for the benefit of women in his country. The new minister had no recourse but to let the project proceed.

USAID and the MOH continued to deliberate over the design of the project for months. Family planning was controversial. What if adolescent girls were to get hold of contraceptives? Was abortion part of this project? (It was not). What about resistance from the Catholic Church? Finally, on the last day of the fiscal year when the US government could sign a contract (September 30, 1982), USAID finalized its agreement with the Ministry of Health and CNND[66] for a new urban family planning project: the *Projet des services des Naissances Désirables* (known locally in English as the Family Planning Services Project), PSND.[67]

PSND in its infancy

The *Projet des services des Naissances Désirables* officially began in October 1982, with Mme. Chirwisa Chirhamolekwa as its first director.[68] The goal of the project was to increase the use of voluntary family planning to permit Zairian families to space their births and continue to have the number of children they desired. The project aimed to increase the use of contraceptives from (an estimated) 3–5% to 12% by 1987 in 14 urban areas of Zaïre.[69]

The 14 cities were Kinshasa, Lubumbashi, Kananga, Kisangani, Mbuji-Mayi, Likasi, Bukavu, Matadi, Kolwezi, Mbandaka, Kikwit, Boma, Goma, and Bandundu.

The agreement outlined nine activities to achieve this result: improve coordination of family planning services, develop technical competencies, train personnel in different domains, produce educational materials, renovate health facilities, and provide basic equipment, supply facilities with contraceptive products, develop an improved logistical support system, deliver contraceptive services, and (and as a single activity) conduct supervision, collection of service statistics and evaluation.[70]

The methods to be provided included the IUD, condoms, spermicidal foam, oral pills, natural methods, permanent methods (sterilization), and the Depo-Provera injection.[71] Although the program was purportedly designed to encourage birth spacing, in the 1980s USAID globally was promoting permanent

methods (tubal ligation and vasectomy) as part of a comprehensive method mix. Thus, tubal ligation was introduced into the program from the start.

The project was a bilateral agreement between the governments of the United States and Zaïre, with the project director named by the minister of health.[72] It called on AZBEF to provide personnel in key administrative roles: management, contraceptive logistics, training, and supervision. The *Unité d'aministration et de la coordination* (the administrative/coordination unit) would include members of the MOH, AZBEF, and one long-term USAID consultant (the deputy director for administration).[73]

Since many of the FP services had previously been CNND/AZBEF "antennae" clinics, this transfer of leadership and money to the MOH ruffled some feathers at AZBEF. Whereas AZBEF had the programmatic experience and the established network of antennae clinics around the country, PSND now had the mandate and money to manage family planning in the name of the Zairian government.[74] Dr. Miatudila, the administrator at AZBEF, realized that the future of family planning lay with this new project. As part of the USAID agreement, he seconded five of his staff to the PSND. The MOH assigned additional staff to work at the PSND. Chirwisa was proud that this growing staff was from different regions, consistent with Mobutu's demand for ethnic diversity, which stood in stark contrast to the tribalism rampant in many Zairian entities.

Although the PSND now had a director and staff, it had no offices. Chirwisa continued to work out of the crowded quarters of the MOH 4th Direction, whereas the five AZBEF staff were working from their own offices, miles away. Rick Thornton threatened that "if you don't have a building in six months, I'm canceling the contract." The search began for a government property with space available to build or renovate. After considerable searching, Chirwisa stumbled upon a vacant space within the compound of the Kintambo Maternity Hospital. Remnants of a dilapidated building remained, with a jungle of trees and tropical vegetation growing through the floorboards. However poor the structure, the location was excellent, especially given the complementarity of maternity services and family planning. Chirwisa obtained MOH approval to replace this ramshackle structure with a new building.

As the project began to take shape, Thornton needed a COP (chief of party, USAID-speak for the administrative lead responsible to USAID for the project). This individual would assist Mme. Chirwisa in programmatic and administrative aspects of the operation in the role of deputy director for administration (*Directrice adjointe chargée de l'administration*), while safeguarding USAID's financial investment.

In 1982, Eileen McGinn was in Kinshasa working as a USAID consultant to prepare a detailed work plan of how this new project should operate. She had eight years of international health and family planning experience from previous jobs (including Family Planning International Assistance and AVSC) and was fluent in French from her stint with the Peace Corps in Niger. She and Rick had known each other from their days at the University of Pittsburg, where they both received their master's in public health (and Rick a master's in international affairs).

While in Kinshasa on this consultancy, Eileen interviewed for the COP job on the new "Urban Project" (as it was called to distinguish it from SANRU which operated in rural areas). According to McGinn, USAID lowballed her salary and she refused the job. Later, USAID made her a better offer and she accepted it, only to learn that the project had been put on hold for several months. As she quipped years later, "Thornton wanted me to be chief of party, which was a pretty funny title since there was no party at all. I was it."

Eileen McGinn arrived in Kinshasa for her new post in June 1983. As she and Chirwisa got down to business, they realized that the USAID project paper left much still to be defined. These two women set about to develop the operational details of a national program: service delivery infrastructure (sites and equipment), training curriculum and manuals, information-education-communication, contraceptive logistics, finance systems, and service statistics reporting. They incorporated issues that were attracting attention in international circles: quality of services, continuity of care, and informed choice. They decided against broadening the project to cover other aspects of reproductive health, such as infertility, sexually transmitted infections, HIV, and post-abortion care; instead, they maintained a more focused approach to contraception. The one clear instruction that Eileen had from Rick Thornton: "You make sure you watch the finances."

Back in Kinshasa, Eileen made the rounds to meet the key actors from the MOH and AZBEF, who were still working in their separate offices. What she encountered was a hornet's nest of disgruntled employees. Despite strong support from Dr. Miatudila, his second in command at AZBEF refused to endorse this new arrangement. Two of the AZBEF staff did actively embrace their new responsibilities at PSND: Mr. Kazadi Polondo for training and Ms. Kazadi Salwa for service delivery. Mr. Onanga Bongwele later joined them to work on evaluation. Among the MOH-appointed staff were Mr. Jean de Dieu Mutombo, a nurse who served as Head of Training, and Mr. Ngoie Mubeya Fidel, a well-respected senior ministry official. However, the MOH personnel (except for Chirwisa) refused to work because they knew AZBEF staff were making far more than they were. Thornton thought one could assign the MOH staff extra work and they would do it, but they saw it otherwise. Initially, USAID refused to pay any *primes* to the MOH personnel, leading to a standoff that dragged on for months. Eventually, USAID gave in and agreed to provide *primes* to the MOH staff.

In September 1983, the Zairian government devalued the currency by 80% to conform with the terms set by the IMF. Overnight, one US dollar was worth five times more in zaires than it had been the day before.[75] Although the construction of a new building was not included in the original PSND budget, the project found itself awash with zaires. USAID authorized the use of local currency to extensively renovate the building overgrown with vegetation in the Kintambo Maternity compound. According to Chirwisa, "Thornton found some money to chop down those trees," and USAID contracted with a local company under the supervision of a US engineer to complete the construction work.

In October 1983, USAID organized a study tour to Tunisia for the team that would work together on the new project: PSND staff appointed by the MOH and

those seconded from AZBEF, the newly arrived USAID Population Officer Ken Heise, and McGinn. Tunisia offered an excellent learning opportunity since it had a highly functional national family planning program and French was the lingua franca. Thus, the team could observe first-hand how a national family planning program could operate. With input from AVSC and Jhpiego, Tunisia developed a training program in clinical service delivery, including tubal ligation, for participants from African countries. Equally important, the trip served as a team-building exercise for a group of individuals who barely knew each other yet were expected to coalesce into a team that would develop a national program in Zaïre.

The completion of the PSND building in mid-1984 was celebrated with great fanfare. The US ambassador, government officials, representatives from the other health projects (SANRU and PEV), and staff from other USAID sectors participated in a rousing celebration, with Zairian dancers decked out in matching *pagnes* swaying to songs composed for the occasion, while invitees consumed ample amounts of Primus beer. Much was made of the fact that both the project director and chief of party were women, which had never happened before. What most did not realize at the time was that the PSND was the first major national family planning program in francophone sub-Saharan Africa and this group was entering unchartered territory.

Figure 5.7 From left to right, front row: Bombute w'Ekoliaka, Eileen McGinn, Chirwisa Chirhamolekwa. Back row: Dr. Sambe Duale, Ken Heise, Dr. Alexis Ntabona, Dr. Nlandu Mangani

The new facility – constructed on a single floor – looked more like a motel than a government office building. The freshly painted walls, carpeted executive office, air conditioners in every office, and functioning toilets made it an outlier in a city where most government facilities had fallen into disrepair. Offices and conference rooms ran along both sides of a 60-meter central corridor, divided in two by a clinic. *Centre Libota Lilamu* ("good family" in Lingala) was designed to serve as a training site for clinical personnel working throughout the country, as well as a source of family planning services for the local community.[76] Lined up in the parking lot were a couple of Jeeps, purchased from the United States to assist with supervision and commodity distribution. Whereas British-made Land Rovers were the vehicle of choice in development work in rough terrain, USAID required the project to "Buy American," resulting in endless headaches to find spare parts and mechanics able to work on American-made vehicles in Zaïre.

With the study tour to Tunisia and the opening of the Kintambo facility behind them, PSND staff got down to the challenging business of managing a national family planning program. Chirwisa and Eileen worked to forge a unified vision, consistent with the project objectives. They collaborated with PSND staff on developing curriculum, reporting systems, training materials, and medical standards in preparation for the rollout of a national initiative. There was a certain pride in being the "first" francophone country to attempt a national program, yet few staff had any vision of what this would entail.

From the start, the five staff seconded from AZBEF felt superior to their government counterparts, given their considerable experience with FP programming. Mme. Chirwisa paired the AZBEF staff with the government employees who could then learn from them. It became clear from corridor talk that in this new "family," the AZBEF staff saw themselves as the parents, the other PSND employees the children whose role it was to follow instructions. These five staff expected everything to be done according to the AZBEF model, and initially, they succeeded. Over time, the situation evolved, and the line blurred between the AZBEF and MOH staff at PSND. By 1986, PSND felt it had sufficient experience to administer its own program and sent the AZBEF staff back to their old offices.[77] Those who had worked themselves out of a job at PSND were unhappy, losing both job status and their monthly *prime*.

The PSND was organized by departments corresponding to its main areas of activity: training, supervision, contraceptive logistics, information-education-communication (the precursor to social and behavioral change), and service statistics. Initially, the project worked to establish family planning services with state hospitals and clinics but later expanded into community-based distribution (influenced by the encouraging results from PRODEF in Bas Zaïre) and commercial social marketing.[78] In each province, there was an officer in charge of *Naissances Désirables* working out of the office of the provincial medical inspector as well as a representative of AZBEF. The intent was to mirror the same structure that existed at the national level, and it worked well. The PSND continued to operate the *Centre Libota Lilamu* and later established two additional training facilities in Kisangani and Katanga.[79]

PSND experienced the growing pains of creating an entirely new project where none had existed before, as explained by Georges Ntumba, director of special projects at PSND. The tripartite arrangement – with shared leadership between the MOH/Chirwisa, USAID/Eileen and AZBEF – was the source of confusion and frustration at times.[80] Chirwisa had her vision based on what she perceived that USAID expected, but it was not necessarily shared by the different division chiefs. Many staff lacked experience in working for a mission-driven organization, in which the rewards would come from reaching shared objectives, not just receiving a paycheck (a situation not uncommon for government programs in developing countries). Staff focused on the short-term (conducting specific activities) over the longer-term objectives (improving access to services and increasing contraceptive use). The prevailing rule of thumb – "you don't want to make a mistake" – did little to foster innovation. In retrospect, the project was amazingly ambitious for its time, but for those on the ground, day-to-day operations could seem chaotic.

In the mid-1980s, PSND also saw personnel changes. Eileen McGinn departed in 1985, replaced by two individuals. Brad Barker, a former Peace Corps volunteer in Lubumbashi, assumed the role of deputy director for administration. He focused primarily on commodities/logistics and administrative systems, working to improve administrative efficiency with the new office innovation – the personal computer. Dr. Peter Knebel, an Austrian physician, came on in the role of chief of party/technical adviser.

Whereas national family planning programs were by then commonplace in many countries of Latin America and Asia, the same was not the case in sub-Saharan Africa, especially francophone Africa. The basic concept underlying the project – to promote the use of contraception – challenged deeply seated societal norms about childbearing and women's roles in marriage. Moreover, the project evolved at a time when international family planning had grown more contentious back in the United States.[81] At the 1984 International Conference on Population in Mexico City, the administration of President Ronald Reagan imposed the Mexico City Policy on the developing world. Dubbed the "Global Gag Rule" by its critics, it blocked US government funding to any private organization in a developing country that promoted or performed abortion, even if the funds were from another source and abortion was legal in the country. Many equated this ruling with the US "trying to police the world against abortion." In contrast to the strong bipartisan support that international family planning had enjoyed since 1965, the messaging from Washington became more nuanced,[82] which could not have helped the fledging program in Zaïre.

As the PSND worked to implement family planning on a national scale, it faced inevitable comparisons with SANRU, also funded by USAID in the early 1980s. Whereas family planning was controversial, SANRU's objectives were seen as laudable. Whereas PSND worked with a disjointed set of clinics, SANRU worked with an existing network of Protestant Church hospitals. Whereas PSND struggled with logistics in terms of supervision and contraceptive resupply, SANRU could rely on the MAF's fleet of small planes for regular flights to their sites in the Interior. Lamented one PSND staff, "SANRU was the favored child."

Centrally funded cooperating agencies

By the 1980s, USAID had a well-oiled machine for supporting the implementation of family planning in developing countries worldwide, and Zaïre benefited from it in multiple ways. First, USAID/Washington procured and shipped the lion's share of contraceptive commodities to the country. Most were stored in the PSND warehouse, built in 1985–86 behind PSND within the Kintambo Maternity Hospital compound for distribution to PSND and other USAID-funded projects in the country. Like everything else, the initial shipment of contraceptives for the PSND was delayed for many months, but the shipment eventually arrived in dribs and drabs. Service statistics showed that as of 1985, the pill was the most widely used method (45% of users), followed by injectables (33%), condoms (7%), IUDs (5%), female sterilization (1%), and others (9%). Meanwhile, by the mid-1980s, large quantities of IUDs were expiring in the PSND warehouse.[83]

USAID also provided technical assistance to national family planning programs through centrally funded projects. USAID/Washington would identify different areas of specialization within the broader topic of family planning, such as policy, service delivery, logistics, behavior change communication, and monitoring and evaluation. They would then put out requests for proposals (RFPs) or requests for applications (RFAs) for a specific set of objectives or tasks. Because of the size (multi-million dollar) and geographical scope (often covering vastly different countries within the developing world), different US-based and in some cases well-respected organizations from a developing country would join together to form a consortium to bid on a particular RFP or RFA. After months of deliberation and negotiation, USAID would award the project to a single organization or consortium. Recipients of such funding were called "cooperating agencies" and it made them prequalified for project work at USAID Missions (offices) worldwide.

Besides bringing specialized expertise, centrally funded projects were also the source of additional funding for specific initiatives. In the case of Zaïre, IntraHealth supported training activities in Kinshasa and the Interior. Management Sciences for Health set up management and information systems at a time when computers were just being introduced into development programs in Africa. As a subcontractor on the Enterprise project, John Short Associates ran the TIPPS (Technical Information on Population for the Private Sector) project, working to integrate service provision into the large private companies operating in Zaïre, such as the textile factory UTEXCO, the *Banque commerciale du Zaire*, and *Compagnie sucrière* in Kwilu Ngongo. Other organizations provided support from their headquarters in the United States, such as CEDPA in Washington, DC, which continuously ran training courses for women in management in family planning for developing countries. UC/Santa Cruz offered multi-week training sessions in program design and management.[84]

Both Jhpiego and AVSC supported the training of clinical personnel and donated equipment for permanent contraception, consistent with the principle of USAID to offer a full range of contraceptive methods. Jhpiego's focus was on training theater teams (Ob-Gyn specialists and nurse/anesthetists) in laparoscopy, a procedure

typically done with the patient under general anesthesia.[85] After training, they provided local doctors with laparoscopes and essential equipment for administering anesthesia. The International Program of AVS (IPAVS), later renamed AVSC, identified operating theaters where tubal ligation via mini-laparotomy using lower-risk local anesthesia could be performed. They updated these facilities by providing operating room tables, theater lights, rolling tables for supplies and equipment, essential emergency equipment, as well as expendable supplies, and funds for locally purchased items. And they trained providers in counseling, equipping them with educational materials.[86]

Another example of the specialized nature of these cooperating agencies was the work done in the mid- to late-1980s by the Futures Group, based in Washington, DC, under the auspices of the USAID-funded Options Project.[87] The Futures Group worked over many months to build the RAPID model specific to Zaïre in concert with the staff from the ministry of plan. RAPID modeled the impact of alternative scenarios of population growth on various aspects of development: education, healthcare, and employment. Philip Claxton – President of the Futures Group – visited Kinshasa to personally present the RAPID model to President Mobutu, who was reportedly receptive to it.

During this era, having a population policy became in vogue in international family planning circles. In view of the major constraints facing family planning in Zaïre – hostility to all policies affecting the traditional role of women, religious opposition, competing demands on scant resources, and a lack of motivation to effectively implement programs – both USAID and UNFPA sought to encourage the government to formulate a population policy and to reinforce this commitment. In 1986, the GOZ created a National Population Committee (*Conseil national de la population*, or CONAPO), consisting of representatives of various ministries and directed by the secretary general of the Ministry of Plan. Its secretariat was CECAP (*Cellule de coordination des activités en matière de population*). In 1988, the Futures Group sent Mr. Herve Ludovic de Lys to serve as an in-country adviser for the Options Project. By 1990, CONAPO approved the policy, and the minister of plan pledged to include it in the next five-year development plan.[88] Yet the work completed under this project and the resources devoted to developing the population policy met the fate of all donor-funded development work in Zaïre in the wake of the 1991 political unrest.

In relation to operations research, Jane Bertrand of the Tulane School of Public Health and Tropical Medicine directed the PRODEF activities in Bas Zaïre from 1980–85. USAID agreed to extend the contract for another five years on the condition that Tulane establish an Operations Research Unit at the PSND. The Bertrand family moved to Kinshasa from 1986–89. Jane headed up the *Unité de recherche opérationnelle,* which conducted a series of studies on family planning and HIV. Her husband, William Bertrand, directed the project that USAID awarded to Tulane in 1984 to establish the KSPH in collaboration with colleagues from UNIKIN and other universities. In 1990, the Population Council would take up at PSND where Tulane left off.

Although these cooperating agencies brought much-needed technical expertise to the country, they also brought an additional burden to the PSND. At a time when PSND was struggling to put its management structure into place and to ensure that staff understood their roles within the organization, the visit from a cooperating agency's staff could be disruptive and demanding on PSND time. Activities that were not part of PSND's core objectives were added to the workload, without acknowledgment that this work was "extra." Worse yet, if the activity "failed," the fault might be laid at the feet of PSND.

PSND and the Catholic Church

It was inevitable that the Catholic Church would raise opposition to the newly established PSND. At the time, the Church continued to occupy a powerful position, both in the politics of the country and the heart and soul of its parishioners.[89] Consistent with the teachings of the Vatican Council II on the dignity of marriage and the family, the Church counseled couples to take responsibility for their fertility as humans and Christians should.[90] The Catholics were not against birth spacing, but rather against the so-called artificial methods (the conscious prevention of impregnation or conception by using different drugs, devices, or other scientific techniques).

In 1981, a Belgian religious sister, Marguerite Dobbels, traveled to France for a training course on natural methods of birth spacing. Upon returning to Zaïre, she met with the archbishop, who understood that his parishioners would benefit from birth spacing. In 1982, he authorized the establishment of a service to counsel couples on natural family planning methods: *Conduite de la Fécondité* ("Managing Fertility").

Sister Marguerite continued to visit local communities in Kinshasa, educating couples about natural methods, which at the time included the symptothermal methods of fertility awareness (observation of cervical mucus, basal temperature control). When she identified particularly committed users of the method, she would recruit them to be trained as counselors. In 1986, she had four couples successfully using natural methods who gave witness to their satisfaction first in their own parishes and then others. With this experience, *Conduite* effectively began. In the same year, Mme. Odia Berthe and her husband, Banza Mutombo Augustin, attended these sessions organized by the parish. Mme. Berthe was pregnant with her sixth child, a result of incorrect "counting" using the rhythm method, but she was determined to master the techniques of natural methods for use after her delivery. Although *Conduite* initially trained her husband as an educator, he had other commitments, so after her delivery, they trained Mme. Berthe for the task. In the years that followed, she would rise through the ranks of *Conduite*, first as an educator, then as a group discussion leader, trainer, supervisor, and eventually, director. At the time, staff received no monetary compensation. Her family wondered why she dedicated so much time to this cause, teasing her for proselytizing like a Jehovah's Witness.

The work in Zaïre occurred in parallel to a larger movement at the international level to promote natural methods. In 1974, the International Federation for Family Life Promotion (IFFLP in English, FIDAF in French) was established in Washington, DC, with support from USAID. FIDAF worked with the Episcopal Conference in the United States and organized conferences every 3–4 years in different countries, which served to create momentum around the use of natural methods and to update country representatives on trends in the field.[91]

Box 5.6 Mme. Chirwisa and the Catholic Church

Soon after the PSND began service delivery, attacks surfaced from the pulpit. The leaders of the Church labeled women using contraceptives as "demonic." They confronted Mme. Chirwisa publicly: "You were brought up Catholic; now you are turning a sword on your religion by promoting family planning." Even her family was worried. Chirwisa prayed. "I don't have a bad heart."

Yet Chirwisa had a certain leverage unknown to most at the time. The same priests who would attack family planning during the day came to consult her privately after hours on the mounting reproductive health problems facing their parishioners: unwanted teen pregnancy, clandestine abortion, and sexually transmitted diseases, among others. Chirwisa soon realized that she could convert her attackers into allies. She had already established good relations with two Catholic sisters who were also conscious of the tremendous problems facing young people – Sister Betsy Brock who worked for *Service central education à la vie* (SCEV, the Central Office for Family Life Education), and Sister Marguerite Dobbels with *Conduite de la Fécondité.* Together they met with Cardinal Malula to explain their work in *Naissances Désirables.*

The parties arrived at an agreement – and even signed a written protocol with Cardinal Malula's approval – whereby the priests would put a stop to harangues from the pulpit against family planning. In return, Chirwisa would extend the support of PSND to Catholic facilities that promoted natural methods sponsored by the Church. Eventually, she donated one Jeep to *Conduite de la Fécondité* and a second to SCEV to facilitate their work in the community, and she arranged for staff to receive training in family planning. To this day, the Catholic Church – while not supporting the promotion of artificial methods – raises little public opposition to family planning in the DRC.

In contrast to some countries in which the Catholic Church went to great lengths to prevent the expansion of family planning, Zaïre took a different – and far more harmonious – path. The PSND and the Catholic Church became strange bedfellows in an arrangement that benefited both. Staff at the field level had occasional skirmishes, one side denigrating the effectiveness of natural methods, the other camp maligning the side effects of "artificial contraception." But the leadership of PSND and *Conduite* maintained a cordial relationship. Both understood the role of the other in meeting the needs of different groups within society.

Figure 5.8 Beverly BenSalem, Dr. Jean-Pierre Muka, and Mme Chirwisa Chirhamolekwa

Challenges facing PSND in its first decade of operation

Logistics, devaluation of the currency, and cultural norms conspired to make life difficult for the PSND. These problems were by no means unique to Zaïre, but they thwarted progress from the start.

The project faced the seemingly intractable problems of poor transportation and communication in a country the size of Western Europe. Many of the 14 cities could not be reached from Kinshasa by road, and the national airlines were notoriously unreliable.[92] If Mobutu needed to transport his guests to his palace in the jungle, Gbadolite, he thought nothing of tapping a plane from Air Zaïre, leaving ticketed passengers stranded for hours in a hot, crowded airport waiting for another plane to arrive. The postal system was in shambles, and many offices in the Interior did not have landlines (in the decades before cellphones).[93] Thus, the PSND had difficulties communicating with the clinics scattered across this vast country, resulting in chronic delays in the shipment of contraceptives.[94]

Administering a large-scale operation using cash was another logistical nightmare for PSND, especially when the currency was constantly devaluing. The entire operation – paying salaries, purchasing supplies, printing materials – functioned with cash, when mid-decade the largest bill in circulation was worth $20 USD. On payday, the PSND finance manager would go to the bank with several large maroon metal trunks. The banks themselves were often short on cash and would

find pretexts (any slight irregularity in the signature) for refusing to cash checks. When the banks did have money, the finance manager would return to PSND with the maroon trunks full to the top with packets of local currency the size of bricks. To pay per diem for a training event in another city, PSND staff would travel with blocks of zaires and laboriously count the money before distributing it to participants. Successfully completing any event – a training course, a survey, a meeting with participants from multiple provinces – was cause for celebration; it had occurred against all odds.

Fraud or financial mismanagement was a constant source of concern in a country where the average citizen struggled to meet the most basic needs of his family. President Mobutu had publicly condoned small *tricheries* (financial shenanigans) when he instructed the citizens of the country to "*Debrouillez-vous*" ("fend for yourself," or "figure out how to get along"). He made it known that it was acceptable to "steal a little," so long as the theft remained within limits.[95]

A prevalent Zairian perspective was that anyone lucky enough to have access to large amounts of money owed it to their family to take advantage of that situation. In some circles, "if you haven't stolen something, you're not a man yet." The PSND – with its spacious new office building and fleet of vehicles – gave off an aura of money. One would have expected that Mme. Chirwisa – with obvious access to international funding – would have been under relentless pressure from her family members to take advantage of the situation. Yet Rick Thornton had chosen well. Chirwisa stood up to these pressures and strictly enforced the rules imposed by USAID. Even her tight control, though, did not preclude the mysterious loss of a PSND Jeep, which "disappeared" when a PSND driver parked it in front of the *La Voix du Zaire* (National Radio Station) and went into the building on an errand. Though no one ever got to the bottom of this theft, there was strong suspicion of an inside job.

Contraceptive forecasting – estimating the quantities of each contraceptive needed to fulfill demand – was a nightmare. There were no reliable service statistics on the quantity of contraception consumed by PSND-supported facilities during a given period, making it impossible to base forecasting on actual levels of use. Initially, USAID and PSND (Heise and McGinn) had this unenviable task. Later, the experts from the US Centers for Disease Control and Prevention (CDC) who came to Kinshasa periodically to assist in contraceptive forecasting made estimates of "unmet need." Embedded in these estimates was the assumption that women defined as "needing" contraceptives would actually want to use them. The overly optimistic forecasts resulted in excessive quantities of contraceptives being ordered and imported to the country, many of which sat on the shelves of the PSND warehouse until they expired.

Communication between USAID/Zaïre and PSND could be contentious. PSND staff did not appreciate the "interference" from persons who they felt did not fully understand the complexity of their day-to-day problems or the culture in which they were operating. USAID staff were frustrated that PSND did not take full advantage of the technical assistance and international experts made available to them to improve the efficiency and effectiveness of operations.

When asked what the greatest challenge for PSND had been, Mme. Chirwisa replied "*la mentalité Congolaise*." Most people were not yet ready for family planning. Despite the repeated emphasis on child spacing, many in the population interpreted PSND's raison d'être as stopping couples from having children. Chirwisa lamented the lack of public consciousness that birth spacing could save lives, that it helped both the mother and her children to prosper, and that death from childbirth was preventable. "People thought that having money, personnel, and a nice building would be enough to change attitudes toward birth spacing," Chirwisa mused, "but it was not so. We needed to work with communities to change social norms and that would take some time."

Ironically, the *Libota Lilamu* clinic housed within the PSND administrative offices became a daily reminder of this problem. Despite the convenient location, clean appearance, and availability of well-trained clinical personnel ready to provide quality services, the clinic languished. A handful of clients might trickle in during the week; some days none would appear. Some speculated that the clinic was simply too public. A woman would need to make her way through a busy parking lot and through the gate to the Kintambo compound, turn to the right and, in plain sight of everyone, pass through the doors clearly marked "*Projet des services des Naissances Désirables*." (Had she instead turned left into the Kintambo Maternity Hospital, no questions would have been asked.) By entering the building, she would be labeling herself a contraceptive user, in a society that still had major reservations about the practice. In short, *Libota Lilamu* was a "model site," but it went largely unused.[96] Those few who wanted to use contraception found it easier to go to a clinic where family planning was integrated with other health services, and where passersby did not need to know their reason for being there. To confirm this premise, one had only to observe the far heavier client load at the AZBEF-supported clinic in Matonge across town.

Box 5.7 Crispin and his three closely spaced children

Mary Anne LeJeune, author of *Congo Days* (2020)[97] writing about her experience of living in Zaïre as a Belgian expat from 1960–99, recalls an incident reflective of the cultural mindset of the time. One of her workers, Crispin, had three children in a row. "They just popped out – one, two, three," she said. She advised him to take a break, even if he and his wife planned to have more children later. Mary Anne arranged for him and his wife to visit the Salvation Army clinic *Naissances Désirables*, where after several education/counseling sessions they finally obtained a method. But rather than bringing positive benefits to his family, according to Crispin, his wife grew increasingly irritable. She was miserable and short-tempered; she became such an ogre that he finally sent her back to her village. What had been the problem? Everyone else was continuing to have babies, except her. Mary Anne never knew if the marriage survived, but it was her last foray into giving her workers advice on family planning.

AZBEF adjusts to its new role

At the start of the 1980s, AZBEF was the unquestioned leader in family planning in Zaïre. In addition to its headquarters in Kinshasa, it had three provincial offices: Bukavu, Lubumbashi, and Matadi. Dr. Miatudila Malonga remained at the helm (until 1989). In addition to having national recognition, it was part of the IPPF and received financial and technical support from the IPPF regional office in Nairobi.[98]

One of its successes in the early 1980s was the production of the film *N'Gambo*. In direct response to the study by Dr. Alexis Ntabona on *Les avortements provoqués à Kinshasa*, Dr. Miatudila contracted a well-known Zairian filmmaker Kwamy Nzinga to produce a 55-minute movie entitled *N'Gambo* ("Trouble" in Lingala) in 1984. The film – based on Dr. Miatudila's incident with the young woman dying of a botched abortion at Mama Yemo – was nominated for the Best Screenplay at the 1985 FESPACO (*Festival panafricain du cinéma de Ouagadougou* 1985, the Ouadadougou Panafrican Film Festival). The riveting story captivated multiple audiences in Zaïre and other sub-Saharan francophone countries where it was shown for years afterward, serving to trigger debates on how best to address this devastating social problem of unsafe abortion.[99]

AZBEF was one of the partners named by USAID on the Zaïre Family Planning Project that created the PSND in 1982. Specifically, AZBEF agreed to the secondment of five of its experienced managers to the PSND to launch the new national project.[100] However, there was little in the USAID agreement to foster the growth of AZBEF as an independent organization. Prior to the creation of the PSND, AZBEF had a virtual monopoly on family planning service delivery and information-education-communication programming. Yet as the PSND expanded, AZBEF lost its predominance in family planning.

In retrospect, this shift in power and resources from AZBEF to the PSND was consistent with the IPPF model: to fund a local NGO working in family planning to pioneer the delivery of family planning while advocating for the government to include family planning in its public sector services. When the government agreed to implement family planning through the PSND, AZBEF might have claimed victory and sought to take on a new role. In fact, it did expand its programming for adolescents and youth, still a controversial topic in Zaïre. And with the influx of HIV funding, it developed programming in that area. Yet with the bulk of resources going to PSND, AZBEF could no longer compete on an equal footing.

In 1984, the minister of health asked Dr. Miatudila to join his Cabinet. Dr. Miatudila was able to negotiate with the AZBEF board of directors to retain his position as administrator while serving as an adviser to the minister. His leadership did not go unnoticed. In 1989, he was recruited to join the World Bank in Washington, DC.

The shift of resources toward PSND and the departure of Dr. Miatudila led to a slow decline in AZBEF's institutional capacity. Since its inception in 1978, it had changed office location five times, requiring it to move its large supply of contraceptives and find a new secure space for its vehicle. By the late 1980s, AZBEF

began to experience management and organizational problems. The 1989 annual report showed that the organization earned a modest income from the sale of contraceptives plus minor income from volunteer dues and occasional special projects.[101]

Cliniques Universitaires de Kinshasa attempts to treat infertility

In the late 1970s, contraception was relatively unknown in Kinshasa, even among those trained in medicine. In 1977, to promote interest in *Naissances Désirables*, Dr. Tshibangu Kalala invited Dr. Anatole Sabwa, chief of CNND, to give a lecture on contraceptive methods to the Ob-Gyn service of the *Cliniques Universitaires de Kinshasa*. The lecture met with generalized disinterest among most of the doctors, who were more concerned with providing routine care for their obstetrics and gynecology patients.

In 1979, with the aim of integrating the concepts of *Naissances Désirables* into the work of the obstetrics and gynecology service, Dr. Tshibangu opened a new research unit, the *Unité de recherche sur la fertilité et stérilité*, which would work in tandem with CNND. Dr. Aloys Nguma was selected to direct the section on family planning and fertility regulation. Dr. Alexis Ntabona – after finishing his training in 1980 – was appointed to lead the section on infertility management. Both became volunteers of CNND/AZBEF, which was the only other entity in Kinshasa that worked on both fertility and sterility. Usually, infertility treatment, such as it was, occurred in the private practice of a handful of specialists, whereas family planning had moved into the domain of government programming.

In 1981, Jhpiego and AVSC provided one laparoscope and one set of mini-laparotomy instruments to the family planning/fertility regulation section to broaden the available tubal ligation techniques.[102] However, the demand for female sterilization was very low.[103] This new laparoscope proved far more valuable to the infertility management team because it improved their capacity to diagnose blocked fallopian tubes and detect other abnormalities in the reproductive organs. Later Jhpiego stopped supplying the service with Yoon rings used in tubal ligation when they realized that the laparoscope was used almost exclusively for diagnosing and treating infertility.

In 1983, the two above-mentioned sections were upgraded as separate units in the department of obstetrics and gynecology, as part of other reforms taking place at the *Cliniques Universitaires*. The mission of the infertility management unit was to provide care to infertile couples, train Ob-Gyn interns in service delivery, and conduct research. The protocols for case management were formalized, with separate days for consultation, diagnostic tests, and operations.

The infertility unit examined both the male and female partners. In cases of inadequate sperm count or other diagnosable deficiencies in the male partner, these cases were referred to the urologists in the sister department of surgery. Although no precise records exist, Dr. Ntabona estimates that in approximately one-third of the cases, the problem rested with the male partner. Many, he observed, suspected they might be the main cause of the couple's infertility.

For women, diagnosis involved examining the uterus and fallopian tubes for physical abnormalities (e.g., fibromyomas or sequelae of chronic pelvic inflammatory diseases), as well as assessing the quality of ovulation. The basic technologies available at that time were hysterosalpingography, used to evaluate the shape of the uterus, combined with laparoscopy with a dye test to determine whether the fallopian tubes were open. In parallel, staff monitored the ovulatory patterns of women over a period of two to three menstrual cycles, mainly by conducting one endometrial biopsy at the end of one of these cycles and at least one post-coital test at mid-cycle to examine the interaction between the sperm and the cervical mucus after sexual intercourse.

The success rate in the Kinshasa infertility unit – similar to that in developing countries worldwide – was abysmally low ("less than 10%," Dr. Ntabona estimated for the select few who were candidates for a surgical procedure, and even lower for the rest). Often, couples arrived for treatment with conditions that had existed for years; others presented with particularly complicated cases. Among the women unable to conceive, close to 80% had a tubal blockage, largely the result of untreated sexually transmitted infections or other chronic pelvic infections, including long-term complications of unsafe abortions and postpartum sepsis. A minority of women had problems with ovulation, and for some, there was no apparent reason for not conceiving. The widespread belief in the power of sorcery (curses inflicted by family members for any number of reasons) was often seen to explain the problem.

The low success rate was disheartening, not only to the patients but also to the team of specialists (doctors, nurses, lab specialists, and radiologists), given that case management was labor-intensive and expensive. Some clients dropped out because of the intensity of visits required to complete treatment; others became discouraged once they learned of tubal blockage.

During the 1980s, certain gynecologists in private practice in Kinshasa began to experiment with in-vitro fertilization (IVF) and other assisted reproductive techniques. Often, the cost of these procedures was exorbitant, even catastrophic for the family budget, but couples would sell everything they owned in hopes of achieving a live birth.

The lack of success in managing infertility caused Dr. Ntabona to move from the clinical setting to the realm of public health. Many of his patients would not have been infertile had they had ready access to contraceptive methods to prevent unwanted pregnancies, early detection and management of unsafe abortion complications, access to skilled birth attendants, and appropriate management of sexually transmitted infections ("upstream factors"). In 1986, he joined the faculty of the newly established KSPH. A year later he headed to the United States for his MPH training at San Diego State University, California. Upon his return, Dr. Ntabona served as a lecturer in maternal child health and worked at the community level as MCZ in Mont-Amba Health Zone for the MOH/*Projet Santé Pour Tous/Kinshasa,* where he put into practice his academic training.

With Dr. Ntabona's departure, others continued to work in the infertility unit, which remains operational to this date. The rate of success may have increased with new technologies (including IVF), but the challenge of treating infertility in low-resource settings remains monumental.

HIV/AIDS and the Zaïre Social Marketing Project

By the early 1980s, Zaïre faced a new and growing public health menace: AIDS, the acquired immunodeficiency syndrome (known locally as SIDA, *le syndrome d'immunodéficience acquise*). Two years after the first cases were diagnosed in the United States (1981), Zaïre registered HIV – the human immunodeficiency virus – in hospital patients in 1983, making it among the first African countries to do so. In contrast to cases in the United States that were predominantly male, the early cases in Kinshasa were evenly divided between males and females, making Zaïre the first country to establish the heterosexual transmission of AIDS. Men with power and money were among the early victims of the disease; they had the means to support multiple sexual partners, a major risk factor for HIV transmission.[104]

In 1984 *Projet SIDA* (the AIDS Project) was established at Mama Yemo Hospital in Kinshasa, with joint funding from the CDC, the National Institutes of Allergy and Infectious Disease at the National Institutes of Health, and the Belgium Institute of Tropical Medicine. Unique at the time, it was intended as a collaboration between foreign experts trained in epidemiology and Zairian scientists and doctors who knew the country and the context. Dr. Jonathan Mann, its first director, quickly became the leading American voice for HIV/AIDS in Zaïre. (Tragically, he and his wife perished in a Swissair plane crash in 1998.) The research conducted by *Projet SIDA* yielded among the earliest and most robust findings on HIV transmission in Africa, alerting the global health community to the potential severity of the epidemic.[105] It was by far the best-funded research operation for HIV/AIDS in sub-Saharan Africa.

The Zairian government also supported *Projet SIDA* and had direct authorization over certain politically sensitive decisions.[106] PSND had regular discussions with staff at Project SIDA over topics such as condom availability and contraceptive use for HIV-positive women.

Initially, President Mobutu tried to keep the existence of AIDS in Zaïre under wraps. The government strictly controlled the terms under which blood samples could be sent out of the country, and Projet SIDA was not authorized to publish statistics on HIV prevalence.[107] One of the lead Zairian researchers who made the mistake (perhaps intentionally) of presenting data on the country's HIV prevalence at the 1986 Paris International AIDS Conference came home to threats of arrest for revealing this information. Consistent with this pattern of denial, the local community dubbed the acronym for AIDS (*SIDA*, in French) as a *syndrôme imaginaire pour décourager les amoureux* (an imaginary syndrome to discourage lovers). A pernicious rumor began circulating in Kinshasa that condoms actually contributed to the spread of HIV, possibly an anti-Western deflection of "blame" for the epidemic.

Yet, evidence of this disease was mounting. President Mobutu would become the first African leader to recognize the presence of HIV/AIDS in his country.[108]

In 1987, the widely popular musician Franco recorded a cassette with the advice *Keba na Sida* (Beware of AIDS) and two years later succumbed to the disease. Prodded by international donors, a public health campaign began soon

after, using pamphlets and radio and TV dramas, based on humor, not fear. Campaigns often targeted the vast majority of the population that was poor, but the greatest risk of transmission was among older, powerful men who had the resources to consort with younger women. As in other countries, condoms became the major public health defense against HIV transmission.[109]

Today, AIDS is considered a chronic disease that can be successfully managed on a long-term basis, but in the mid-1980s it was a death sentence. AZT – approved by the Food and Drug Administration in 1987 – prolonged life, but antiretrovirals would not become widely available in Africa for at least another decade. These drugs left HIV-positive individuals vulnerable to other opportunistic infections. The modeling of the epidemic in Kinshasa forecast an ominous future, leaving many with little or no hope.

The urgency of the AIDS epidemic gave a major push for "social marketing," which was already an established distribution mechanism for contraception. Throughout Latin America and Asia, selected countries were using this type of service delivery to complement clinic-based and community-based distribution programs. Social marketing programs employed a commercial approach to promoting contraceptive use (the four P's: product, price, promotion, and place), using consumer insights and marketing research to fine-tune their products to clients' needs, values, and preferences.[110] These programs were generally subsidized by USAID or another donor for the purposes of expanding access to contraception (and later HIV/AIDS prevention). Because the products were sold in pharmacies, kiosks, drug shops, CBD outlets, and other highly accessible locations without the need for a prescription and with anonymity, they appealed to clients who could bypass the long waits in local clinics and the added costs of purchasing a client registration card (*fiche*) in clinics.[111]

PSI had been exploring the social marketing of contraceptives in Zaïre in late 1985. Tibo van der Does, a Dutch consultant for PSI, visited Kinshasa off and on for two years, testing the waters and considering alternative strategies for setting up social marketing. He recognized the need to coordinate his work with the PSND, which by then was the de facto clearing house for family planning. Yet this relationship was not without conflicts. Family planning service providers complained that social marketers were trying to sell contraception like chewing gum. The social marketing staff in countries worldwide were sometimes labeled the "cowboys" of international family planning, and frequently they make public servants nervous. With a fierce entrepreneurial spirit and a certain disdain for governmental roadblocks, they put a premium on getting the job done: reaching their customers with products that appealed to them and met their needs. For the PSND, they were moving too quickly. Tibo van der Does and Chirwisa butted heads on several occasions.

When Zaïre – the third most populous sub-Saharan country – emerged as a major hotspot for HIV/AIDS, PSI headquarters in Washington, DC, went into full gear to expand its social marketing program from contraception to HIV/AIDS prevention. In 1987, PSI collaborated with the Ministry of Health and the National AIDS Program to pilot-test the social marketing approach in three of the 24 zones of Kinshasa. At the time public mention of condoms was widely considered taboo.[112]

The most popular and widely promoted product was their condom, branded as *Prudence*. The packaging showed a leaping leopard against a brown background, projecting power and style. The slogan read "For the man sure of himself." Appealing to lifestyle rather than fertility motives, the brand sought to empower men to use condoms in casual sex, to prevent both the spread of HIV and pregnancy. Their second product was a vaginal foaming tablet, *Graine* (meaning "seed"), that served to prevent pregnancy but not HIV transmission.[113]

The results from social marketing were sufficiently promising that in 1988 USAID amended its contractual agreements for the Family Planning Services Project (PSND) to include funding for CSM, as well as funding for the development of a population policy.[114]

In conjunction with the fledgling social market project, PSI launched the Zaïre AIDS Mass Media Project, also funded by USAID, that reached 15 cities and neighboring areas. Using an entertainment/education approach, it developed a combination of media targeting different audiences to use condoms.[115]

Ads promoting *Prudence* condoms were everywhere. Radio and TV spots were broadcast during prime time in the five national languages. Popular songs carried the message through concerts, music videos, and cassette tapes. The Prudence logo was plastered on T-shirts, baseball caps, and automobile sun deflectors. TV and radio dramas portrayed the tragic consequences of AIDS.[116]

From eight new staff in 1988 with experience from other countries, the staff grew exponentially. The project expanded from 15 cities in 1988 to 30 by 1991. Bill Martin, by then the USAID/Zaïre Officer for both Population and HIV/AIDS Prevention, observed that "PSI's untraditional approach to social marketing began to take flight."

Condom sales skyrocketed: from less than 300,000 per year in 1987, to one million in 1988, to four million in 1989, to eight million in 1990, and more than 18 million in 1991 (the highest level in any sub-Saharan country). Sales of *Graine* also grew rapidly from 246,000 packets in 1988 to 1.4 million in 1991.[117]

Many would argue that most of the *Prudence* condoms were used by men with their *deuxième bureau* ("second office," a colloquial term for a mistress) or for one-night stands, but not with their wives as a means for birth spacing or limitation. Others would argue that "a pregnancy prevented is a pregnancy prevented." A survey of users at different sales points found that the majority (72%) used condoms for both AIDS and pregnancy prevention, whereas 27% said they used them for pregnancy prevention alone.[118]

Initially, the government felt the need to reign in this marketing machine, given the sensitive nature of the subject matter – HIV and sexuality – in Zaïre. But in light of its effectiveness in combating AIDS, the MOH signed a decree allowing the project greater freedom to operate as it saw fit.

The Zaïre Social Marketing Project became a model for the rest of sub-Saharan Africa and was replicated in a dozen African countries.[119] The elements for success were the systematic marketing of high-quality condoms sold at affordable prices in attractive packaging, advertised by the extensive use of mass media.[120] Little did anyone realize that a decade later, PSI would be one of the few remaining sources of contraceptives in the country.

If social marketing had started under the umbrella of PSND in the mid-1980s, by the end of the decade it had totally eclipsed PSND in effectiveness, funding, and visibility. True, it benefited from the urgency of HIV/AIDS and the substantial funding that supported the project. It had different goals, a different distribution network, and a different target audience (men who had money). Any objections from PSND to "selling contraceptives like Chicklets" faded into the background.

Box 5.8 Condom use was a hard sell

Not everyone embraced the use of condoms. Brad Barker, deputy director/administration at PSND during this period, recounts the trips he made to oversee PSND's work in the cities in the Interior. He often traveled with one of the division heads – an individual who had major responsibilities for promoting contraceptive use – and by then, condom use for AIDS prevention – on behalf of PSND. Brad soon learned that his colleague had a woman in every port. He would besiege his colleague: "My friend, we are sitting on the national warehouse for condoms. You have GOT to use them when you visit your women." His response to Brad: "I'm a strong man, and these women need the cash." He could not be persuaded to use condoms. Brad lamented, "If the message couldn't get through to our own staff traveling in the name of PSND, why should we expect others to heed our advice?" Several years later, this individual died of AIDS.

The Kananga Project

In 1987, the Population Council won a USAID-funded Operations Research and Technical Assistance Project for sub-Saharan Africa.[121] Even before it set up operations at the PSND (in 1990), it negotiated a new project with the IMCK (*Institut médical chrétien du Kasai*, the Christian Medical Institute of the Kasais), located in the city of Kananga. The project was to be directed by Dr. Judith Brown and staffed by local residents.

Located in the West Kasaï region, Kananga was the fifth largest city in Zaïre with a population of 299,000. From Kinshasa, one could reach Kananga in one hour by plane or four days by car over difficult roads. Unemployment was high, and most residents "made do" by farming fields outside the city or by petty trading. The 1982 Contraceptive Prevalence Survey showed that women in Kananga married early (median age 15 years), had high fertility, and wanted even higher fertility. Only 2% of married women were using modern contraception, and the idea of limiting the number of children was unacceptable. However, as in other parts of the country, women were conscious of the need to space their pregnancies, and they attempted to do so by some combination of breastfeeding, rhythm (the "calendar method"), coitus interruptus, or a string tied around the waist.

The Kananga Project was designed to address the chronic stockouts experienced by local clinics dating back to the 1970s. Initially, AZBEF was responsible for supplying them with contraceptives but was unable to do so reliably because of the expense and logistical difficulties of getting commodities from Kinshasa to Kananga. In the 1980s, PSND took over this role (Kananga being one of its 14 cities). However, the PSND's bureaucratic reporting procedures resulted in 6- to 12-month delays in contraceptive resupply.

The Kananga Project aimed to address the deficiencies in family planning service delivery through three activities, which became operational by mid-1988.

Strengthening clinical services: Project staff trained, supplied, and supervised personnel in 11 existing health facilities (two operated by IMCK, the others by community groups, the army, or local businesses) to provide both information on family planning and AIDS prevention, and deliver a range of contraceptive methods and condoms.

Information-education-communication: Nurses trained a team of community members, who held 2,500 sessions in clinics, churches, and community meetings about family planning and HIV/AIDS, and where to get services and supplies.

Social marketing: The project IEC team included these products in their messages and where to find them. The new national Social Marketing project (offering condoms, a vaginal cream, and oral contraceptives) supplied all its outlets in Kananga through the large Protestant medical warehouse.

As an operations research project, Kananga had data to demonstrate the impact of this work. In terms of service statistics, clinic visits shot up from less than 300 in the two main clinics in 1987 to nearly 1,500 in one facility and to 3,400 in the other in 1988. Nine other clinics later incorporated into the project registered similar spikes in family planning visits. In terms of the quantity of contraception distributed, both the clinics and social marketing outlets showed dramatic gains. By far the strongest evidence of the effects of the Kananga Project came from the before and after community surveys. In 1987 modern contraceptive prevalence among married Kananga women was at 4.1%, but within three years (1990), it had reached 17.4%.

Several factors contributed to the success of the Kananga Project. The project staff – nearly all local people – remained sensitive to traditional attitudes, religious feelings, and economic forces. They stressed the importance of breastfeeding and spacing pregnancies to ensure the survival and health of children and mothers. Rather than focusing on socio-cultural obstacles, the project concentrated on improvements in service delivery. It used existing service points (clinics, pharmacies, and shops) to deliver contraceptives, and it assured constancy of personnel and supplies. Further, they emphasized the quality of care: "clients come for contraceptives; don't let them leave without one."

During the project, a number of women chose Norplant, a contraceptive implant consisting of six matchstick-size silicone capsules that are inserted in a

woman's upper arm to prevent pregnancy for up to five years. Strangely, after six months or so, some of the women came back to have the Norplant removed, which Dr. Richard Brown did without hesitation. After several cases, he began to ask them why they wanted the device removed so soon, since it had been promoted as a method to be used for at least two years. Finally, he learned that in recruiting for Norplant users, the educators were telling the women that after its removal, they would return to normal fertility. These women interpreted that Norplant would return even a sub-fertile woman to normal fertility. The team hurriedly corrected their educators' spiel.

One innovation in the Kananga Project was to promote birth spacing – not by the age of the previous child, as is done in many developing countries – but by the weight of that child. This approach seemed particularly appropriate in a country where date of birth is relatively unimportant, but local market women were very familiar with the measure of weight. The average (median) weight of a child at 39 months was 11 kilograms. Thus, educators encouraged women to wait until their youngest child weighed at least this before becoming pregnant again. It was a self-correcting admonition; a scrawny child should be cared for until they attained more heft before having to compete with a new baby. A study to test the concept of pregnancy spacing by weight was underway but ended abruptly in 1991 when political unrest halted all project activity.

Based on their experience of working in family planning in Africa, Richard and Judith Brown wrote and published a field manual entitled *The Family Planning Clinic in Africa*. [122] A clear, non-technical but medically sound source of advice to health workers, it was subsequently updated and reprinted in 1990 and 1998.

The Kananga Project was one of the two well-documented operations research projects in Zaïre in the 1980s. The other was PRODEF, conducted in Bas Zaïre. After the grants that supported both projects ended, Jane Bertrand and Judith Brown synthesized the lessons learned from these two experiences in a paper entitled "Family Planning Success in Two Cities in Zaïre." The two projects differed in terms of the model used. PRODEF strengthened existing clinical facilities to deliver services, but also conducted outreach with salaried health workers to conduct home visits and set up CBD posts. The Kananga Project also reinforced existing clinical facilities through training and contraceptive resupply. In addition, it incorporated contraceptive social marketing into its activities and promoted family planning in churches, schools, neighborhoods, as well as with printed materials and a weekly radio program.

Despite the differences in the two models, Bertrand and Brown identified four elements in common that contributed to their success: single-minded dedication on the part of the staff to making family planning work, an uninterrupted supply of contraceptive methods available through multiple outlets, organizational autonomy necessary to respond to problems as they arose, and regular and supportive supervision of the people delivering services. The authors also recognized these pilot projects had benefited from a concentrated investment of human and financial resources that were not available to the PSND or AZBEF for larger-scale

programs. Still, the authors concluded that these four elements would be useful in replicating the successes of Matadi and Katanga in other cities in Zaïre.

Although these two operations research projects in the 1980s had provided useful guidelines for replicating success in other Zairian cities, such replication was not to be. The political turmoil of the 1990s would change the trajectory of family planning in Zaïre for at least two decades.

UNFPA plays a major role in the 1984 population census

Many would consider that UNFPA's main contribution to Zaïre in the 1980s was its support for the 1984 census.[123] It also played a role in developing a population policy for the country and, to a lesser degree, it supported the expansion of family planning work in Zaïre.[124]

Until 1986, UNFPA continued to operate in Zaïre under the oversight of the United Nations Development Program. Serving as program managers were Mr. Mpoyi Mandkona (1980–84), Roger Razafinanja (1985–89), and Hans de Knocke (1989–91). In 1990, the UNFPA office in Kinshasa became autonomous, and De Knocke was elevated to country director.

The first UNFPA country program ran from 1986–90. It was intended to support the government on activities related to MCH/family planning, population development issues, family life education in schools, further analysis of the 1984 census data, support for the UNIKIN demography department, development of a national population policy, and women in development. The budget for this program came to $7.5 million, with a part of the family planning funding going to AZBEF. Both UNFPA and IPPF had a global agreement whereby UNFPA would provide support to the country's member association, which in Zaïre was AZBEF.

An independent evaluation conducted in 1989 gave a disparaging assessment of this program, citing many factors that hampered its effectiveness: start-up delays, disagreement over recruitment procedures, slowdowns in making funds available, ineffective personnel and high turnover, poor logistical capacity, frequent contraceptive stockouts, among others. The evaluation indicated that the family planning work had not been fruitful, the census data received no further analysis, and the national population policy was never approved by the government. The evaluation also concluded that the implementation structures had proven too fragile to effectively support the poorly integrated and complex projects of UNFPA's program. In the opinion of the evaluators, the national structures depended too much on the external financial contributions of the projects for their survival and their perpetuation.

In terms of positive gains from the UNFPA 1986–89 program, they would include support for the creation of PSND, the data collection that provided raw census data available for future analysis, a growing consciousness of a link between population growth and economic development, and the introduction of family life education into schools.

Kinshasa School of Public Health trains a new generation of health specialists

USAID/Zaïre had begun to send promising local physicians to schools of public health in the United States and Europe. Drs. Miatudila Malonga and Ngwala Ndambi were in the first cohort to graduate with an MPH from the Tulane School of Public Health and Tropical Medicine (SPHTM). Upon their return to Zaïre in 1977, they began to promote the idea that it would be far more cost-effective to establish a School of Public Health in Zaïre to increase the number of beneficiaries rather than to send a handful of individuals each year for training abroad. Eventually, USAID agreed with them.

In 1984, USAID/Zaïre awarded a contract to a consortium led by Tulane University SPHTM to work with the University of Kinshasa in establishing the Kinshasa School of Public Health (*Ecole de santé publique*). Other members of the consortium included the Harvard Institute for International Development, UCLA School of Public Health, the School of Public Health at Louvain University in Brussels, and the then King Leopold Institute of Tropical Medicine in Antwerp, Belgium. Dr. William Bertrand was the PI of the USAID contract and one of the co-directors of the new school, along with Dr. Kashala Tumba Diong from the faculty of medicine at the University of Kinshasa.

Initially, the minister of university/higher education opposed the creation of the KSPH, because UNIKIN – formerly known as Lovanium – had been established by Belgian professors from the Catholic University of Louvain. As he tells the story, Dr. Miatudila managed to pass this information to President Mobutu through the US ambassador. Infuriated by these devious efforts to block this initiative, Mobutu signed the contract with USAID immediately – in place of his minister – and fired him the next day.

The first year (1988) was dedicated to refurbishing the building that the Mont-Amba School of Nursing had agreed to make available for the new School of Public Health. Yet the high rates of inflation and constant devaluation of the currency – by as much as 10% every month – wreaked havoc in budgeting for the project. Fortunately, the purchase of vehicles and operating equipment such as computers was covered by the USAID budget in dollars. The first cohort of some 25 students attended classes at the medical school, but by year two (1989) the renovations were completed and KSPH opened its doors in the refurbished building.

The early years were challenging. The presence of well-paid expatriate professors made the school a target of envy in the resource-scarce environment of UNIKIN. KSPH was the only unit of the university that received USAID funding. University administrators tried multiple creative strategies to wrest control of this flow of funding, but the school quickly established a multi-sectoral administrative committee that helped to stave off these attempts.

Second, the presence of an American entity at the helm of this project at a university that only had prior experience with Belgian or French expatriate professors ruffled feathers. At one point the Belgian ambassador lodged a formal

complaint with the US ambassador that the project was anti-Belgian. At a high-level meeting convened to resolve the issue, the Belgian ambassador was blindsided when he learned – apparently for the first time – that two of the primary collaborating institutions were Belgian: the King Leopold Institute of Tropical Medicine and the Catholic University of Louvain. He sheepishly withdrew the protest.

The format of courses also clashed with the traditional model of pedagogy in higher education, consisting of rote memorization and professor veneration to the extreme. Rather, the classes in the new school were learner-centered and problem-focused, with a strong dose of practical application. Courses were held in three-week blocks with field training a part of every block.

Ethnic differences within the faculty and student body also brought an unanticipated set of problems. Zaïre was a country with hundreds of different ethnic groups, and cronyism based on tribe was a deeply engrained cultural practice. The new administration of the KSPH found it necessary to introduce a system where promotions and grading were based on competence and objective criteria, not ethnicity or family ties. The problems of tribalism in the early days caught the expats off-guard, but their presence contributed to the development of more performance-based and transparent standards that are still the hallmarks of the school's activity.

In terms of family planning, KSPH initially kept the topic at arm's length. The University of Kinshasa was founded as a branch of the Catholic University of Louvain in Belgium, and a local bishop still served as chairman of the board. Yet by the late 1980s, the university could not turn its back on the growing HIV/AIDS epidemic in the country. One of the earliest externally funded research projects at KSPH involved HIV. As the first cohort of PhD students returned to KSPH from abroad with an appreciation for the epidemiology of HIV transmission, the school became less reticent in dealing with reproductive health issues.

Although KSPH did not have a specific program in family planning or reproductive health, it would have a major impact on family planning work in subsequent decades. SANRU – which introduced family planning as part of primary healthcare throughout the country in the 1980s – sent many young doctors to receive MPH training at the KSPH. In addition, other doctors who obtained an MPH from the school went on to become MCZs. The curriculum exposed them to the basic principles of epidemiology, biostatistics, and management, as well as the multiple areas of primary healthcare (malaria, tuberculosis, HIV/AIDS, maternal and child health, water, and sanitation). In short, KSPH produced a steady stream of public health specialists who became the backbone of public health work throughout the country.

From early in the school's history, HIV/AIDS was an important focus of activities, continuing through the 1990s and to the present. Along with CDC's Project SIDA, the school implemented the first major cohort field studies of heterosexual behavior in a local textile factory and bank with respect to HIV/AIDS transmission worldwide. This expertise in field data collection regarding sexual behavior broadened the perspectives and knowledge base of family planning related issues in the country.

Despite the challenges of the early years, KSPH along with CDC's Field Epidemiology Program went on to become the model for the Rockefeller Foundation's innovative initiative "Schools of Public Health Without Walls," which created six similar institutions in Africa and one in Vietnam.

Key research advances knowledge of population and family planning

The family planning service delivery projects conducted a great deal of programmatic research that guided new initiatives or pointed to needed mid-course corrections to ongoing projects. Two operations research projects – PRODEF/Matadi and Kananga – documented the effectiveness of intensified family planning activities in increasing modern contraceptive use.[125] In addition, considerable formative research helped to shape messaging for communication programs and test comprehension and acceptability of messages. Some of these studies ended up in reports, others in academic journals on family planning and public health.

Three other data collection efforts shed light on the dynamics of population and family planning in the 1980s. The 1982–83 Contraceptive Prevalence Survey provided a measure of contraceptive use – albeit in a handful of locations – before the rapid expansion of family planning programming in the 1980s.[126] The 1984 population census yielded the first and only nationwide count of the entire population of the country since independence.[127] The third – a mixed methods study of attitudes toward permanent contraception – revealed the visceral aversion to the concept of limiting births among men and women in the late 1980s, unless it was medically essential.[128]

Contraceptive prevalence in Zaïre in the early 1980s

Countries worldwide gauge their success in family planning based on contraceptive prevalence: the percentage of women of reproductive age that use contraception. By the early 1980s, numerous developing countries were conducting contraceptive prevalence surveys (CPS) to measure this indicator. In 1982, USAID agreed to fund a CPS for Zaïre, to be conducted by the National Institute of Statistics and led by a local demographer, Mr. Paul Bakutuvwidi Makani. Westinghouse Applied Health Systems provided technical assistance. Given the vast geographical expanse of the country, the weak transport and communication networks, and the relative inexperience of local personnel in survey research, the decision was made to limit the survey to four cities (Kinshasa, Lubumbashi, Kisangani, and Kananga), plus two rural areas (Vanga and Nkara). Vanga was chosen as the rural health zone with the most advanced primary healthcare services including family planning; Nkara – with no FP services – would serve as a comparison zone.

The survey results showed very low levels of modern contraceptive use among married women: ranging from 2–8% in the four urban areas, 11% in Vanga, and 2% in Nkara. Whereas these levels were comparable to other sub-Saharan francophone countries, they were rock bottom by international standards.[129]

Figure 5.9 Survey research team in Menkao village, 1988. From right to left: Bakutuvwidi Makani, Mme. Nabintu, Luya N'Lendi, Mbadu Muanda, Kashangi Chiruba, and Amundala Twaforla

The study also yielded evidence of the relatively widespread use of traditional methods. In all four urban areas and both rural areas, the percentage of women using a traditional method (rhythm, abstinence, withdrawal, or a folk method) was two to three times higher than those using a modern method.[130] These findings suggested a motivation for preventing pregnancy that was yet to be matched by the use of effective contraceptive methods to achieve that end.

The 1982–84 CPS whet the appetite of donors, program managers, and researchers for a nationally representative survey of contraceptive prevalence. Indeed, several USAID projects stated their objectives in terms of specific levels of modern contraceptive prevalence to be attained. Yet it would be 25 years before the DRC Demographic and Health Survey of 2007–08 would provide nationally representative reliable data on contraceptive use.

*The Population Census (***Recensement scientifique de la population***) of 1984*

Since independence in 1960, the country had not had a population census. UNFPA worked with the government in preparing the census in Zaïre, and on September 5, 1980, a presidential ordonnance called for the *Recensement scientifique de la population* (scientific census of the population). To this end, the government created a national census commission. Initially planned for 1982, the data

collection was delayed until 1984.[131] The work was organized under the Department of Plan, with the National Institute of Statistics responsible for data collection. It was funded by the *Conseil exécutif du Zaïre* (President's Cabinet), UNFPA, and Great Britain.[132]

In preparation for the event, local census committees were created in the nine regions of the country, 27 sub-regions, as well as 13 urban committees and 143 rural committees. The National Secretariat for the census divided the country into 28,151 enumeration areas, each with its own enumerator, and 2,896 *aires de control* (supervisory areas, with one supervisor for every ten enumerators).[133]

Training in multiple waves ("cascade training") involved the training of trainers, regional and subregional supervisors, subregion supervisors in the municipalities, zone supervisors, and enumerators. Then, between July 1–15, 1984, data collection occurred simultaneously in all enumeration areas.[134]

A post-enumeration survey was conducted to evaluate the coverage and error rates for the census. The census yielded an estimate of 29,671,407 persons on July 1, 1984. The results were published in December 1984.[135]

The only primary data that survived from the 1984 census were the questionnaires, which quickly deteriorated under poorly archived conditions.[136] To preserve these data, the Demographic and Statistical Observatory of the Francophone Area (ODSEF) successfully digitized these questionnaires in 2012–13. The database for the 10% sample disappeared.

What makes this census remarkable is that no census has taken place in the country since 1984. Current estimates of population size by province still must be based on extrapolations from the 1984 census, combined with data from surveys, including the Multiple Indicator Cluster Surveys (1995 and 2001) and the Demographic and Health Surveys (2007 and 2013–14). Vital statistics, used in other countries as complementary data sources for demographic projections and prospects, are not of sufficient quality for this purpose in the DRC.[137]

One might assume that the government would be eager for a new census to obtain updated estimates of the size and distribution of the population, which has undoubtedly shifted over the decades since the 1980s. Instead, there seems to be a strong aversion to conducting another census, not only because of the financial and logistical challenges but more importantly, the political implications of having exact numbers that could bring into question the allocation of resources. For one, it might change the number of seats allocated to different provinces in the parliament. In a country where population size is equated with strength and power, some within the government prefer to have softer "estimates" that can be manipulated to fit their political purposes.

Attitudes toward limitation of births

The mantra for family planning in Zaïre since its inception was *Naissances Désirables*, with an emphasis on birth spacing. Some Western population experts conjectured that if couples began to space, there might be a gradual transition to birth limitation (smaller families). To this end, a number of Zairian physicians were

trained in tubal ligation, abroad or in Zaïre, to ensure that tubal ligation (and in some cases vasectomy) would be available as part of the method mix. Yet few women opted for this practice as an elective means of pregnancy prevention. Rather, the few who had the procedure did so out of medical necessity.

In 1987, the Operations Research Unit at the PSND conducted a study to better understand community norms around permanent methods of contraception. Since vasectomy was virtually unknown (except in one or two church hospitals) and presumed unthinkable in this society, the study focused instead on tubal ligation for women. Focus groups among men and women (separately) were carried out in the local language in five different Zairian regions, in addition to a survey among women who had undergone the operation. The following excerpts from this research reflect the deep-seated aversion to birth limitation.[138]

> The ability to have a child was so closely linked to manhood and womanhood that most considered it out of the question to voluntarily do away with that potential. Even if one thought they had all the children they wanted, one never knew what the future would bring and if one day they would want or need to have another child. As one male participant explained, "Both families aspire to numerous progeniture. If we decided on tubal ligation, my wife's family could interpret that I didn't love my wife and was looking for a way to have children outside of marriage… My own family would be tempted to believe that I am contaminated by my wife and that she is the one who commands in the household."
>
> Economic hardship was not reason enough to limit the number of children one would have. Couples should be willing to make economic sacrifices for the sake of expanding their clan. It would be selfish to hold back on having children for monetary reasons. As one man explained, "The high cost of living can in no way cause a couple to limit their births. Whoever would yield to the program of tubal ligation is incapable of taking responsibility, because our parents who had fewer resources than we do managed to raise us relatively well."
>
> Even the women who underwent sterilization and were satisfied with their operation felt it should be done for medical reasons only. As one woman said, "If I knew of someone who was sick all during her pregnancies or had a problem delivering, I would recommend that she have the operation since she risks dying and leaving her children behind… But if she tells me that her husband is unemployed, that they don't have a house, that they are incapable of taking care of their children, then I could not recommend it."
>
> Having a tubal ligation would result in marital conflict. "The woman's role within the marriage is to produce children, and a deliberate cessation of this could result in loss of the husband's affection or dissolution of the marriage." One man explained, "It is very difficult for a sterilized woman to be a respected wife since she can't have children anymore."
>
> One woman who had undergone tubal ligation recounted the consequences. "In my case, all our neighborhood made fun of me when they learned I'd had a tubal ligation, more so because my husband took another

> woman to give him children, even though he'd agreed to my operation because of the difficulties I had in giving birth. Sometime after the operation he took another woman without warning me or even telling me. I have even heard my friends say that it's good, that I was too proud. Now my co-wife has become their friend. But I say let them mock me. My five children are enough for me."

These stories speak volumes about the norms and beliefs that prevailed across the country in the 1980s, as family planning programming was beginning to expand in both urban and rural areas. Rare was the woman or her husband who wanted to definitively cease childbearing. Societal approval for spacing remained widespread, but few were ready yet to voluntarily put an end to their ability to produce a child.

Reflections on the 1980s

At a time when USAID/Washington wished to shift population funding toward Africa, Zaïre offered an interesting opportunity. Despite Mobutu's despotic rule of the country, Zaïre was an ally of the United States, thanks to the Cold War.

Given the size of the country and its high levels of maternal and infant mortality, family planning could make a sizable contribution to the development of the country and to improving the lives of women and families. Despite the strong pronatalist societal norms, by the late 1970s, AZBEF and the ECZ had demonstrated an opening to family planning programming.

Through the 1980s, USAID/Zaïre stepped up to address this challenge with funding to three major initiatives that would increase access to contraception: PSND, SANRU, and the Zaïre Social Marketing Project. To this end, it channeled funding through three different mechanisms: the Ministry of Health, a faith-based organization (ECZ/SANRU), and the private sector (the Social Marketing Project), respectively.

Centrally funded projects brought additional technical assistance and resources that advanced family planning programming across a wide range of specialized areas: training in service delivery including permanent methods, program management, population policy, private sector initiatives, behavior change communication, and operations research, among others.

The obstacles were colossal. Politically, birth spacing was not a priority in a country overridden by high levels of malnutrition and every infectious disease imaginable. Logistically, the country struggled with the absence of passable roads, a reliable national airline, a postal system, and telecommunications. Managerially, public sector health programs lacked trained staff, functioning systems, and a culture of accountability. Culturally, large families were the societal norm and children were widely considered a source of wealth.

Against this backdrop, numerous Congolese and their American counterparts worked to develop a system of family planning service provision for both urban and rural areas. USAID provided ample financial resources to drive these three initiatives to expand and flourish. Of the three main projects – PSND, SANRU,

and the Zaïre Social Marketing Project – PSND was the flagship for family planning, intended to improve the acceptance of birth spacing and increase contraceptive prevalence in urban areas across the country. Its greatest achievement was to establish a network of some 140 family planning units in 14 cities across the country, thus increasing the availability of services in these locations. Yet, for multiple reasons – managerial shortcomings, logistical hurdles, and societal norms – the work of the PSND did not result in an appreciable increase in contraceptive use. By contrast, both SANRU and the Zaïre Social Marketing Project were judged to be model projects that achieved their respective objectives, despite the challenging environment of the DRC. SANRU developed an extremely effective mechanism for supporting rural health zones across the country in delivering primary healthcare, but family planning – while part of the package – was not a priority. The Zaïre Social Marketing Project excelled in creating demand and selling large quantities of condoms and one spermicide in urban and peri-urban areas, but its main focus was HIV/AIDS prevention, not family planning. In short, both contributed to family planning but less directly than was expected of the PSND.

Despite the extensive family planning initiatives in the 1980s, contraceptive prevalence had yet to increase. By the end of the decade, MCPR was still estimated at 2%.[139]

Unquestionably, these three major projects, supplemented by the operations research under PRODEF and the Kananga Project, created an awareness of birth spacing and contraceptive technology that far exceeded what had existed even ten years earlier. In the span of a decade, this portfolio of projects produced a very solid foundation for the future development of family planning demand creation and service delivery. Had the country evolved to become more politically viable and economically stable, the foundation established in the 1980s could have been the springboard for an impressive national program in the 1990s. But it was not to be.

Notes

1 "Elections in Congo – Kinshasa." African Elections Database, October 10, 2012. https://africanelections.tripod.com/cd.html
2 *Zaire: Social Sector Project*. Washington, DC: The World Bank, 1990, p 1–2
3 Kisangani, Emizet F. *Historical dictionary of the Democratic Republic of the Congo*. Fourth ed. London: Rowman & Littlefield Inc., 2016, p 355–6
4 Ngandu, Mudiayi S, and Stephen H Kolison. "Zaïre." In *Sustainable Agriculture and the Environment in the Humid Tropics*, 625–57, Washington, D.C: National Academy Press, 1993, p 627
5 Schoepf, Brooke G. "'Mobutu's Disease': A Social History of AIDS in Kinshasa." *Review of African Political Economy 29*, no. 93/94. 2002: 561–573. https://doi.org/4006796, p 562
6 Schoepf, Brooke G., 2002, p 563
7 Rubbers, Benjamin. "When Women Support the Patriarchal Family: The Dynamics of Marriage in a Gécamines Mining Camp (Katanga Province, DR Congo)," *Journal of Historical Sociology* 28, no. 2.2015.: 213–234
8 Lauro, Amandine. "Women in the Democratic Republic of Congo." Oxford:*Oxford Research Encyclopedia of African History*, May 29, 2020. https://oxfordre.com/africanhistory/display/10.1093/acrefore/9780190277734.001.0001/acrefore-9780190277734-e-544, p 17

9 The World Bank, 1990, p 5
10 Kisangani, 2016, p 208
11 Lauro, Amandine, 2020, p 16
12 Druiet, Dirk. "II. the Makings of the Public Health System and the Root Causes of Conflict in the DRC." *Peace Operations at the Intersection of Health Emergencies and Violent Conflict: Lessons from the 2018–2020 DRC Ebola Crisis* | American Academy of Arts and Sciences, n.d. https://www.amacad.org/publication/peace-operations-intersection-health-emergencies-violent-conflict/section/3
13 The World Bank, 1990, p 1–2
14 "Aid and Reform the Case of the Democratic Republic of Congo – the World Bank." World Bank, n.d. https://documents.worldbank.org/curated/en/481111468025777429/pdf/357260ZR0Aid010reform0congo2.pdf, p 2
15 Kisangani, 2016, p 355–6
16 Lecomte, Jean, and Jay Friedman. "An Assessment of the Goals, Activities, and Performance of the National Committee for Desired Births, Government of Zaïre". Washington, DC:USAID, May 12, 1982. https://pdf.usaid.gov/pdf_docs/PNAAL438.pdf, p A-2
17 Bertrand, Jane, Victoria Ward, and Roberto Santiso-Galvez. "Family Planning in Latin America and the Caribbean: The Achievements of 50 Years." Chapel Hill, NC: MEASURE Evaluation, April 2015. https://www.measureevaluation.org/resources/publications/tr-15-101.html, p x
18 Lecomte and Friedman, 1982, p 33
19 Tierny, John. "With 'social Marketing,' Condoms Combat Aids." The *New York Times*, September 8, 1990 https://timesmachine.nytimes.com/timesmachine/1990/09/18/986290.html?login=smartlock&auth=login-smartlock&pageNumber=1
20 Bertrand, Jane, and Judith Brown. "Family Planning Success in Two Cities in Zaïre." Washington, DC: *The World Bank: Population, Health, and Nutrition*, November 1992, p 1
21 Bertrand, Jane T., Nlandu Mangani, and Matondo Mansilu. "The Acceptability of Household Distribution of Contraceptives in Zaïre." *International Family Planning Perspectives* 10, no. 1. 1984. https://doi.org/10.2307/2948030, p 21
22 Bertrand, Jane T., Nlandu Mangani, and Matondo Mansilu, 1984, p 21
23 Bertrand, Jane T., Nlandu Mangani, and Matondo Mansilu, 1984, p 21–2
24 Bertrand, Jane T., Nlandu Mangani, and Matondo Mansilu, 1984, p 22
25 Bertrand, Jane T., Mark E. McBride, Nlandu Mangani, Nancy C. Baughman, and Mombela Kinuani. "Community-Based Distribution of Contraceptives in Zaïre." *International Family Planning Perspectives* 19, no. 3 (September 1993): 84–91. https://doi.org/10.2307/2133241, p. 84
26 Bertrand, Jane T., Nlandu Mangani, Matondo Mansilu, Mark E. McBride, and Jeffrey L. Tharp. "Strategies for Family Planning Service Delivery in Bas Zaïre." *International Family Planning Perspectives* 12, no. 4 (1986): 108. https://doi.org/10.2307/2947981, p 109
27 Bertrand, *et al.*, 1986, p 109
28 Bertrand, Jane, and Judith Brown. "Family Planning Success in Two Cities in Zaïre." *The World Bank: Population, Health, and Nutrition,* November 1992, p 9, 16
29 Bertrand and Brown, 1992, p 16
30 Bertrand, et al., 1993, p 85
31 Bertrand, *et al.*, 1993, p 88–9
32 "Final Report: Zaïre Family Planning Operations Research Project." Prepared by Tulane University. New Orleans, LA: Family Planning in the DRC, September 1990. http://familyplanning-drc.net/documentation-sur-la-rdc-rapports.php, p 19
33 Tulane University, 1990, p 55
34 Tulane University, 1990, p 11
35 Tulane University, 1990, p. vi, 16, 10, 44
36 Tulane University, 1990, p vi

37 Baer, Franklin. "SANRU: Lessons Learned (1981–1991)." Harrisonburg, VA: USAID, 1991. https://pdf.usaid.gov/pdf_docs/PNABM846.pdf, p 69
38 Fountain, Daniel E. *Health for all: The Vanga Story*. Pasadena, CA: William Carey Library, 2014, p 33–38
39 Baer, 1991, p 7
40 Baer, 1991, p 6
41 "Evaluation of Basic Rural Health Project (660–0086) and Basic Rural Health II Project (660–0107)." Kinshasa, DRC: USAID, December 1986. https://pdf.usaid.gov/pdf_docs/XDBBF376A.pdf, p 1
42 Baer, 1991, p 55
43 Baer, 1991, p 70–1
44 Baer, 1991, p 71
45 Baer, 1991, p 71
46 USAID, 1986, p 1
47 Baer, 1991, p 6
48 Baer, 1991, p 32
49 USAID, 1986, p 91
50 Baer, 1991, p 12
51 Baer, 1991, p 69, 29
52 Baer, 1991, p 8
53 Baer, 1991, p 8
54 Hylander, Charles D. "Statement of Charles D. Hylander Deputy Director, International Division before the Subcommittee on Africa of the House Committee on Foreign Affairs on the Food-For-Peace Program and the Foreign Military Sales Program in Zaïre." Washington, DC: United States General Accounting Office, February 28, 1980. https://www.gao.gov/assets/111681.pdf, p 4
55 Baer, 1991, p 19
56 Baer, 1991, p 9
57 Baer, Franklin, 1991, p 62
58 USAID, 1986, p 99
59 *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*. Geneva: WHO, 2007, p iv
60 Baer, 1991, p 22, 58–9
61 Baer, 1991, p 51
62 "Evaluation of the Zaïre Family Planning Services Project (Project No. 660–0094)." Prepared by Checchi and Company Consulting, Inc. for USAID/Zaïre, February 1991. https://pdf.usaid.gov/pdf_docs/PDABC433.pdf, p 9–10
63 USAID, 1986, p 86
64 USAID, 1986, p 68
65 *Accord de don au projet entre la République du Zaïre et les Etats-Unis d'Amérique pour les services des naissances désirables*. USAID, 1982, p 1-5
66 Curiously the document referred to CNND, although the organization had formally changed its legal status and name to AZBEF in 1978. Although many people working in family planning in Kinshasa in the 1980s continued to call it CNND, this chapter uses the official name of the organization at the time: AZBEF.
67 USAID, 1982, p 62
68 Ewan, Neal, and Michael Descouens. "Foreign Trip Report (AID/RSSA): Zaïre Logistics Consultation to Projet de services des Naissances Désirables (PSND), National Family Planning Program." Washington, DC: Department of Health & Human Services, October 1, 1987, p 2–3
69 USAID, 1982, p 6
70 USAID, 1982, p 6
71 USAID/Zaïre, 1991, p 29
72 USAID, 1982, p 30

73 World Bank. "Zaïre – Population, Health and Nutrition Sector Review (English)." Washington, DC:The World Bank, 1989. https://documents.worldbank.org/en/publication/documents-reports/documentdetail, p 52
74 The World Bank, 1989, p 52
75 Kisangani, 2016, p 306
76 Tulane University, 1990, p 5
77 The World Bank, 1989, p 52
78 The World Bank, 1989, p 53–57
79 Tulane University, 1990, p 57
80 The World Bank, 1989, p 52
81 Bertrand, *et al.*, 1993, p 84
82 "The Mexico City Policy: An Explainer." KFF, January 28, 2021. https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/
83 Ewen and Descouens, 1987, p 4
84 USAID/Zaïre, 1991, p 17, 47, 9
85 USAID/Zaïre, 1991, p 16
86 Lecomte and Friedman, 1982, p 33–34
87 De Malvinsky, Jean. "Options I: Zaïre Final Report." Washington, DC: The Futures Group, March 9, 1992. https://pdf.usaid.gov/pdf_docs/PDABJ537.pdf, p 1–2
88 USAID/Zaïre, 1991, p 7, 14
89 The World Bank, 1989, p 39
90 "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation Replies to Certain Questions of the Day." Congregation for the Doctrine of the Faith, n.d. https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html
91 "International Federation for Family Life Promotion: UIA Yearbook Profile." Global Civil Society Database, n.d. https://uia.org/s/or/en/1100047235.
92 Ewan and Descouens, 1987, p 1
93 Close, William T. *Beyond the Storm: Treating the powerless and the powerful in Mobutu's Congo/ Zaire*. Marbleton, WY: Meadowlark Springs Production, 2007
94 Ewan and Descouens, 1987, p 5
95 Kisangani, 2016, p 76
96 Tulane University, 1990, p 59–9, p v
97 LeJeune, Mary Anne. *Congo Days*. Claremont, South Africa, 2020
98 "Programme Development and Financial Statements 1983–1985." Report to Donors 1984, October 1984. https://pdf.usaid.gov/pdf_docs/PNAAU792.pdf, p 100–101
99 Zoppelletto, C. "Decolonisation Through 'Development Films': Constructing and Re-Constructing the Zairian Spirit on Film." Doctoral thesis, University of Westminster, 2020. https://doi.org/10.34737/v218w. "Decolonisation through 'Development Films': Constructing and Re-Constructing the Zairian Spirit on Film." Westminster Research, August 2020. https://westminsterresearch.westminster.ac.uk/download/4838ccaf91ad99f13038e94a37ca2e70a5a3307614b75d0ca210dab104d0b5b2/10759808/C.Zoppelletto.PhDThesis.August2020.pdf
100 USAID, 1982, p 2–3
101 USAID/Zaïre, 1991, p 6, 11
102 Friedman, Jay. "Foreign Trip Report AID/RSSA, Zaïre: Program Evaluation of the Comité national des naissances désirables-CNND (National Committee for Desired Births)." USAID, March 12, 1982, p. 34
103 Chibalonza, Kashwantale, Chirwisa Chirhamolekwa, and Jane T. Bertrand. "Attitudes toward Tubal Ligation among Acceptors, Potential Candidates, and Husbands in Zaïre." *Studies in Family Planning* 20, no. 5 (1989): 273–80. https://doi.org/10.2307/1966764, p 278
104 Cohen, Jon. "The Rise and Fall of Projet Sida." *Science* 278, no. 5343 (1997): 1565–68. https://doi.org/10.1126/science.278.5343.1565

105 Cohen, Jon, 1997, p 1565–8
106 World Bank, 1989, p 51–2
107 Cohen, Jon, 1997, p 1565–8
108 Close, 2007, p 322
109 Close, 2007, p 321
110 "Social Marketing in Family Planning Programs." HIPs, July 5, 2023. https://www.fphighimpactpractices.org/briefs/social-marketing/
111 Tierney, John, 1990
112 Bair, William, Peter Clancy, John Paul Clark, Ann Leonard, Juan Londono, William Lyerly, Joseph Wiseman, and Celia Woodfill. "Prévention et lutte contre le VIH/SIDA et population/ planification familiale: Possibilités d'intégration des programmes et des activités en Afrique subsaharienne." Washington, DC:USAID, March 5, 1993. https://pdf.usaid.gov/pdf_docs/PNABU486.pdf. p 165–6
113 USAID/ Zaïre, 1991, p 37–40
114 USAID/ Zaïre, 1991, p 37–40
115 Convisser J. "Mass media entertainment for AIDS communication in Zaïre". *Development communication report*, (77), 1–8. (1992), p 1
116 Tierney, John, 1990
117 USAID, 1991, p 38.
118 USAID/ Zaïre, 1991, p 37–8
119 Bair, et al., 1993, p v-vi
120 World Bank, 1989, p 54
121 Bertrand and Brown, 1992, p 26–36
122 Brown, Richard and Judith. 1987 (1990 and 1998). *The Family Planning Clinic in Africa*. London and Basingstoke: Macmillan.
123 *Deuxième programme d'assistance au* gouvernement de la R.D. Congo (2002–2006). Fonds des Nations unies pour la population (FNUAP). *Kinshasa, 2007. https://digitallibrary.un.org/record/606171?ln=en*
124 The World Bank, 1989, p 77
125 Bertrand and Brown, 1992
126 Makani B, KL N'vembo, A Way. Planification familiale, fécondité et santé familiale au Zaïre, 1982–84. Kinshasa, Zaire and Columbia, Md.: Institut national de la statistique and Westinghouse Applied Health Systems. 1985
127 Brandt, Cyril, and Tom De Herdt. "On the Political Economy of Data Collection: Lessons from the Unaccomplished Population Census (DR Congo, 2006–2018)." *Secure Livelihoods Research Consortium Working Papers* 72 (March 13, 2019). https://doi.org/10.2139/ssrn.3352369, p 1
128 Chibalonza, Kashwantale, Chirwisa Chirhamolekwa, and Jane T. Bertrand, 1989
129 Makani B, KL N'vembo, A Way. Planification Familiale, Fécondité et Santé Familiale au Zaïre, 1982–84. Kinshasa, Zaïre and Columbia, Md.: Institut National de la Statistique and Westinghouse Applied Health Systems. 1985
130 Makani B, KL N'vembo, 1985
131 Gendreau, Francis, R. Dackam-Ngatchou, *Histoire de recensements de la population en Afrique*, Ouvrage en cours d'édition. N.d.
132 Brandt and De Herdt, 2019, p 4
133 "Recensement scientifique de la population." Institut national de la statistique, December 1984. https://www.odsef.fss.ulaval.ca/sites/odsef.fss.ulaval.ca/files/fonds_gp/c-doc_291_odsef.pdf, p 12
134 Institut national de la statistique, 1991, p 14
135 Institut national de la statistique, 1991, p 15
136 Brandt and De Herdt, 2019, p v
137 Brandt and De Herdt, 2019, p. 3–4
138 Chibalonza, Kashwantale, Chirwisa Chirhamolekwa, and Jane T. Bertrand, 1989
139 The World Bank, 1990, p 8

6 The 1990s

Development Work Paralyzed by Pillages and War

Family planning is well-positioned to build on the progress of the 1980s

The 1990s started with considerable promise for family planning. USAID funded PSND (Desirable Births Services Project), the largest project of its kind in francophone sub-Saharan Africa, was hitting its stride. Over 100 *Unités de planification familiale* were operating in 14 cities around the country. SANRU (Basic Rural Health Project), heralded as an effective model for delivering primary healthcare services, including family planning, to rural health zones, now operated in 100 of the 306 health zones in the country. AZBEF (The Zaïre Association for Family Welfare) had coordination offices in four provinces. The USAID-funded operations research project in Kananga showed a measurable increase in modern contraceptive use in response to targeted interventions. Many large private companies (such as the mining giant Gécamines) had incorporated family planning into their employee health services. USAID remained by far the largest donor for family planning, though UNFPA (United Nations Population Fund) and IPPF (International Planned Parenthood Foundation) contributed additional funding.

The Zaïre Contraceptive Social Marketing Project was delivering impressive results in selling condoms and spermicides.[1] The project had expanded to 44 cities and nearly 1,500 outlets. The urgency of the AIDS epidemic reduced barriers to explicitly promoting condoms through the media.[2] Whereas government officials and religious leaders had been moralistically opposed to exposing young people to contraception, in the face of the AIDS epidemic they were now desperate to keep their young people alive through condom use.

Because of the success of the Social Marketing Project, PSI's (Population Services International) visibility had skyrocketed.[3] Dr. Michael Mersen, then Director of the WHO's (World Health Organization) Global Program on AIDS, stayed over an extra day in Kinshasa after the 1990 International Conference on AIDS and Sexually Transmitted Diseases in Africa, to visit the PSI Social Marketing Project. This visit reportedly played a role in convincing WHO, which traditionally favored aid to governments, of the potential of channeling support through the private sector.

DOI: 10.4324/9781032718897-8

By the early 1990s, the ministry of health (MOH) was pressuring PSI to spin off a local social marketing entity, ostensibly to ensure the sustainability of this initiative in future years.[4] One project insider explained it otherwise. The non-profit sale of condoms was mind-boggling to MOH counterparts. Clearly, someone was making a lot of money, judging from the affluent lifestyles of the expat staff on the project. The MOH had authorized PSI's work in the country but felt they were due their cut. One day, the MOH sent a car to pick up a PSI staff member for a meeting at the MOH; only half-jokingly, he added, "Bring the PSI checkbook." Because a formal agreement protected PSI's work, the project staff continued to operate – deflecting these requests for a cut in the proceeds.

To further bolster the work of the PSND, USAID/Zaïre brought in the Population Council to work with Mme. Chirwisa and other PSND staff in two areas: management systems and operations research. This contract was part of a larger centrally funded regional project known as Operations Research and Technical Assistance (OR/TA) for family planning. In 1990, the Population Council established its presence at PSND by setting up a management support unit, run by Mr. Hervé Ludovic de Lys and assisted by Dr. Mamadou Diallo. It also provided technical and financial support to the operations research division[5] (upgraded from a "unit"), directed by Mr. Mbadu Muanda, who had worked with Jane Bertrand as a supervisor on several Tulane studies. Hervé's vision was to conduct operations research from a management perspective – to show what worked and what did not, for the purpose of scaling up effective approaches.

Box 6.1 Having friends in high places

One strong advocate for family planning was Mr. Charles Johnson, the USAID/Zaïre director. Mr. Bitshi Mukengeshayi, then *Chef de supervision* at PSND, tells the story of Johnson's visit in 1990. "How many family planning outlets does PSND currently have in Kinshasa?" Johnson asked.

Mr. Bitshi answered, "110."

"And how many could you scale up to operate, if you had additional funding?"

Without missing a beat, Bitshi answered, "160."

Within days, the wheels were set in motion for additional funding to PSND. On a follow-up visit several months later, Johnson was astonished that PSND had scaled up to 160 units so quickly. What Bitshi had not mentioned at the time was the recent termination of the Enterprise project that had assisted private companies to incorporate family planning into the legally mandated health services for employees. Many of these enterprises had already come to PSND, asking for help with training, equipment to insert IUDs, and contraceptives. With extra funds from USAID, PSND was able to incorporate these outlets into its program in record time.

During another of their meetings, Johnson advised Bitshi to give large quantities of contraceptives to the different facilities. Bitshi argued against this idea, citing the possibility of loss or theft. Mr. Johnson replied, "Is someone going to steal something they don't use? Go ahead and give it to them."

It is historical serendipity that four surprisingly detailed accounts exist of the status of the national family planning program as of 1990–91. Consistent with its procedures for large development projects, USAID/Zaïre commissioned an evaluation of the Zaïre Family Planning Services Project – covering both PSND and the Zaïre Social Marketing Project – conducted in October–November 1990. At roughly the same time, the Regional Inspector General's (RIG) office in Dakar, Senegal, carried out an audit of the project from September–December 1990. Independently, the PSND, with technical support from the Population Council, collected data for a Situation Analysis of family planning nationwide in July 1991, providing a detailed snapshot of service provision at the start of the 1990s. In preparation for the extension of the SANRU project, USAID consultants produced a "Project Identification Document" (PID) for the Zaïre Integrated Family Health Project, with rich details about family planning services. In retrospect, the timing of these assessments was eerily prescient, for they captured the family planning landscape in Zaïre before the country would be upended in late 1991.

The first of these assessments – the 1991 evaluation of the Zaïre Family Planning Services Project – analyzed the project's technical accomplishments, institutional arrangements, and management practices for both PSND and the Zaïre Contraceptive Social Marketing Project. The three-person evaluation team reviewed project documents, interviewed key informants, and conducted field visits to project sites.[6]

The results of the PSND evaluation were mixed. On the positive side, PSND had exceeded expectations in establishing family planning units: 140 in total (by the count of the evaluators), compared to the target of 125. The project had some staff who were well-trained and highly qualified. Two of three regional training centers were operational and had trained large numbers of providers. Financial accountability had improved. And a population policy has been crafted and approved by CONAPO.[7]

Yet the 1991 evaluation was critical on numerous points. Some of the 140 family planning (FP) units were not functioning or inadequately supplied. The report described the planning process as "ad hoc and top-down." Service providers outside of Kinshasa had no role in setting objectives and were not aware of their existence. PSND's organization of human resources was headquarters-heavy rather than field-oriented. The number of divisions and bureaus within PSND had proliferated, and the staff had grown from 41 to 89 between 1984 and 1990. The evaluators recommended that "USAID and the major actors in family planning needed to clarify the goals and specific objectives of US family planning assistance in Zaïre."[8]

The second assessment – the RIG audit – aimed to determine whether USAID/Zaïre planned, implemented, and monitored the project's inputs as

required by USAID policy.[9] In effect, it was evaluating USAID's performance in ensuring that the project correctly accounted for funds, appropriately planned for contraceptive procurement, monitored the work of technical experts hired to assist the PSND, oversaw training activities, and monitored the government of Zaïre's (GOZ) contribution of counterpart funds as specified in the original agreement. By definition, the audit was far more focused on financial and logistical management than on programmatic accomplishments.

The RIG audit concluded that "While contraceptive social marketing has achieved considerable success in attaining and in some cases exceeding its goals, PSND has been largely ineffective in expanding family planning services in government and private employers' healthcare programs." Part of the report dealt with bureaucratic procedures within USAID/Zaïre, whereas other issues were laid squarely at the feet of PSND: the inability to track service statistics from the clinics in its network; unauthorized use of project vehicles for non-project purposes; failure to act on the advice of the management support unit set up specifically for this purpose. Finally, the audit criticized USAID/Zaïre for inadequately monitoring the government's contribution of counterpart funds to the project.

Charles Johnson, the Director of USAID/Zaïre, fired back at the RIG with an 18-page cable, acknowledging "several accurate criticisms," but rebutting multiple findings from the preliminary report and making several insightful comments.

- The draft adopts the perspective that the family planning (FP) project is being carried out in a low-risk environment where there has always been effective demand for FP services. Not the case in Zaïre.
- The draft does not say there has been progress since the project began in 1982. FP services in Zaïre did not exist to any appreciable extent prior to the project start date in 1982. They are provided at a national scale in 1991, albeit not as effectively as we would like, due to the success of the Family Planning Services Project.
- Contraceptive product demand estimation is not an exact science in nations with fledgling family planning programs.
- (In response to the superior performance of the Social Marketing Project) We must continue to support to some extent the public sector component. To do otherwise is not politically feasible in Zaïre.
- Family planning services are of great importance to Zaïre's future. In Zaïre, like the rest of Sub-Saharan Africa, family planning is a high-risk endeavor, justified by high payoffs in the future.[10]

The third assessment – a Situation Analysis Study of family planning – was conducted in July 1991 by the PSND and the Population Council's OR/TA project. Based on a standard methodology used in multiple African countries, the study provided data on 108 family planning service delivery facilities countrywide.[11] Over half, 52%, were supported by PSND, 35% by SANRU, and 13% by AZBEF. The

study revealed low levels of family planning activity. The median number of new and continuing clients seen per facility per week was 7.5, less than one client every two working days of the month. PSND facilities saw the highest number of clients per week (16.4 on average), compared to SANRU facilities with the lowest (2.7). These averages masked the fact that a handful of facilities served the vast majority of clients. Quality of care was also an issue: many facilities lacked the equipment necessary to provide quality family planning services and over a third (37%) had not received a supervisory visit in the past six months. The study concluded that PSND would need to address these shortcomings "once political conditions allow it." Unbeknownst to the researchers, that would take another two decades.[12]

The fourth document, the Zaïre Integrated Family Health Project PID, described family planning in the larger context of primary healthcare and provided valuable insights into the dynamics surrounding this subject. The PID labeled family planning as the "weakest link in Zaïre's primary healthcare program" and foreshadowed the increased emphasis that USAID planned to give to family planning in the follow-on project. Among other background information, it summarized the obstacles facing family planning:

> "In Zaïre, major constraints to family planning program implementation stem from the cultural ideologies of many of the political elite and the large proportion of the population. The tendency to view population efforts as a diversion from fundamental structural changes; hostility to all policies affecting change in women's traditional roles; religious opposition to family planning; competing claims by government ministries over the allocation of scant resources; and the lack of motivation and skills needed to effectively implement programs impede advancement. Arguments based on the fact that Zaïre has vast uninhabited tracts of land coupled with the overall low population density continued to fuel pronatalist beliefs."[13]

The 1991 evaluation and the 1991 audit by the RIG had consequences. Mme. Chirwisa was relieved of her post.[14]

By late 1990, relations between USAID and Mme. Chirwisa had begun to fray. Chirwisa realized she was in hot water but described it in more political terms. Her deputy director was a close relative of the minister of health, and she claimed that the minister wanted "one of his own" in her position. She began to feel pressure from her compatriots to step down and even received death threats. One day, a large group came from the MOH to announce that she should leave the PSND. They expected she would resist, but instead she responded, "There is no problem." She signed her *mise et reprise* (resignation) and exited without fanfare. They were stunned, including the director of the cabinet. As Chirwisa tells it, the onsite search for money began immediately. Mr. Ngoie Mubeya Fidel was named PSND director.

In retrospect, Mme. Chirwisa Chirhamolekwa did a remarkable job spearheading the introduction of family planning into a geographically vast, predominantly Catholic pronatalist country, where the talent pool included few strong managers,

and the principles of accountability were foreign. Rick Thornton had been right; she had the grit to steer through these troubled waters. USAID/Zaïre had chosen her specifically because she was an experienced operator within the GOZ system. Yet they had not anticipated her need to remain loyal to the political hierarchy, right up to President Mobutu, whom she knew personally. USAID undoubtedly expected that their multi-million-dollar investment in the PSND would garner a certain loyalty from the chief executive, and Chirwisa initially followed USAID directives closely, working in collaboration with the expat advisers housed at PSND. Yet as Chirwisa became more established in her post, she felt less compelled to heed the advice of the technical experts that USAID had hired to assist PSND in achieving its objectives. This tendency became particularly clear when USAID contracted the Population Council to create a management support unit within PSND, headed by Hervé Ludovic de Lys. The 1991 evaluation gave the unit high marks for its efforts to improve financial and administrative systems within the organization. But it cited Chirwisa's frequent disregard of these advisers.[15]

Hervé – who was also advising the CECAP (*Cellule d'Etudes et d'Accompagnement des Activités de Population*) of the Ministry of Plan – remembers the day that his Zairian counterpart at CECAP called him into his office. "You are trying to address certain management issues at PSND, but there are 100 people who are pulling in the other direction. And guess who is going to win?" Thirty years later – with experience in other turbulent environments (Mali, Côte d'Ivoire, Venezuela, and Afghanistan), he offered piercing insights into the situation at PSND. "Chirwisa had good intentions but little margin to maneuver as she struggled to reconcile the efficient resource management for family planning service delivery with the higher political motives of the ruling party (*Mouvement Populaire de la Révolution*)." As director, Chirwisa complied with most USAID directives. But to survive in the government system, her first loyalty had to remain to the political power structure. (Several high-ranking physicians working in HIV/AIDS allegedly lost their lives for disrespecting the demands of the hierarchy.) Within those circles, her power came not from increasing contraceptive use in the country (the objective of USAID), but from adhering to the party line and sharing resources (e.g., the occasional loan of vehicles) if asked. When the advice from technical experts provided by USAID did not align with her priorities, she followed her instincts. USAID/Zaïre had chosen her because of her tenacious management style, but they had not reckoned with her role within the larger political apparatus.

Thanks to PSND, SANRU, the Social Marketing Project, and AZBEF, by the early 1990s the Zairian population was far more knowledgeable about contraception and had far better access to family planning services than a decade earlier. Consistent with the vision of USAID to establish a national family planning program, tremendous strides had been made and technical capacity strengthened to put contraception within reach of potential users in many urban and rural areas.

Yet the adage "build it and they will come" did not apply to family planning in the early 1990s. Demand for modern contraception for birth spacing – much less birth limitation – remained low. Anecdotes abound about the cases of women with eight or ten children, desperate to put an end to childbearing. Yet for the

majority, the deep-seated norms and practical realities still favored having large families. Too many obstacles remained: fear of side effects, husband's opposition, community disapproval, religious beliefs, costs, and lack of knowledge about contraceptives and where to get them. Ironically, the felt need for contraception was most apparent later in the decade when obtaining contraceptives, even in Kinshasa, became all but impossible.

Mobutu faces increasing opposition with fast-dwindling support from the West

The 1990s started poorly for President Mobutu. With the fall of the Berlin Wall in 1989 and the dissolution of the Soviet Union in 1991, the Cold War was over. The West no longer needed Mobutu as a counterweight to countries with Communist sympathies.[16]

Five months into the new decade, trouble was brewing on the campus of the University of Lubumbashi, the second-largest city located in the wealthiest province, Shaba. Students were protesting for larger study grants, better conditions, and Mobutu's resignation. To quell the unrest, on May 11, 1990, a squad of Mobutu's elite commandos – *Les Hiboux* (the Owls) –descended on the campus and massacred at least 50 students.[17] A US official would later comment, "the security forces which used to be the glue that held Zaïre together are now themselves the cause of deepening instability."[18]

In response to this brutal incident the European Community (now European Union, EU), the United States, and Canada suspended non-humanitarian aid to Zaïre. Western support for Mobutu's regime was nearing its end.[19] An already tense political climate became more incendiary, as actors in all sectors feared what might come next.[20]

After 25 years of tolerating Mobutu's abuses of power, violations of human rights, and pilfering of the country's mineral resources, the international community pressured Mobutu toward a more democratic approach to governance.[21] In 1990, Mobutu took a fact-finding trip to different parts of the country to gather feedback from the population on his regime; people were even allowed to express their grievances. At the first hearing in Goma, Mobutu listened as person after person ranted against the evils of his regime. They were angry that wages were low, that living conditions were abysmal, and that the military created such an oppressive environment. Mobutu was shocked, hurt, and outraged to learn the extent to which the population had turned against him, and he refused to attend the remaining sessions in person.[22]

US support for Zaïre was rapidly declining. Whereas in 1989 Zaïre was sub-Saharan Africa's largest recipient of US economic assistance, in November 1990 the US Congress imposed restrictions on economic aid to Zaïre, barring any further military assistance.[23] On June 1, 1991, Zaïre hit the 12-month mark for failure to repay its debt on loans under the Foreign Assistance Appropriation Act, triggering the Brooke sanctions that halted further development assistance. US foreign assistance dropped from $643M in 1989 to an estimated $250M in 1991, leaving only PL 480 food aid operative.[24]

Mobutu appeared to bend to the international pressure in October 1990 by allowing for a proliferation of political parties, while trying to buy loyalty from several of them.[25] He announced that the country was entering the Third Republic. In a gesture toward power sharing, he called for a National Conference – a dialogue among a range of individuals, from powerful party leaders to representatives of associations and churches. Some 2,800 delegates from across the country descended on Kinshasa for the National Conference, which began on August 7, 1991.[26]

Citizens dared to hope that this conference might bring about a new start, that it would mark the end of Mobutu's rule, but the cagey leader found ways to cling to power. His forces went into high gear to buy off representatives to the conference with cash and gifts, but many would not have it. Mobutu named a Chair for the conference who was so closely linked to him that the participants booed him off the stage when he tried to speak. Yet within a week, the conference dissolved over accreditation disputes and political infighting.[27]

Mobutu could not have been disappointed that the National Conference collapsed. Yet within weeks, he was faced with a new form of protest, this time from his own soldiers. On September 23, 1991, his disgruntled, unpaid military showed its wrath by ransacking the entire city of Kinshasa, an event that has gone down in infamy as the *pillage*. [28]

Kinshasa erupts in violence and destruction: the pillage of 1991

The blow that would cripple the country for more than a decade came in September 1991. Military personnel – disgruntled by their low wages – mutinied in Kinshasa. Starting in the predawn hours they shut down the control tower at N'djili airport and ransacked a supply depot. From there they drove the military vehicles 15 miles to the main boulevard of Kinshasa, *30 Juin*, and laid waste to storefronts, pharmacies, and gas stations.[29] By 10 am the city had descended into chaos. The rampage expanded to other parts of Gombe, where the villas constructed during the Belgian Congo era became fair game. They completed their path of destruction by moving up the hill to Binza, where well-to-do Zairians and expat families lived in spacious houses. Soldiers were eager to *régler les comptes* (settle accounts).

The looting began with anything that was portable: merchandise, foodstuffs, alcohol, TVs. From there, the soldiers continued tearing out the plumbing, light fixtures, metal grating, wiring, and paneling. Caught up in the frenzy of protest, ordinary citizens joined the soldiers in plundering the city, able for the first time to express their rage against government oppression and a lifetime of injustices. The rampage spread to Lubumbashi, Kisangani, and other major cities, laying waste to them as well.[30] Some 30–40% of businesses in Kinshasa were destroyed, 70% of small retailers were ruined, some 117 people were killed and 1,500 injured.[31]

Mobutu did nothing to quell the rioting that was instigated by his own troops, nor did he ever discipline them for their actions.[32] Some speculated that Mobutu may even have provoked the rampage to derail the National Conference.

According to observers on the scene, he delighted in seeing the city torn apart, leaving citizens with nothing. "That's what they deserved for turning against me." He hoped that this apocalypse would demonstrate once again that he, and only he, could bring order to the chaos. He is famously quoted as saying, "*après moi, le deluge*," (After me, the deluge).[33]

The Western embassies reacted swiftly to ensure the safety of their citizens. Within 48 hours, Belgians and French troops brought in planes to evacuate foreign businessmen, missionaries, diplomats, development staff, and Peace Corps volunteers to the safety of Brazzaville (across the river from Kinshasa), where they could temporarily hold up or find airline connections out of the country. Within a week, the US embassy had evacuated almost all its personnel. Many expats who had lived in Kinshasa for years were forced to pack up in a matter of hours, clutching their passports and whatever belongings fit into a few suitcases. An estimated 10,000 expats fled the country, closing their businesses and causing some 100,000 "middle-class" Zairian workers to lose their livelihood.[34]

The International Committee of the Red Cross and the Belgium *Médecins Sans Frontières* (MSF) were first responders to this pillage, arriving with surgical teams and emergency medical support. The UN considered that they had no mandate to coordinate the response of the international donor community. No other international donors came to the rescue.[35]

The pillage gutted the local economy. Factories that employed thousands closed their doors and laid off their personnel. Expat owners of companies fled the country, disgusted that they had believed in Mobutu's ability to maintain stability.[36] Technicians of every stripe – factory workers, mechanics, carpenters – could not get work. Civil servants returned to their jobs, but most offices had ceased to function. As reported in Brooke Wind-up Plan, from the end of October to the end of November 1991, average house rents quadrupled, school costs increased ten-fold, and bus ticket costs increased by 200%. By year's end, the banking system had collapsed as a result of loan defaults, lack of deposits, and the non-availability of Zairian currency in the system.[37]

Unemployment rose to 80% in the wake of the pillage.[38] For families already living on the edge of poverty, the loss of employment was catastrophic. The disruption of markets caused the price of goods to skyrocket. Families were reduced to eating one meal a day, consisting largely of high starch, low nutritive *fufu*. [39] Residents of Kinshasa, already adept at hustling for additional income in the informal sector – sought any means possible to bring in a few zaires. Except for those with special job qualifications or political connections, the informal sector became the major source of survival.[40] Some attribute the phenomenon of street children in Kinshasa to the pillage, where parents no longer had the means to take care of their children and left them to fend for themselves in the streets.

Retail stores, shops, and pharmacies lost much of their inventory to looting. Small neighborhood markets around the city continued to function, but the scarce goods commanded high prices. A few private pharmacies still carried some contraception but at exorbitant prices. One type of commercial activity thrived: the sale of looted merchandise in sidewalk markets that sprung up around military camps.

The devastating effects of the pillage reached well beyond Kinshasa. Companies in the Interior providing raw materials to factories in Kinshasa such as cotton for UTEX or palm oil for soap production at Lever Brothers (through their subsidiary Plantations Lever au Zaire) overnight lost the market for their products.[41] Businesses providing foodstuffs to Kinshasa found that the urban population could no longer pay for their goods. Once a top producer of coffee and cotton, Zaïre never regained the market.[42] The pillage ruined business in both urban and rural areas.

Likewise, the flow of goods from Kinshasa to the Interior slowed to a trickle, as retail stores and pharmacies in Kinshasa had little to sell. Fuel, too, became more expensive, making the cost of shipping products to and from Kinshasa exorbitant.

The pillage inflicted economic misery on the population of Kinshasa and beyond. Mobutu reacted to the economic crisis in a familiar fashion – by printing more money, resulting in hyperinflation: 205% in 1990, close to 10,000% in 1991. The value of one dollar US dropped from 459 zaires at the end of 1989 to over 60,000 zaires per dollar by the end of November 1991.[43]

As Kinshasa smoldered in the ruins of the pillage, the political intrigue continued. Mobutu named his archrival Étienne Tshisekedi as prime minister on September 29, only to dismiss him within a week for failure to sign a pledge of allegiance to the president.[44] The following month the Sacred Union formed a parallel government. And the beat went on.

International donors halt development assistance

In response to the pillage, most international donors abruptly halted aid to Zaïre. The executive team of USAID/Zaïre regrouped in Washington, DC, and operated as a "Mission in exile." Within three months, the dollar funding for PSND, SANRU, and the Zaïre Social Marketing Project was cut off, as well as support to centrally funded contractors working in Zaïre on population and health. Wheat shipments under PL 480 were allowed to continue to Zaïre as scheduled in October and December 1991, the proceeds of which would be used to close out program activities.[45]

Because of the Brooke sanctions that took effect before the pillage, the US government had already assembled a team to oversee this drawdown of funding. Following the pillage, the team's mandate was expanded to include all US development assistance. The Brooke Wind-up Plan outlined what was to happen with each of the US government projects.[46] Annexed to the document are barely legible cables sent back to Washington during the period, providing a window into the thinking of this team.

Given the chaos, uncertainty, and general unrest, the Western embassies evacuated personnel and their families through Brazzaville within three days of the pillage. All USAID dependents and most staff left.[47] Ray Martin, head of the Health, Population, and Nutrition Office, stayed on in case USAID decided to resume some health-related humanitarian work. But even he, the mission director, and a few others left before the end of 1991 when it appeared obvious that continuing any development work would be futile. Linda Gregory, USAID's

Administrative Officer, however, remained at her post to finish various administrative details and to maintain a minimal US presence.

The USAID offices in the Mobil building at the end of *30 Juin* were not attacked, but the looters had emptied the depot in downtown Gombe.

USAID retained a staff of nine foreign service nationals, Zairians who had worked for USAID for many years and earned the trust of the leadership. Their primary job was to assist in closing out projects and closing down the office.[48] In October 1992, they emptied the Mobil building – furniture, computers, office supplies – and transferred everything to a USAID depot near the Ndolo airport, in preparation for a future resumption of operations. They moved their own offices – along with a mountain of files – into the GAO (Government Accountability Office) building, near the Mobil building.

Since UNICEF had decided to remain open, operating with a skeleton staff, USAID arranged to pass unspent funds – one million dollars from PSND and three million dollars from SANRU – to UNICEF to procure and distribute essential medicines and contraceptives to health zones, to the extent possible. This allowed USAID to continue to contribute to the humanitarian relief effort without any in-country presence.

At the time of the 1991 pillage, UNFPA had recently promoted Dr. Hans DeKnocke to UNFPA country director; until then UNFPA had functioned under UNDP (United Nations Development Program). He rapidly evacuated, leaving two Zaïrois – Mr. Sébastien Mutumbi Kuku and Mr. Mpoyi Mankonda – in charge. The absence of a country representative from 1991–97 and the ongoing socio-political crisis made it impossible for UNFPA to enter into an agreement with the Zairian government for new programs. However, UNFPA did contribute with the intermittent purchase of contraceptives benefiting the few services still open during the 1990s.[49] In its own report, UNFPA called it "ten years of floating." In 1996 UNFPA brought in an expat representative, Mme. Tamany Safir, an Algerian, who remained at the post until 2001.

One organization that stayed open and active was the Order of Malta, a lay Catholic religious organization that historically has specialized in medical services and other humanitarian aid in countries worldwide. Operating a full-service operation for philanthropic reasons, it worked with the Catholic Church in Zaïre to procure medications. Although run by the Catholics, the services were intended to benefit the entire population. Given the emergency measures taken, the situation for procuring medications became marginally better within four to five months of the pillage, though the scarcity of products continued throughout the medical supply chain.

The 1991 pillage leaves the PSND barely functional

The PSND offices at Kintambo had escaped the worst of the pillage. The main offices and adjacent warehouse had not been attacked or looted. The inventory of contraceptives, audio-visual materials, spare parts for the vehicles, and other goods were largely intact. However, a fleet of ten vehicles, numerous motorcycles, and

bicycles housed at the USAID depot awaiting shipment to the Interior were gone. Staff in the communication division who had been working in offsite offices lost all their equipment.

USAID cut off its dollar funding to the PSND in December 1991.[50] With the pillage came the sudden realization of the disparate employment status of PSND staff. Over half (47 out of 87) were government employees, with a quasi-lifetime contract but a meager salary. The remaining 40 staff were hired with USAID project funds, at far more attractive salaries. To close the gap, MOH employees received both their government salary and a *prime* (bonus) that brought them to the same level as their co-workers. Often the *prime* was much larger than the government salary itself. In the period immediately following the pillage, the government still had access to counterpart funds, which were used to pay government salaries. But in the months and years that followed, salary payments became irregular and sometimes failed to arrive.

The pillage brought to light a related problem. The PSND was a USAID-funded project, which had never obtained official status as a government program. Official documentation labeled it as an organization "officially designated to promote GOZ family planning activities."[51] As such, "project staff" were not entitled to earn a government salary. With the withdrawal of USAID funding, all salary support – including the *primes* – stopped abruptly. Half the PSND staff lost their jobs; the other half lost a major chunk of their salary.

The drastically reduced take-home pay left staff hard put to feed their families. Anyone who had a salary – however meager – became a magnet for the extended family, desperate for access to any resources. Following the Mobutu slogan of *débrouillez-vous*, people sold household possessions and hawked whatever skills they could offer.[52] Bitshi – a health administrator and trained nurse – reopened his welding business to produce anti-theft covers for exterior lights. Mbadu Muanda went back to teaching because parents with money wanted to keep their children in school. Mme. Virginie Kangololo fled to Angola where she started a restaurant.

The PSND remained open but hardly functional. Staff stopped coming to work every day. Initially, it had contraceptives in the Kintambo warehouse but there was no project funding to ship them to the clinics elsewhere in the country. Staff from the Interior had to pick them up in Kinshasa.

Over time, PSND's stock of contraceptives dwindled, until there was nothing left to distribute to partner clinics. Bitshi explained that he gradually stopped coming to work, entirely demoralized that he had nothing to offer. "The *matrones* from Sona Bata came to us, offering to pay for contraceptive products, and we had nothing to give them."

Entrepreneurs jumped into the void. They went to neighboring Angola to get oral pills, returning with a brand previously unknown in Zaïre. Others brought them back by ferry from Brazzaville. The churches used other channels. An evangelical church (*église du réveil*) had a connection in Nigeria and brought in a suitcase full of Depo-Provera. The ECZ (Church of Christ of Zaïre) managed to obtain a shipment of Noristerat (an injection). These efforts reflected the felt need – at least for a small portion of the population – to use contraception.

Whereas international donors had withdrawn funding from large-scale projects on the ground, they were willing to send promising young professionals for training outside the country. Those who benefited from the training became well-known names in family planning circles in subsequent decades. In 1993–94, Emmanuel Buhendwa received a ten-month training at the University of Montreal on demography, MCH, and management. In 1994–95, Mr. Bitshi traveled to Mauritius for a diploma in human resources management and training at the local School of Public Health. In 1995, the WHO supported the travel of Mbadu Muanda and Prof. Yanga Kidiamene to Togo for a 3-week course in epidemiological research. And in 1996, with funding from the World Bank, WHO sent Mbadu Muanda and Lina Piripiri for a three-week training in operations research in Benin.

SANRU struggles after the pillage

At the time of the pillage, SANRU was riding high. The project had avoided the Brooke sanctions. USAID had argued that the project was managed by ECZ, a private voluntary organization (PVO). Moreover, discontinuing its funding would result in significant losses in healthcare coverage and an increase in infant mortality in rural health zones, because government services were weak or non-existent.[53] The SANRU II project was scheduled to end in 1992, but SANRU staff were working with USAID on the design of the follow-on project entitled the "Zaïre Integrated Family Health Project," to be implemented through ECZ, PSND, and PSI.[54]

The pillage of 1991 brought those plans abruptly to a halt, disrupting the momentum – built up over a decade – for developing primary healthcare throughout the country. Franklin Baer tried to stay on with a small team at USAID to coordinate possible emergency assistance, but the US embassy vetoed that plan. By March 1991 USAID had discontinued its dollar funding to SANRU.[55]

The ECZ continued to operate as a PVO with a small local staff through June 30, 1992, using its counterpart funds and donations from churches back in the United States to provide a minimal level of support to the health zones. Dr. Sambe Duale resigned as director of SANRU in February 1992 and moved to Washington, DC, where he and Frank Baer continued as informal advisers from afar. Dr. Nkuni Zinga, director of the ECZ medical office since 1985, assumed a second title of director of SANRU to oversee the final months of the project close down. From there, USAID redirected three million dollars of unspent SANRU funding through UNICEF to provide limited assistance – primarily medicines and contraceptives – to health zones.[56]

In February 1991 (before the pillage), the World Bank authorized the $30.4M Social Sector Project (PASS), designed to meet the basic needs of the population in health, population, nutrition, and education. Among its aims was to increase access to family planning for five million people. ECZ – one of the recipient organizations – began to receive funding in 1992.[57] The minister of plan balked at giving the funding directly to the ECZ, preferring to manage financial transactions themselves. It became a moot point when in November 1993, the World Bank

ended the PASS project because of Zaïre's inability to pay its debts.[58] Less than a half-million dollars from this project was ever disbursed to ECZ.

ASF and Johnny Loftin operate social marketing on a shoestring

The Zaïre Social Marketing Project was also a casualty of the abrupt halt to USAID funding in Zaïre.[59] PSI's (Population Services International) office and vehicles emerged unscathed from the pillage. Its warehouse containing 20 million condoms and cartons of *Graine* spermicide remained intact. Shortly after the pillage, PSI headquarters recalled its expat director to Washington and dismissed him, presumably for reasons unrelated to the pillage.

USAID suspended PSI's funding in November 1991.[60] By then, PSI was working with a local NGO, *Association de Santé Familiale* (ASF), which had been created by Professor Payanzo Nsomo and colleagues in response to the HIV epidemic. Under their arrangement, PSI obtained project funding from USAID contracts and multiple other sources. ASF became the implementing partner for much of this work. Although operational, ASF's status as a fully registered NGO remained in legal limbo.[61] USAID authorized ASF to continue the social marketing of condoms and contraceptives through a self-liquidating scheme, whereby it could finance its operations from the sales of existing stock – until the supply was exhausted.[62]

PSI had a vested interest in Zaïre, which was its first and highest-profile condom social marketing project in Africa; it became the model for similar PSI projects in other African countries. To this end, PSI used corporate funds to "perch" – maintain some presence in the country for a period of time until conditions improved and funded project work could resume.[63]

Although most Americans fled Kinshasa after the pillage, one who remained was Johnny Loftin. Married to a Zaïroise and with three children in The American School of Kinshasa (TASOK), Loftin opted to stay in Kinshasa, where he and his colleague Wally Herzog assisted USAID to evacuate the personal effects of expats who had abruptly left the country. Although new to HIV/AIDS prevention work, in 1992 he became a consultant for ASF, assisting them with logistics, finances, donor reporting, and small fundraising activities. Initially, PSI hired Loftin to work a few days a month to oversee its operations and finances, but it quickly evolved into a near fulltime job "that put my three kids through TASOK," quipped Loftin.

From a multi-million-dollar project before the pillage, the social marketing operation shrank to three local staff, two guards, and Loftin. Max Kibondo Kilongozi was the lead administrator; Claude Disuemi ran sales, production, and marketing; and Mami Batonda did the admin/bookkeeping. To pay salaries and rent, they set to work selling the 20 million condoms and stock of *Graine* spermicide that they had. Eventually they ran out of the colorful wrappers with the *Prudence* logo used to repackage the generic condoms provided by USAID, so they fabricated a paper pouch locally that lacked pizzazz but kept them in business. They also had a large stock of plastic shopping bags with the imposing panther from the *Prudence* logo, which they had previously given away as a

promotional item. They realized the potential value of these bags when they found them being recycled and sold in local markets, so soon they, too, began selling these shopping bags to bring in extra revenue.

Despite their best efforts, ASF was operating hand-to-mouth. Loftin helped with fundraising. Because the expat community had contracted so drastically, Loftin found himself golfing with ambassadors and the few remaining businessmen in town (it was only men at the time). As secretary-treasurer of the American Business Association, he recruited speakers for the monthly luncheon meetings and exposed his expat colleagues to the ASF social marketing model. Soon, he began obtaining donations for ASF: Oxfam gave two separate grants of $7,000 and $14,000. The Dutch chipped in $5,000. DFID/British embassy donated audio-visual equipment. The Koreans purchased a vehicle for ASF. The World Bank gave $15,000. "These were small grants, but they helped," Loftin explained. "These donors were more interested in helping a local NGO than one based in the US."

By 1996, with no consistent source of support for family planning and no further stock of *Graine*, ASF focused entirely on condom use for HIV/AIDS and pregnancy prevention.

Life in Kinshasa in the mid-1990s, especially after the second pillage, was grim. Services were not available, large sections of the city experienced electrical blackouts and shortages of water, and soldiers circulated throughout the city with impunity.[64] At a time when most development workers had long since departed, Johnny Loftin was viewed as the lone ranger, carrying on the good fight to make condoms available in Kinshasa. His Zairian deputies also deserve a great deal of credit for keeping the lights on.

AZBEF's financial irregularities further hinder the organization

Even before the pillage, AZBEF had lost much of its stature as a family planning agency in Zaïre. The creation of PSND in 1982 ate into the monopoly that AZBEF had in service delivery and IEC. The departure of Dr. Miatudila Malonga for the World Bank in Washington, DC, in 1989 left a leadership void from which AZBEF never fully recovered.

As of 1990, AZBEF continued to receive modest funding from IPPF/Nairobi to cover salaries and service delivery costs. It supported FP units in clinics in Kinshasa, Katanga, Bas Zaïre, and Equateur, for which UNFPA and IPPF/Nairobi provided contraceptives.

None of the AZBEF offices suffered physical harm from the 1991 pillage. Rather, the damage it sustained was self-inflicted, resulting from its inability to manage its finances. A series of audits showing financial irregularities caused IPPF/Nairobi to discontinue its support of AZBEF between 1991–95. UNFPA continued to provide contraceptive products to AZBEF, but the organization was largely inactive for several years.

AZBEF was struggling. Despite having plans and ideas, AZBEF suffered a chronic lack of funds. It had 26 staff and 100 volunteers, but according to the

1991 Work Plan, most of its central-level staff had been placed on "administrative leave."[65] The 1991 evaluation of the Zaïre Family Planning Project spoke of the need to revitalize AZBEF and recommended placing an expatriate adviser at the deputy director level.

Prior to the first pillage, the evaluation team saw potential in AZBEF and recommended that USAID allocate a greater proportion of its family planning resources to this private non-profit organization for several reasons: lower salary and overhead costs, fewer cumbersome bureaucratic procedures, experience in working at the grass roots level, and fewer political constraints in promoting the still controversial topic of family planning. Yet this recommendation never got serious consideration, as the donors pulled out of Zaïre in 1991.

Surprisingly, at a time when the city of Kinshasa was on life support, AZBEF received its official designation as a non-governmental organization on March 14, 1992. It is unclear that this designation changed anything in the day-to-day routine of the organization, but it was useful for AZBEF to have clarified its legal status.

The Kinshasa School of Public Health loses its primary source of funding

After a successful start, USAID approved a second five-year contract to continue its support of the Kinshasa School of Public Health (KSPH). In the months between approval and signature, the city of Kinshasa erupted into violence during the pillage of 1991. KSPH became yet another casualty of the pillage, as USAID withdrew funding for all development projects in Zaïre. Only those students receiving support for their doctoral studies at foreign universities were allowed to finish.

In contrast to many other institutions of higher education, KSPH kept its doors open. The first generation of Congolese professors, recently returned from their doctoral studies abroad, received less than $200/month in salary – if they were paid at all. Personal security became an issue, as did the widespread scarcity of food.

In the face of these disastrous conditions, Professor William Bertrand found a solution that would allow the KSPH to keep the lights on. He created a US-based foundation – Support for the Kinshasa School of Public Health – and obtained a modest grant of $30,000 a year from the Rockefeller Foundation's Schools of Public Health Without Walls project.

Despite the untenable conditions in the DRC, the school was able to continue operations with funding from the Rockefeller Foundation and small private donations while the rest of the university was shut down. Some of the training was moved to Nairobi. Of note, all but one of the PhD students who trained overseas returned to work in the country or region, indicating a satisfactory working environment at KSPH and a commitment on their part to give back to the country.

The second pillage (1993) wreaks further havoc on the country

In January 1992, the newly appointed Prime Minister Nguza reopened the National Conference, only to close it down two days later. In an attempt to bring

pressure to bear for its reopening, the Catholic clergy organized a March for Hope on February 16, 1992. It devolved into yet another blood bath, first in Kinshasa, then in other major cities. Over one million people participated in what was the largest mass march in the country's history, many holding Bibles and rosaries. Mobutu brought out his troops to confront the marchers, leaving more than 50 people dead.[66] Mobutu had allowed his troops to use napalm on his own citizens for crowd control.[67]

Following this bloody massacre, Mobutu was further pressured to reopen the conference. In April 1992 the National Conference reconvened, renaming itself the Sovereign National Conference. A new constitution was drafted and plans were made for elections. Its newly elected chairman, Archbishop Laurent Monsengwo Pasinya subsequently proposed a Transitional Act, intended to curb Mobutu's interference in the proceedings. On August 15, Etienne Tshisekedi was elected prime minister of the transitional government, which Mobutu accepted without acknowledging the Transitional Act. One of Tshisekedi's first acts was to try to curb inflation, by then over 4,000%, by taking measures that would block Mobutu from printing more money to cover government expenses. But Mobutu foiled these attempts with countermeasures. Despite the exuberance of the delegates over the prospect of Tshisekedi's ascent to power, the opposition leaders lacked the vision and strategy needed to carry their victory over the finish line. The Sovereign National Conference ended in early December 1992, with mixed results. There were still no concrete plans for new elections.[68]

With the economy in shambles and the population in turmoil, Mobutu resorted to his time-honored practice; he printed more money. In December 1992, his government introduced five million Zaïre banknotes worth about two dollars each, which he used to pay the salaries of his army. Tshisekedi in his position as prime minister opposed this move as unlawful and urged shopkeepers not to accept them. When the military tried to change these bills, the local money-changers refused. This time it was not rank and file solders but Mobutu's Presidential Guard (the DSP) that sought revenge.[69]

On January 28–30, 1993, the elite forces (DSP) began a violent rampage through Kinshasa, murdering rank and file soldiers, tearing through businesses, terrorizing the population, and ransacking public and private property. Nuns in the district of Limete were reportedly raped. An estimated 2,000 people were killed, including the French ambassador. French troops swept in and carried some 1,300 foreigners to safety. Belgian troops – denied entry into the country by Mobutu – evacuated foreigners from Brazzaville.[70]

Many described the second pillage as worse than the first. What little remained of the country's infrastructure and functioning businesses was further destroyed, causing a new flight of expats and wealthy *Zairois* to leave. Elite soldiers turned on the rank and file, slaughtering them through bloody acts of violence. Rioters broke into the USAID depot near Ndolo airport, making off with a hundred vehicles. What they could not steal, they destroyed. Kinshasa was in chaos; smoldering vehicles were strewn across the city. With guns coming in from the east, business people and government officials armed themselves. As the economic

situation worsened, people were reduced to eating wheat bran, previously fed only to animals. Women went back to preparing manioc as they had in the village. Less than 15% of the population had access to healthcare.[71] Despite the widely touted unity of the African family, even those with jobs struggled to feed their own children.

After the 1993 pillage, USAID reduced its staff of Zairians from nine to four. Any hopes that USAID could resume operations were shattered.[72] Instead, the US Office of Foreign Disaster took the lead for the US government in directing its humanitarian assistance. Relief agencies flocked to the country. MSF, Catholic Relief Services, Action against Hunger, Handicap International, and others had set up operations in the country.

International observers monitored the disintegration of the country that Mobutu had decimated with his violent acts and personal greed. The US government officials surmised that Zaïre "still does not have a functioning government, there is no consistent control over the military, the economic catastrophe continues, and the threat of national disintegration looms larger every day."[73] As US officials contemplated their options, they realized that the country risked an even more dire future of civil war, famine, and national disintegration. If the president could not reach a compromise with his political foes, they envisioned the destruction of the country's infrastructure, with waves of refugees that would destabilize the region and require a massive humanitarian relief effort from the international community.[74]

While Zaïre teetered on the brink of collapse, an even greater catastrophe struck across the border in Rwanda: the 1994 genocide. The Rwanda Civil War began in 1990 when the Rwandan Patriotic Front (RPF), consisting largely of Tutsi rebels invaded the country. For several years, tensions escalated between the ethnic group in power, the Hutus, and the minority group, the Tutsi. President Juvenal Habyarimana sought to bring the war to a peaceful conclusion by signing the Arusha Accords in August 1993. Yet on April 6, 1994, the aircraft carrying President Habyarimana and Burundian president Cyprien Ntaryamira, both Hutu, was shot down by surface-to-air missiles, killing both.[75] This event triggered the genocidal killings that would last close to 100 days, when majority Hutu soldiers, police, and militia killed over 500,000 Tutsi and moderate Hutus. The genocide sent shock waves through the international community, though no country attempted to intervene to stop the killings.[76] When the Tutsi-led RPF seized control of Kigali, two million refugees fled to neighboring countries, many to eastern Zaïre. In the face of this human tragedy, the international community once again courted Mobutu to provide a temporary safe haven to these refugees. For a time, the calls to depose Mobutu were muted, and he maintained his faltering grip on power.[77]

In 1995, a new scourge emerged in Zaïre: the Ebola outbreak. In May, Dan Fountain's son Paul made a call to Larry Sthreshley, then working with the ECZ medical office, to report the emergence of an unknown disease in the town of Kikwit (in the province of Bandundu). Dan reported that everyone involved in an operation on a patient with this unknown disease had died unexplainably, and there were more patients with the same symptoms in the hospital. Larry scrambled

to put together $5,000 and took it to the Indian businessmen to buy personal protective equipment. The next day Mission Aviation Fellowship flew the drugs and materials to Kikwit as first responders. Larry borrowed a friend's phone to call the Centers for Disease Control and Prevention (CDC) in Atlanta, providing a detailed description of the dire situation on the ground. The CDC responded the next day with a 40-page fax, identifying the outbreak as Ebola. In a meeting back in Kinshasa, several high-level officials in the international community met to discuss how best to quell the panic that threatened to escalate. The head of the EU approached Larry and said, "the only way this is going to get under control is if you [the Americans] take the lead." Larry went to the US ambassador who gave him $50,000 to cover immediate expenses. Within three days, CDC experts were in-country, working out of the ECZ offices. Larry became the official local representative, attending strategy meetings, receiving Department of Defense flights at the airport, and warehousing materials from the US. Within 11 weeks, the outbreak was contained. The ECZ medical office gained street cred as an organization able to operate effectively in a crisis, despite poor communication systems and minimal resources.[78]

Given the downward spiral of the country, in March 1996 USAID further reduced its in-country staff – to a single individual: Mr. Victor Mandingula. A US-trained Zairian economist who had worked for USAID for over 15 years, Mangindula moved to a small office in GAO, where he was the only employee in the building. He helped health experts visiting the country for different outbreaks to get into and out of the country, and he regularly shipped human and animal specimens from the Kikwit region to labs in Atlanta/CDC, Germany, and South Africa via DHL.

For those familiar with the mammoth USAID operation in a large country with extensive development programming, the idea of a single individual holding down the fort for USAID for two years defies imagination. When a surveillance survey conducted in 1996 showed that Ebola was under control, Victor feared that USAID might no longer need him. As political events unfolded in 1997, he need not have feared for his job.

Box 6.2 The military had wives, too

Almost all accounts of Mobutu's military describe the elite forces and regular soldiers as heartless brutes, bordering on savages, as they carried out orders to terrorize civilians and massacre students. Dr. Gilbert Wembodinga, a practicing Ob-Gyn with a clinic in Kisangani in the 1990s, might not disagree, but he experienced first-hand their humanity on several occasions.

In the early 1990s, a soldier knocked on his door, begging him to care for his wife who was experiencing life-threatening pregnancy complications (*placenta previa*). The University Hospital and another clinic had turned them away because he did not have the money to pay. Dr. Wembodinga agreed to operate on her and managed to save her and the baby's lives. All in a

day's work. Several years later, during the pillage of 1993, soldiers destroyed much of the infrastructure in Kisangani, including stores, pharmacies, and clinics. Yet to Wembodinga's surprise, his clinic had been spared. He traced it back to the actions of the man he had helped, a major named Yelima, who had deterred other soldiers from attacking the clinic.

Several years later, Dr. Wembodinga had a narrow escape with Mobutu's soldiers. In 1997, he was living in the professors' quarters at the University of Kisangani. One night, well after the military-mandated curfew, he heard a knock on the door. A panicked husband beseeched Dr. Wembodinga to care for his wife, who was in labor with a breached birth. Violating curfew, he took her to the hospital.

En route, a band of soldiers jumped out to arrest him. "If you violate curfew, we will kill you."

But Dr. Wembodinga protested, "I have to save this woman's life." The soldiers took mercy on her situation, and two military were assigned to escort them to the hospital. The story ended happily.

In 1997, as the population in Kisangani waited anxiously for the war, life became uncertain. Military personnel would enter private homes without warning. Outside of Kisangani in the Tingi Tingi forest, groups of Rwandan refugees (Hutus) were camped out in squalid conditions, many dying of malaria and diarrhea. A UN rescue team came for Wembodinga and escorted him to the refugee camp, where he spent a week ministering to the ailments of this destitute population. He came back a second week with a truck filled with humanitarian supplies. The third week, a military escort came to his home to suggest that he "rest" that week, making an oblique comment that "we are only two and we can't protect you against a larger group." That week the Rwanda army descended on this community in the Tingi Tingi camp and killed hundreds of the refugees.

Thanks to the warning from the military, Dr. Wembodinga was spared.

Resuscitating family planning in Zaïre

By the mid-1990s, the situation for family planning had reached new lows. The PSND, though functional, received only enough money from the government to pay salaries, with little or no funding for operations or programmatic activities. ECZ received small amounts of funding from different sources, barely enough to keep it afloat. ASF and Johnny Loftin were struggling to keep condoms on the market, with modest support from PSI. Already marginalized by the growth of PSND and the Social Marketing Project, AZBEF struggled with chronic funding shortages.

But 1995 marked a turning point for reviving family planning work in Zaïre. In 1994, the landmark International Conference on Population and Development (ICPD), held in Cairo, Egypt, revolutionized the field of international family planning. Government officials from 179 countries participated in the official conference, with a parallel conference attended by some 4,000 participants from

international NGOs, women's groups, donors, and advocates. A major outcome of the conference was the rejection of the demographic thrust of family planning programming. Country programs needed to look beyond "women as breeders" and consider a wider range of their health and social needs. Gender equality was seen as pivotal to women being able to take their rightful place in society and to have the autonomy necessary to control their own fertility. The Cairo Programme of Action was highly client-centered, rather than working to achieve the demographic objectives of a country. At the international level, donor funding spiked in response to the enthusiasm over this new direction, only to succumb to the greater urgency of the HIV/AIDS epidemic shortly thereafter.[79] The tumultuous political situation in the DRC did not allow for the country to benefit from the new-found interest in a broader definition of reproductive health until the end of the decade.

In 1996, the government recognized the need to convert its family planning *project* to a government *program*, both to underscore its importance to the public health and development of the country and to engender a greater sense of country ownership. On February 20, 1996, the PSND was renamed the *Programme national de Naissances Désirables* (PNND) through Ministerial Decree No. 1250 / CAB / miniSP / 0096. The acronym became PNND or PND. But many continued to refer to the organization as PSND, despite the official name change.

Some project staff who had lost their jobs after USAID withdrew funding in 1991 were able to obtain a matriculation number that authorized them to receive a government salary; others were less fortunate or did not follow through on the tedious administrative process.

In 1997, Mr. Ngoie stepped down as the director of PNND for health reasons. The following three years would see rapid turnover in the leadership of PNND, with varying levels of dedication and competence. Dr. Lusikila Samba Chantal held the post for one tumultuous year (1997–98), accused by her senior staff of bad governance. She was replaced by Mr. Tambwe Yelumba, who passed away while in office in 1999. Mr. Kwanzaka Izanza took over as interim director from 1999–2001. If the pillage had started the PSND/PNND on a downward spiral, these few years further accelerated the decline.

PSND staff did play a role in the expansion of service delivery, in collaboration with ASF/PSI and Pathfinder. Using a social marketing approach, the project distributed condoms, pills, and spermicides to pharmacies, as well as to selected clinics. Mr. Mutombo Yatshita, former director of training at PSND, recruited personnel who had been trained by PSND to train clinical providers and pharmacy personnel in family planning, thus expanding access to contraception in Kinshasa, Lubumbashi, and Bukavu.

******

The ECZ also benefited from an infusion of funds in the mid-1990s that allowed it to revive its work in family planning. In 1995, the EU awarded the ECZ the PATS I project, a $1.32 M two-year general support contract (*Appui Global*) to maintain primary healthcare including family planning in six health zones in

Kinshasa and five in Kasaï.[80] With this funding, the ECZ continued to distribute whatever contraceptives it had until its stocks were depleted or the products expired.

In 1996, the ECZ received an additional $107,000 contract ($65,000 from the World Bank, $42,000 from the Presbyterian Church/USA), specifically for family planning work. Dr. Nkuni, director of the ECZ medical office, was keen to revitalize family planning in Kinshasa. The ECZ staff who worked under this agreement attributed it to Ray Martin, who in mid-1992 left USAID and was hired by the World Bank. With this funding, the ECZ established a *Cellule de population* (population unit) within its medical office and recruited Drs. Dick and Judith Brown to return to Kinshasa for what would be their third tour of duty for family planning in Zaïre in three decades. When they arrived, they found Mme. Yvette Mulongo, trained in community health and behavior change communication, already working at ECZ.

The population unit focused on integrating family planning into existing health facilities in Kinshasa. With this funding, the ECZ set up a depot to house the contraceptives brought into the country by UNFPA. Because of frequent stockouts of methods requiring resupply, the Browns chose to train providers in counseling and insertion of the IUD.

With a pickup truck and local driver provided by the ECZ medical office, the Browns and Yvette made the rounds of largely church-supported clinics in Kinshasa, determining which ones were providing services and had contraceptives. Papa Lukoki, the driver, would use his network to identify trouble spots to avoid (unrest and burned tires were big clues). They made schedules day-by-day, depending on where they could go.

A survey conducted in 1996 yielded a mixed picture of family planning operations in the city. The Browns ran into a number of nurses whom they had previously trained, who were still on the job, but many lacked equipment or had no contraceptives in stock. They also surveyed the local markets, where they found large quantities of oral pills, Depo-Provera, and spermicides for sale. They checked pharmacies, some of which had products for sale. "Where are they getting these supplies?" The answer: Brazzaville, Nairobi, and Zambia. The Browns came away with two conclusions: there was a demand for contraception in Kinshasa, and anything they could do to retrain people and resupply them with contraception would be a plus.[81]

The ECZ adopted four strategies in revitalizing family planning: work with viable institutions that had survived the political crisis, concentrate on providing clinical services, emphasize long-term methods, and build in cost-recovery schemes for all levels of providers. They succeeded in re-establishing family planning services in some 30 health centers and hospitals in Kinshasa. Yet they were acutely aware that the momentum for family planning had been lost. The population was now less knowledgeable about contraceptive methods than in previous years. Moreover, many women were simply too poor to pay for contraceptive services. They concluded that revitalizing family planning services in a disrupted country would require highly personalized, labor-intensive efforts. Even then, contraceptive use would be slow to return.[82]

In 1996–97 refugees from the civil war in Brazzaville started pouring into Kinshasa, squatting in makeshift housing near N'djili airport. With authorization from the ECZ medical office, the Browns and Yvette set up a temporary service delivery point in the area where they gave counseling and delivered IUDs and condoms to this refugee population. In 1996 they had set up a similar temporary refugee service on the grounds of the campus of the University of Kisangani for refugees flowing into the country from the east.

At the end of their two-year term, the Browns packed their belongings for one final time, departing Kinshasa in 1998. ECC had received additional funding of $730,000 from the EU[83] for a PATS 2 project, including family planning.

According to Ray Martin, the World Bank had operated on the principle that "what countries needed was finance; they could implement the projects." But by 1998, even the World Bank decided it did not make sense to continue to support projects in this chaotic environment and closed its development assistance to Zaïre.

*****

In the mid-1990s, the tides also turned for ASF/PSI. In 1995, the European Union Development Fund contributed $40,000 to ASF to procure condoms. This funding provided a bit of a lifeline until they got their major break.

However, the EU funding came with strings attached. The EU project officer insisted that ASF/PSI conduct quality testing on its existing stock of condoms. He did not accept the results of local testing; it had to be done overseas. The PSI condoms did not fail the overseas test, but the results were inconclusive. To Loftin's disbelief, at a time of great scarcity of goods in Kinshasa, the EU project officer ordered ASF to destroy the entire lot. With the threat of losing the funding if they failed to comply, Loftin and the ASF team borrowed a truck from the US embassy and loaded their entire stock of condoms onto it. En route to Matadi, they found a dirt road off the highway, drove to an abandoned lot, and dumped the entire load, creating a mound of condoms five feet tall and twenty feet in diameter. They doused it with diesel, lit a match, and took off. From ten miles away, they could still see the plume of black smoke on the horizon. It took another three to six months for the new lot of condoms to arrive.

In 1998, PSI was part of the winning consortium for the USAID centrally awarded AIDSMARK project, operating in multiple countries including DRC.[84]

ASF had kept the condom social marketing operation afloat during the lean years after the first and second pillages, with support from PSI.[85] When PSI returned in 1998, with funding for the AIDSMARK project, they operated as a single entity.[86] The donor funding flowed through PSI to ASF, and expat staff worked for PSI. Yet in DRC, they operated as ASF or ASF/PSI.[87]

AIDSMARK was an HIV/AIDS prevention project targeting vulnerable youth, commercial sex workers, and people living with HIV/AIDS. It promoted the ABCs, widely used in USAID-funded projects of that era: Abstinence, Be faithful, or Condom use.[88] The same year PSI launched the Zaïre AIDS Mass Media project, which worked hand-in-hand with AIDSMARK. The approach to behavior modification included peer education, mass media information dissemination, and

social marketing of the condom *Prudence*. PSI brought in market research experts to conduct focus groups and pretest ads for different market segments.

PSI hired Loftin as chief of party for AIDSMARK. Having stretched every penny for years, Loftin was now confronted with a different challenge: spending the vast sum of money now available for programming. He opened an office on Boulevard du *30 Juin* and built a studio to produce audio and video spots onsite. He worked with various local musicians who remained in the country including keyboardist/producer Alfred Nzimbi, composer/vocalists Lokito and Nzaya Zaidio (from Lipua-Lipua), guitarist Felix Mbetu (from Zaiko Langa-Langa), and other personalities. ASF/PSI would provide the messages that the musicians would then incorporate into their songs.[89]

Within a year, the ASF/PSI staff grew from five to 75. They were once again "everywhere" – in the capital cities of all the provinces. In addition to the conventional media and educational songs, they staged other attention-grabbing activities: parades with horses, and showy exhibitions at the annual International Fair. They connected with at-risk populations through their *Soirée de Prudence* (an Evening with *Prudence*). After obtaining permission from the owner of a bar or nightclub, their youthful staff would take to the stage for some 10–15 minutes. A dynamic MC would introduce the idea of protection against HIV, then move into a game-like format, shouting out questions about HIV/AIDS and handing out prizes for the right answers: a T-shirt or baseball cap with the *Prudence* logo. From there, members of the team would circulate among the tables, offering condoms (at low prices) for the clients, all as Congolese music pulsated in the background.

Although ASF/PSI worked almost exclusively in HIV/AIDS prevention, not family planning, this work resulted in high levels of awareness of condoms among the general public. The presence of ASF/PSI in Kinshasa and their ability to reach large numbers of people in cities nationwide gave them a first-mover advantage when family planning funding returned in the 2000s.

******

AZBEF, too, experienced a change of fortune. Starting in 1996–97, IPPF/Nairobi again began to fund salaries and small projects for AZBEF. They were able to fully reengage in service delivery and demand creation work, starting in Kinshasa. They then opened regional coordination offices in Matadi and Lubumbashi, and shortly thereafter in Bandundu and Equateur. This funding from IPPF/Nairobi supported training for service providers, contraceptives, equipment, and supplies.

Prior to the 1991 pillage, AZBEF did not have its own clinics. Rather, it signed partnership agreements with private health centers and clinics to incorporate family planning services, which became known as *Unités de Naissances Désirable*s. AZBEF signed similar agreements with the health centers of public and private companies (including ONATRA, Gécamines, and REGIDESO). With the influx of funds from IPPF/Nairobi, in 1997 AZBEF established its own clinic, Bongisa Libota in Kinshasa, first in N'djili then in several other locations before ending up

in Kazavubu. Then later they established another clinic in Matadi. The two Kinshasa facilities would go on to become among of the most frequented family planning clinics in the decades that followed.

AZBEF also used these funds to develop programming for youth and adolescents, starting in 1997–98. Mr. Jules Luanga, who had begun as an administrative secretary in 1991, took charge of this activity. AZBEF trained young people to serve as peer educators who visited schools, churches, youth clubs, and other areas where youth would congregate. These peer educators provided counseling about contraception, distributed condoms, and referred interested persons to nearby facilities for other methods. They did not receive a salary but would get small monetary remuneration when they submitted reports during monthly meetings. At a time when PNND had yet to reengage fully, AZBEF played a useful role in providing services in several key cities, especially to youth. Luanga recalled the period from 1996–2000 as some of the organization's best years.

In 1997, AZBEF changed its name to ABEF-ND (*Association de Bien-Être Familial–Naissances Désirables*, the Association of Family Wellbeing – Desirable Births). With the change in the name of the country, it was no longer appropriate to retain the Z (for Zaïre). The obvious choice would have been to change AZBEF to ACBEF, but that name was already claimed by the IPPF affiliate in Congo-Brazzaville, leading to the decision in favor of ABEF-ND. Often, the "ND" was dropped, and the organization became known simply as ABEF.

*****

There was even relief for some research activities. In 1995, Mme. Sokifuani was named minister of health. She learned of the work of a young demographer named Mbadu Muanda, and soon thereafter established the *Cellule de recherche en santé de la reproduction* (CRESAR, the research unit on reproductive health). Others joined: Chirwisa Chirhamolekwa, Dr. Nguma Monganza, Dr. Yanga Kidiamene (a gynecologist), Lina Piripiri (a doctoral student at Tulane), and Bolie Nonkwa (from the Ministry of Gender, Family, and Children). They received $25,000 to complete their first assignment: a literature review of all research in Zaïre/DRC completed between 1980–95 on sexual and reproductive health. They compiled their findings in a booklet and presented it to WHO. Seeing the promise of this group, WHO began to support further capacity development at CRESAR, sending these individuals to train outside the country. Upon their return, WHO awarded them a grant to identify indicators for MCH. From CRESAR, Mme. Chirwisa would be recruited to work with WHO/DRC, Lina Piripiri with USAID/DRC, and Mbadu Muanda with his subsequent leadership positions in reproductive health.

******

For the Kinshasa School of Public Health, the slow return to normalcy in Zaïre in the late 1990s coincided with the PEPFAR-driven rise in funding for HIV/AIDS worldwide. KSPH was well-positioned to receive funding in this area, given its previous experience with HIV/AIDS research, and to expand into other areas of public health research.

The cadre of US- and European-trained PhDs became the cornerstone to developing a thriving educational institution as well as reinforcing the public health infrastructure of the country as it recovered from two pillages and endless armed conflict. Four of these PhD graduates would go on to become deans of the KSPH (Paul Lusamba, Antoinette Tshefu, Patrick Kayembe, and Mukoko Munyanga). Lina Piripiri would become a senior adviser at USAID overseeing maternal child health. Prof. Ngo Bebe and Paul Lusamba would work in Africa regional offices of the World Health Organziation. Emile Okitolunda would manage major PEPFAR intervention and research programs. Ali Mapatano would hold a senior position within the MOH. Almost all became well-published researchers in their respective fields.

Protestant missionary work evolves by the late 1990s

The Protestant hospitals had been pioneers in introducing family planning, dating back to the 1970s. During the 1980s, many sites became the reference hospitals for the health zones supported by SANRU I (starting in 1982), which included family planning as one component of primary healthcare. As of 1980, 95% of the MCZs (the chief district medical officer) were missionaries, making up for the complete absence of Zairian doctors posted to the Interior.

Well before the pillage, the number of expat missionaries began to drop. In the early 1980s more Zairian doctors and nurses began to occupy posts in church-supported hospitals, which were able to provide them with housing, schooling, and a garage to maintain their vehicles.[90] Also, the government authorized doctors to take a portion of the proceeds from the operating room as a salary. As local doctors more willingly accepted these rural posts, the rationale for using expat physicians became less compelling.

By the end of SANRU II (in 1991), only one health zone had a missionary expat MCZ.

The landscape for church-supported hospitals changed markedly during the 1990s for multiple reasons. The destructive pillage of 1991, followed by the more violent pillage of 1993, caused missionaries in some locations to pack their bags and leave the country for good.[91] In other locations, the missionaries felt sufficiently isolated from the political turmoil to continue their work in health, education, and religious teaching. In both situations, financial support from the churches back in the US and Europe began to dwindle over time, in many cases to nothing. The boarding hostel at TASOK which had housed missionaries' sons and daughters attending high school in Kinshasa closed in 1993 and was converted to the MPH Guesthouse.

In well-known sites such as Karawa, Kimpese, Nyankunde, Tshikaji, and Vanga, expat missionary personnel evacuated after the pillage of 1991, when their personal safety could no longer be assured, and the country appeared on the verge of collapse. Some did trickle back, but as Dr. Duale recounts for Karawa, those returning tended to be religious leaders (pastors), not medical personnel. He readily admits, "Karawa today is not the Karawa of the 1980s." Thanks to

fundraising in the memory of Dr. Paul Carlson (killed in 1963), Karawa continues to benefit from external support. Not all sites are as fortunate.[92]

Other church-supported hospitals – in locations more isolated from the political turmoil of the 1990s and/or with stronger sources of external support – continued their work with a combination of expat and Congolese health providers. Some denominations chose not to cut their ties; they valued the direct interaction and continued to send missionaries, either for healthcare service delivery or development work.[93]

Since church-supported hospitals represented 38% of the hospitals in Zaïre at the time of the pillage, the continuation of this external support was a lifeline for many health zones. With donor-funded programs closed, the church-supported outposts scattered across this vast country became islands of refuge for the local population. Still today, in numerous locations the church tries to make up for many deficiencies of the government, although its presence is far less marked. As of 2022, Vanga still had an American and a German doctor.

The final nail in the coffin came in 1997, with the First Congo War (described below). The insecurity that gripped the country during the transition between Mobutu and Kabila was the final straw for most of the remaining expat missionaries in the country.[94] According to Larry Sthrestley, who grew up in a missionary family in Zaïre and then worked for faith-based organizations, some missionaries left after the 1991 pillage and did not come back, but at least a third did return. After the 1993 pillage, more left, and then the war took the number down even further.

Dr. Thibaut Mukaba (currently Family Planning and Reproductive Health Adviser for USAID/DRC) recounts his own experience. Because of the pillage, the University of Kinshasa closed for two years, delaying his opportunity to take the test that would allow him to become a doctor. When he finally took and passed the test in 1993, he left to become a doctor at a German-financed Catholic hospital in the health zone of Kingangu, province of Bandundu. With no disruption in the German missionary funding, the health zone became a "development pole" in the region, with ongoing training and community agents who counseled on nutrition. Although the government could no longer purchase medications, the Church set up procurement through its own depot in Kinshasa. To attract young doctors, such health zones provided them with a house with electricity six hours a day, a refrigerator, and regular access to a vehicle to get provisions and medications.

By contrast, in church-supported health zones where the expat personnel fled and funding was discontinued in the wake of the pillage, the story was much different. Dr. Théophile Nemuandjare was the MCZ in the health zone of Nyanga, province of West Kasaï (Kasaï Occidental) in Zaïre, supported by the Mennonites. He was in Kinshasa to visit the bank and purchase medications and supplies for the health zone the day the pillage began in 1991. He was shocked by the destruction of property that he witnessed and the total chaos of his surroundings. Soon thereafter, it became difficult to find medicines, even soap, in Kinshasa. Shortly after the pillage, the American and Canadian missionaries in Nyanga held a

meeting with the local personnel. "We have trained you. Now it is your responsibility to carry on." By 1992 the missionaries had left; the funds they sent back slowed to a trickle. The local community did not resent their departure, but they greatly regretted it. The hospital staff struggled to maintain the quality of services and slowly it began to decline. They could not give their patients the right care, and the patients could not pay. "All of today's problems date to the 1991 and 1993 pillages," observed Dr. Nemuandjare.

Dr. Felix Minuku recounts a similar story in Sona Bata, where an American doctor named Glen Tuttle built the Protestant hospital in 1925. From 1975 to 1986, the hospital was run by several Dutch doctors. Dr. Minuku arrived in 1977 as the first Zairian doctor to work at this hospital. Dr. Minuku credits the Dutch missionaries with helping to build or rehabilitate most of the health centers and maternities in the neighboring communities, as well as providing equipment for many health facilities in the region. They also helped to build a new nursing school in Sona Bata. For many years, the hospital in Sona Bata, along with other American-supported Protestant hospitals in the provinces of Bas Zaïre and Bandundu, received linens from the Overseas White Cross (supported by the American Baptist Women's Ministries), as well as cans of corned beef to feed indigent patients and malnourished children. Sona Bata was considered to be one of the best hospitals in the region and attracted patients from as far away as Kinshasa (over 80 kilometers away). But by 1986, the last of the expat missionary doctors had departed Sona Bata. The local community was very favorable toward the missionaries but had grown to depend on them. The church had never tried to make the operation self-sufficient, and the staff did not learn to use local means to maintain their services. Dr. Minuku laments in relation to Sona Bata today, *il n'y a plus rien sinon des bâtiments en ruine et un personnel soignant abandonné à lui-même*. (There is nothing left but buildings in ruin and service providers abandoned to their own means.)

Dr. Albert Mudingayi had similar reflections about the missionaries. He had worked at the Presbyterian-supported hospital in Tshijaki, "the best in the province." Along with other primary healthcare services, they had a well-organized family planning program. "They never had stockouts." His mentor, American Dr. Walter Hull had taught him "what we didn't learn in medical school." The operative principle was to save a person's life without considering the money. When Dr. Hall succumbed to cancer, he was long remembered by the many people he had helped in the community. The population appreciated the sacrifices that the missionaries made to live in remote locations and serve populations that had so little. Yet people came to imagine that this assistance would go on forever. Many missionary groups did not have an exit strategy; they had not prepared their local counterparts to take over these services. "It would have been better to have a transition, say ten years, to train business managers," reflected Dr. Mudingayi. Most patients were not able to pay for their care, in a society where wealth was measured in terms of the number of goats and chickens. "But one chicken cannot pay for a Cesarean." The Presbyterians did send some Zairians for training overseas, but a number failed to return. Under the circumstances they had little choice; there was nothing to return to. Concluded Dr. Mudingayi, "The pillages killed off the missionary system."

The ECC survived the turmoil of the 1990s and continued well beyond as a vibrant actor in healthcare delivery, in addition to religious teaching. But the days of large mission stations – oases in remote areas with electricity, running water, and other amenities – drew to a close, as hospitals and health centers were increasingly turned over to the state to run. Locally trained physicians, many with an MPH, assumed their rightful positions as MCZs in the healthcare system.

Kabila brings an end to the Mobutu reign

By 1996, Mobutu's regime was politically and financially bankrupt. The population was restless, seething with resentment at Mobutu's chaotic repression, and economically devastated by the two pillages. Mobutu's military was in shambles, and his government was losing whatever control it still had over the population. The 1994 genocide in Rwanda had further destabilized eastern parts of the country, where long-lasting regional conflicts festered. Besides, Mobutu was terminally ill.[95]

In September 1996 Rwandan soldiers led by Laurent-Désiré Kabila's Alliance of Democratic Forces for the Liberation of Congo (AFDL) invaded Zaïre to root out the remaining perpetrators of the genocide. They progressively took control of major Zairian towns.[96] Neighboring African countries jumped into the fray, in what became the First Congo War (1996–97). Although Mobutu's army put up resistance, it was easily quashed. The forces of Laurent-Désiré Kabila began a long march overland, hindered primarily by the dreadful state of Zaïre's roads. In the process, hundreds of thousands were killed in ethnic violence, and the already destitute country was further destroyed.[97]

On May 17, 1997, the ADFL captured Kinshasa. From Lubumbashi where he was located, Laurent-Désiré Kabila declared himself head of state. He promised to form a transitional government, ordered the military under his control, called for calm, and promised elections within two years (that never occurred).[98]

The Congolese population was jubilant to see Mobutu deposed. They took to the streets, welcoming Kabila's arrival as liberation, chanting and shrieking with cries of joy.[99] Early in his administration he gained favor with the population by paying soldiers, teachers, and public servants; cleaning up garbage and sewers; and sprucing up the halls of ministries. But his popularity was short-lived.[100]

The Western powers also looked to Kabila's administration with great hope for clean management after decades of kleptocracy.[101] It was not to be.

Mobutu fled first to his jungle palace in Gbadolite, then sought exile in Morocco. Through years of perfecting the practice of embezzlement and corruption, he had gained a fortune estimated between $5–10 billion. Mobutu – who had bankrolled literally thousands of family members and acquaintances for decades – found himself alone with his wife when he succumbed to advanced prostate cancer on September 7, 1997.[102]

Kabila dispensed with the name Zaïre for the country, river, and currency, replacing it with the Democratic Republic of the Congo, the Congo River, and the Congolese franc. Under the new government, Kabila retained the existing

ministries but installed political appointees in high places; civil servants continued their work. Initially, the economy appeared to improve, and petty theft subsided. Both international observers and common citizens dared to hope that the country was moving toward stability.[103]

Although Kabila had been brought to power with assistance from Rwanda, Uganda, and Burundi, he felt threatened by their continued presence in the country and sought to expel their military units. His efforts to secure their departure triggered the Second Congo War in 1998, which eventually drew in the armies of three more African nations. The First and Second Congo Wars ravaged the country's economy, further reducing the government's output and revenue, and increasing the external debt. The influx of refugees after the Second Congo War made a poor country even poorer.[104]

According to UNFPA reports from the time, Kabila's administration saw the link between economic development and population growth. In a speech in May 1998, the minister of plan insisted that slowing rapid population growth from 3.2% to 2.5% a year within two decades was essential to sustainable, equitable economic growth.[105] Yet efforts in this direction were overwhelmed by the political turbulence of the day.

The US government reengages with DRC

The US had been watching the situation in Zaïre closely and anticipated the fall of Mobutu. A month after Kabila's forces triumphantly entered Kinshasa and declared victory on 17 May 1997, the USAID Bureau of Humanitarian Assistance (BHA) sent in a team to assess the prospects for re-engaging with the new leadership at multiple levels and in key provinces. The team issued a report in August 1997 that highlighted the dynamic nature of the transition as well as the ambiguities. Against a backdrop of enthusiasm for change, elite leaders, civil society, and the population at large had serious reservations about the legitimacy of the new political leadership (largely composed of expatriate Zairians), and its ties to neighboring powers.[106] Most of those involved in the armed takeover had been living abroad and had little direct understanding of the country's complex dynamics.

The BHA team concluded that the new central government was still in flux, but that the US should move forward in bringing aid to support positive change where it was occurring. In the summer of 1997 USAID decided to take a dual approach of initiating stabilization activities and support to local confidence-building initiatives through its Office of Transition Initiatives (OTI), while laying the groundwork for reopening the mission.[107]

OTI sent in a team of eight expatriates with extensive in-country experience, headed by Willet Weeks, to reopen offices in the Mobil building and set up three regional offices in Katanga, Lubumbashi, and Bukavu.[108] Max Walton, a highly respected USAID executive officer ("admin guy") who had worked previously in Kinshasa, joined the OTI team to put the necessary physical and communications infrastructure in place. The team reconnected with Victor Mangindula, the Congolese national who had kept the lights on for USAID during the hiatus in operations.

OTI recognized that much of the functional state had collapsed under Mobutu; government services in the provinces had been largely privatized. Where they were operational, they depended on community leadership and financial support. OTI would work to support such operations with a series of small grants, bypassing the still-embryonic central state. With these grants, OTI supported local public-private initiatives, for example, cleaning up the trash from the streets of Lubumbashi, rebuilding bridges in the Kasaïs, creating youth activities to absorb former child soldiers in South Kivu, and promoting peacebuilding activities and provincial-level development planning processes in the provinces where it was present.[109]

In parallel, the USAID Africa Bureau began moving to reinstate a full-scale mission. In January 1998, USAID Senior Foreign Service Officer John Grayzel, who had years of experience in francophone Africa, deployed to Kinshasa as the new mission director.[110] For a period of months, the city bustled with activity by day but was eerily quiet at night. Everything worth stealing had already been taken. Ironically, it was a period of relative prosperity, aided by the de facto dollarization of the economy that ended previous inflationary cycles. Grayzel joined Walton and other Westerners who lived and worked out of the Intercontinental Hotel (later renamed the Grand Hotel, then the Pullman), which was also the de facto seat of government and locus of much intrigue. Fellow hotel guests included countless official and non-official Rwandans who had entered Kinshasa with Kabila's troops. Daily life was fluid. If someone needed legal services, they would go to a government office and pay for a trial. No one was sure what was happening and how things would go.

Across the Congo River in Brazzaville, a violent civil war was raging. The sounds of artillery fire shook Kinshasa, stray shells fell on the city (including on the Intercontinental Hotel), and helicopters could be seen bombarding neighborhoods across the river. Tensions within rebel groups led to frequent clashes and brief exchanges of fire, particularly at night. The city was under a strict night-time curfew.

The director's office had been virtually untouched since 1991, a thick layer of dust blanketing the furniture and an empty pizza carton on a side table. On the advice of a colleague who had served in another post-conflict country, Grayzel immediately called for an audit to identify problems already in existence before he took over. However, he found that French-speaking auditors were not eager to travel to Kinshasa during those turbulent times, and in his two years of tenure, no audit ever occurred.

In August 1998, the Second Congo War broke out, ensnaring eight neighboring countries and some 25 armed rebel groups in the conflict, though fought mostly on Congolese soil.[111] It was a terrifying period for those Americans caught in the crosshairs. At one point the embassy asked Americans to gather at the Marine-protected General Services Warehouse compound, only to find Congolese soldiers forcing entry by scaling the wall. Fortunately, they were looking for Rwandan soldiers, not Americans, and left after seeing that none were being harbored there. Given the persistent danger, the US embassy evacuated all US personnel. By December 1998 the city had stabilized enough for US personnel to return, and USAID was able to officially reopen with no dependents allowed.

Grayzel approached his job by asking "What had worked before that is still around" and "How can we revive it?" He had authorization from Washington to buy into existing centrally funded projects and to make small grants without most of the usual USAID paperwork. "If we had had the normal USAID controls in place, nothing could have happened." He opened up several sectors: environment and democracy first, followed closely by health.[112]

Health was a high priority. Diseases that were somewhat controlled before the pillage had returned with a vengeance: polio (in Mbuyi Mayi), monkeypox (Sankuru), measles (multiple locations), and by far the most insidious: malnutrition (that pervaded the country).[113] Grayzel authorized $4M to UNICEF as part of a multi-donor polio vaccination effort and recruited Dr. Reggie Hawkins, seconded from CDC, to coordinate this effort. It was a perilous environment for health programming, with the presence of rebel forces in four provinces in the east blocking all access to these populations. Eventually, those involved established a de facto truce that permitted the vaccination teams to proceed with the work, often with members of the armed groups helping with logistics.

Two organizations in the health sector fit the criteria of "previously successful and still operating." The first was the Kinshasa School of Public Health. One day Grayzel made an impromptu visit to the UNIKIN campus. To his amazement – against the backdrop of total disfunction in public services in Kinshasa – he found professors at work teaching public health classes to students from both the Congo and neighboring countries. The institution, with substantial assistance from Tulane University under the direction of William Bertrand, had not only survived the pillages but, according to the CDC analysis, was the only African institutional capacity, other than in South Africa, capable of adequately monitoring outbreaks.

The second was ECC (Church of Christ in the Congo, renamed from ECZ when the name of the country changed), which had been highly effective with SANRU. Grayzel discovered communities where village self-help committees – originally established by the SANRU project – were now operating as critical de facto community governance bodies to manage health, schools, and water in response to the total breakdown of official functioning government services. The ECC would go on to play a key role in reinforcing new health services countrywide.[114]

USAID/DRC worked to reengage with the Kabila's central government. With the continuing war of aggression by neighboring countries using proxy Congolese forces and the DRC divided into zones of control, OTI was for a time able to resume some activities in the Kasaïs and parts of Katanga while maintaining remote contact with its Bukavu office (from which expat personnel had been evacuated), with travel in and out via Nairobi. As its original mission wound down in 1999, the OTI became involved in supporting crossline communications between civil society actors, convening off-shore dialogues on national reconciliation, and channeling US support to the Lusaka Accords that would bring an end to the Second Africa War. OTI eventually handed off its work to USAID as it reopened in Kinshasa.[115] President Kabila would eventually quash these efforts for expanded democratic participation in orienting the country's future.

Family planning was only a small part of USAID's development work in the DRC. Yet USAID was the dominant player in introducing family planning to the DRC in the 1980s before all assistance was halted in 1991. With reason, for those in the family planning community, all eyes were on USAID with the dawn of a new decade and century.

Reflections on the 1990s

Thanks to the multiple agencies and projects working in family planning in the 1980s, the decade of the 1990s opened with a sense of progress and optimism for continued growth. PSND had expanded access to contraception in urban areas, despite managerial shortcomings. SANRU and the Zaïre Social Marketing Project exposed millions in both rural and urban areas to the concept of birth spacing and the use of condoms for preventing both HIV transmission and pregnancy. The stated objectives for the Zaïre Family Planning Project included increasing the contraceptive prevalence rate, although the target number varied by document. In the absence of any mechanism to measure contraceptive prevalence at the national level, the exact rate was a moot point. Despite recommendations by evaluators to conduct a national health survey that would measure contraceptive prevalence, no plans were on the books to do so. One can only speculate that the USAID/Zaïre leadership did not consider it a worthwhile investment of funds (millions of dollars) to determine that modern contraceptive prevalence in Zaïre was still in single digits, probably no higher than 5% nationwide, if that.

The pillage of 1991 paralyzed development work, including family planning, for over a decade. The pillage of 1993 brought further devastation and hopelessness to the country. Although PSND/PNND had kept its doors open for the entire decade, it accomplished little, devoid of leadership, contraceptives, and funds to operate a national program. As a local NGO, the ECZ/ECC also remained open with a skeletal crew but insufficient funds to operate effectively. Modest support from PSI headquarters allowed ASF/Johnny Loftin to stay afloat but barely.

By the mid-1990s, several grants breathed new life into family planning, albeit on a limited scale. UNFPA continued to fund PSND with occasional projects.[116] The EU awarded ECZ a large two-year grant for general support in rural health zones (including family planning); shortly thereafter the World Bank gave ECZ funding to revive family planning in Kinshasa, primarily in facilities supported by Protestant churches. ASF/PSI – by now distributing condoms only (no other contraceptives) – reestablished a very successful social marketing activity under the USAID-funded AIDSMARK project. But these activities were trifling in comparison to the portfolio of family planning work in the 1980s.

Did the pillage and Mobutu's demise have a long-term impact on contraceptive use in Zaïre/DRC? Yes, in multiple ways. The momentum built up during the 1980s through the PSND, SANRU, the Zaïre Social Marketing Project, AZBEF, and the operation research projects came crashing to a halt when USAID and other donors withdrew their funding in the wake of the 1991 pillage. Moreover, the political and economic upheavals in every decade since Independence in 1960

left the population traumatized and defeated. If Zaïrois had previously lived day-to-day, the effects of the pillage were to further undermine any sense of normalcy. How could one worry about the future when it was unclear where the next meal would come from?

Among the few individuals who wanted to practice family planning, the pillage left two indelible marks that remained until recent years. First, DRC is one of the few countries in sub-Saharan Africa where the condom has been the leading modern method among married women in every major study conducted from the 1980s to 2017.[117] Anecdotal evidence would suggest that couples do not like to use condoms, which they consider inappropriate in the context of marriage (condoms imply infidelity; one uses condoms outside of marriage, with prostitutes or the *deuxième bureau*). Is the use of condoms as the favored method the result of its being one of the few methods available – often free of charge – in the post-pillage period?

The DRC is only one of five countries worldwide in which the percentage of married women using a traditional method (rhythm or *coitus interruptus*) is higher than for modern methods (pills, implants, IUDs, injections, condoms, among others). Even in Kinshasa, where access to modern contraception expanded dramatically in the 2010s, the percentage of users remains similar for modern versus traditional methods. This practice is often attributed to the deep-seated fear that modern contraception will jeopardize future fertility for the woman (unfounded but widespread).[118] Yet some speculate that the widespread use of natural methods in the period after the pillage – for lack of any alternatives – left its mark on this population.

Notes

1 "Evaluation of the Zaïre Family Planning Services Project (No. 660–0094)." Washington, DC: USAID/Zaïre, February 1991. https://pdf.usaid.gov/pdf_docs/PDABC433.pdf, p 8
2 "Brooke Wind-Up Plan." USAID/Zaïre, January 1992, p 29
3 USAID/Zaïre, 1991, p 8
4 USAID/Zaïre, 1991, p 37–40
5 USAID/Zaïre, 1991, p 40–2
6 USAID/Zaïre, 1991, p i
7 USAID/Zaïre, 1991, p iii
8 USAID/Zaïre, 1991, p v
9 "Audit of USAID/Zaïre's Family Planning Services Project: Project No. 660–0094." Washington, DC and Dakar: Office of the Regional Inspector General for West Africa, April 26, 1991. https://pdf.usaid.gov/pdf_docs/PDABC691.pdf
10 Office of the Regional Inspector General for West Africa, 1991, p 1–2, 45–50
11 "The Zaïre Situation Analysis Study." African alternatives, March 1992. https://pubmed.ncbi.nlm.nih.gov/12285350/
12 "The Zaïre Situation Analysis Study," 1992
13 "Zaïre Integrated Family Health Project: Project Identification Document." SANRU, 1991 https://sanru.org/archives/sanru2/Zaïre_Integrated_Family_Health_Project_PID_1991.pdf, p ii, 9
14 Office of the Regional Inspector General, 1991, p 46
15 USAID/Zaïre, 1991, p 40–1, 25

16 Kisangani, Emizet F. Historical dictionary of the Democratic Republic of the Congo. Fourth ed. London: Rowman & Littlefield Inc., 2016, p 148
17 Kisangani, 2016, p 425
18 Cohen, Herman J. Situation in Zaïre: Hearing before the Subcommittee on African Affairs of the Committee on Foreign Relations, United States Senate, One. Hundred-Second Congress, First Session. Washington DC, US., 1992, p 2
19 Kisangani, 2016, p 286
20 Cohen, 1992, p 10
21 Cohen, 1992, p 2
22 Van Reybrouck, David. *Congo: The Epic History of a People*. London: Fourth Estate, 2014, p 393
23 Cohen, 1992, p 3
24 "Brooke wind-up plan," 1992, p 1, 5–7
25 Cohen, 1992, p 3
26 Kisangani, 2016, p 20
27 Kisangani, 2016, p 20
28 Kisangani, 2016, p 20
29 Kisangani, 2016, p 426
30 Kisangani, 2016, p 455
31 Van Reybrouck, 2014, p 399
32 Berkeley, Bill. "Zaïre: An African Horror Story." The *Atlantic*, August 1, 1993. https://www.theatlantic.com/magazine/archive/1993/08/zaire-an-african-horror-story/305496/
33 McNulty, Mel. "The Collapse of Zaïre: Implosion, Revolution or External Sabotage?" *The Journal of Modern African Studies* 37, no. 1 (1999): 53–82. https://doi.org/10.1017/s0022278x99002979, p 55
34 "Brooke Wind-up Plan," 1992, p 6
35 "Brooke Wind-up Plan," 1992, p 100
36 Richburg, Keith B. "Economic Collapse Withers Lush Zaïre." The *Washington Post*, March 31, 1992. https://www.washingtonpost.com/wp-srv/inatl/longterm/congo/stories/033192.htm, p A01
37 "Brooke Wind-up Plan," 1992, p 8
38 Kisangani, 2016, p 601
39 Richburg, 1992, p A01
40 Schoepf, Brooke Grundfest. "'Mobutu's Disease': A Social History of AIDS in Kinshasa." *Review of African Political Economy* 29, no. 93/94 (2002): 561–73. http://www.jstor.org/stable/4006796, p 562
41 "Histoire." Texaf, 2023. https://www.texaf.be/fr/a-propos-de-nous/histoire
42 Kisangani, 2016, p 138, 170
43 "Brooke Wind-up Plan," 1992, p 5
44 Kisangani, 2016, p 605
45 "Brooke Wind-up Plan," 1992, p 14
46 "Brooke Wind-up Plan," 1992, p 1
47 "Brooke Wind-up Plan," 1992, p 7, 13
48 "Brooke Wind-up," 1992, p 1
49 Deuxième programme d'assistance au gouvernement de la R.D. Congo (2002–2006). Fonds des Nations unies pour la population (UNFPA), Kinshasa, 2001, p 11–2
50 USAID/Zaïre, 1991, p 19–20
51 USAID/Zaïre, 1991, p 4
52 Kisangani, 2016, p 76
53 "Brooke Wind-up Plan," 1992, p 22
54 SANRU, 1991, p 14, 19–22
55 "Brooke Wind-up Plan," 1992, p 23

56 "Brooke Wind-up Plan," 1992, p 64–5, 20
57 "Implementation Complete Report: Republic of Zaïre: Social Sector Project." The World Bank, June 28, 1996. https://documents1.worldbank.org/curated/en/655321468248427733/pdf/multi-page.pdf, p i
58 The World Bank, 1996, p 3
59 "Brooke Wind-up Plan," 1992, p 35
60 "Brooke Wind-up Plan," 1992, p 34
61 USAID/Zaïre, 1991, p 39
62 Loftin, John, and Dana Hovig. "Zaïre: Contraceptive Social Marketing Project." Washington, DC: Family Planning in the DRC, March 1993. http://familyplanning-drc.net/documentation-sur-la-rdc-rapports.php, p 2
63 Loftin and Hovig 1993, p 1
64 Kisangani, 2016, p 352
65 USAID/Zaïre, 1991, p 11
66 Kisangani, 2016, p 407–8
67 Berkeley, 1993
68 Kisangani, 2016, p 151–2
69 Berkeley, 1993
70 "Human Rights Report 1994— Zaïre", Human Rights Watch: January 1, 1994. https://www.refworld.org/docid/467fca7d5.html
71 Kisangani, 2016, p 280
72 "Brooke Wind-up Plan," 1992, p 102
73 "Brooke Wind-up Plan," 1992, p 6
74 Human Rights Watch, Human Rights Watch World Report 1994 – Zaïre, 1 January 1994, available at: https://www.refworld.org/docid/467fca7d5.html
75 Sullivan, Ronald. "Juvenal Habyarimana, 57, Ruled Rwanda for 21 Years." The New York Times. 7 April 1994. ISSN 0362–4331.
76 "Ignoring Genocide. HRW Report – Leave None to Tell the Story: Genocide in Rwanda, March 1999." Human Right Watch, March 1999. https://www.hrw.org/reports/1999/rwanda/Geno15-8-01.htm
77 Kisangani, 2016, p 442
78 Hall, Ryan C.W., Richard C.W. Hall, and Marcia J. Chapman. "The 1995 Kikwit Ebola Outbreak: Lessons Hospitals and Physicians Can Apply to Future Viral Epidemics." *General Hospital Psychiatry* 30, no. 5 (2008): 446–52. https://doi.org/10.1016/j.genhosppsych.2008.05.003
79 "International Conference on Population and Development (ICPD)." Cairo: United Nations Population Fund, September 5, 1994. https://www.unfpa.org/events/international-conference-population-and-development-icpd
80 "Zaïre: ECU 90 Million for Rehabilitation." European Commission – European Commission, October 17, 1995. https://ec.europa.eu/commission/presscorner/detail/en/IP_95_1123
81 Rapport de sondage des activités de naissances désirables à Kinshasa. Cellule de la population, Direction des œuvres médicales, ECZ, Kinshasa, May 1996 (unpublished)
82 Brown, Judith E and Richard C Brown. "Revitalizing Family Planning Services in Kinshasa: Lessons Learned," unpublished report (submitted for publication in the FHI newsletter Network), 1998
83 Miatudila, M. "Five Decades of Evolving ECC and SANRU Partnership in DR Congo." Baltimore, MD: Christian Connections for International Health Conference, July 2018. https://www.slideshare.net/CCIH/five-decades-of-evolving-ecc-and-sanru-partnership-in-dr-congo#7
84 "AIDSMark: A Decade of Innovative Marketing for Health: Lessons Learned." AIDSMark, 2007. https://pdf.usaid.gov/pdf_docs/PNADL283.pdf, p 1
85 "Global Directory of Condom Social Marketing Projects and Organisations." UNAIDS, January 2001. https://pdf.usaid.gov/pdf_docs/PNACN745.pdf, p 69

86 Loftin and Shulman, 2000, p 8
87 UNAIDS, 2001, p 70
88 "ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief." Office of the US Global AIDS Coordinator, n.d. https://pdf.usaid.gov/pdf_docs/Pcaab411.pdf, p 2–4
89 Loftin and Shulman, 2000, p 8
90 Kisangani, 2016, p 520
91 Cohen, 1992, p 10
92 "A Brief Overview of Covenant Ministries in DR Congo, and the Development of Paul Carlson Partnership." Paul Carlson Partnership, November 1, 2014. https://www.paulcarlson.org/2014/11/13389/.
93 Fountain, Daniel E. Health for all: The Vanga Story. Pasadena, CA: William Carey Library, 2014. P. 188–189
94 Kisangani, 2016, p 501
95 Kisangani, 2016, p 469
96 Research Directorate, Immigration and Refugee Board, Canada. "Zaïre: Information on Events That Occurred between 16 and 24 May 1997, Including the Rebel Takeover." Refworld, June 1, 1997. https://www.refworld.org/docid/3ae6aaab48.html
97 Kisangani, 2016, p 469
98 Research Directorate, Immigration and Refugee Board, Canada, 1997
99 Kisangani, 2016, p 547
100 Van Reybrouck, 2014, p 442
101 Kisangani, 2016, p 357
102 Smith, J.Y. "Congo Ex-Ruler Mobutu Dies in Exile." The *Washington Post*, September 8, 1997. https://www.washingtonpost.com/wp-srv/inatl/longterm/congo/stories/mobutu090897.htm
103 Kisangani, 2016, p 24–5
104 Kisangani, 2016, p 547–8
105 UNFPA, 2001, p 4
106 Office of Transition Initiatives. "Transition in the Democratic Republic of the Congo." Washington, DC: US Agency for International Development, August 1997. https://pdf.usaid.gov/pdf_docs/PNACC510.pdf, p 1, 3
107 Office of Transition Initiatives, 1997, p 6–7
108 Office of Transition Initiatives, 1997, p 8–10
109 Office of Transition Initiatives, 1997, p 1
110 Integrated Transition Plan, 1998
111 Kisangani, 2016, p 547–9
112 Grayzel, John. "Integrated Transition Plan." USAID/ D.R. Congo, April 30, 1998. https://pdf.usaid.gov/pdf_docs/pdabq610.pdf, p 10, 20
113 Grayzel, 1998, p 14
114 "CWS Emergency Appeal: IMA-SANRU Congo Health Initiative – Democratic Republic of the Congo." ReliefWeb, April 11, 2001. https://reliefweb.int/report/democratic-republic-congo/cws-emergency-appeal-ima-sanru-congo-health-initiative
115 "Democratic Republic of Congo: Stabilization and Transitions." US Agency for International Development, October 18, 2022. https://www.usaid.gov/stabilization-and-transitions/closed-programs/democratic-republic-congo
116 UNFPA, 2001, p 7
117 Kwete, Dieudonné, Arsene Binanga, Thibaut Mukaba, Théophile Nemuandjare, Muanda Fidele Mbadu, Marie-Thérèse Kyungu, Perri Sutton, and Jane T Bertrand. "Family Planning in the Democratic Republic of the Congo: Encouraging Momentum, Formidable Challenges." *Global Health: Science and Practice* 6, no. 1 (2018): 40–54. https://doi.org/10.9745/ghsp-d-17-00346, p 43
118 Kwete, D., *et al.*, 2018, p 42–43

7 The 2000s

Family Planning – Like the Country – Inches Back to Normalcy

Armed conflict grinds on despite efforts to wind down the war

As the new decade – not to mention the new century – began in the DRC, much remained unchanged from the end of the 1990s. The Second Congo War continued unabated in the eastern provinces of Orientale, North Kivu, South Kivu, and Maniema, despite multiple accords and agreements for a ceasefire. Violence of all types had become commonplace: massacres, kidnapping, rape. Boys who should have been in school were instead recruited as child soldiers. President Kabila continued his autocratic rule, though he only controlled the seven provinces in the Western region of the country; rebel groups had commandeered the east. The war had devolved from a struggle for political control to an outright gold rush for the minerals in the provinces neighboring Rwanda (Ituri) and Uganda (the Kivus). The rush intensified when global demand spiked for a new mineral, coltan, over 80% of which is found in the DRC. Rwanda and Uganda continued to exploit Congo's mineral resources at mind-boggling levels. Rwanda, a country with no diamonds of its own, sold $40M of diamonds annually on the world market.[1]

If the outside world had disengaged from the relentless bloodshed in the Congo, a front-page article in the *New York Times* on June 9, 2000, refocused attention on the plight of the country: "Death Toll in Congo's Two-Year War is at Least 1.7 Million, Study Says."[2] (By its end in 2006, it would become the deadliest conflict since World War II, with an estimated two to five million deaths.)[3] Peace treaties and accords were negotiated to put an end to the violence, but none succeeded.

The DRC population had grown to nearly 50 million, with just over one-third living in urban areas. Men and women struggled to earn a living, largely surviving thanks to the informal economy in urban areas and subsistence agriculture in rural areas.

Shock waves rocked the country when on January 26, 2001, Laurent-Désiré Kabila was assassinated in his office at the *Palais de Marbre* (Marble Palace) in Kinshasa. Within days, members of parliament elected his son Joseph to replace him. To avert unrest, the United Nations Organization Mission in the DRC (MONUC) sent peace keeping forces to the rebel-controlled provinces of the east and later into government-controlled provinces of the west.[4] Initially viewed as weak and inexperienced, Kabila *fils* soon showed his metal in discussions with

DOI: 10.4324/9781032718897-9

Rwandan counterparts and extolled the virtues of peace, national unity, and international cooperation.[5]

With the help of international intermediaries, in 2002 the DRC signed a peace agreement between DRC and Rwanda in Pretoria; a similar agreement was then signed between the DRC and Uganda in Luanda. In the same year, a UN panel documented that the governments of Burundi, Rwanda, and Uganda were plundering the natural riches of the DRC: gold, diamonds, timber, and ivory.[6]

With the help of international advisers, President Kabila brokered the *Accord Compréhensif et Inclusif* (Global and All-Inclusive Agreement of Transition) designed to create a new transitional government. Building on this new government, the Sun-City agreement (2003) was formed to combine all past agreements and fully rid the Congo of both Rwandan and Ugandan soldiers, as well as militia groups. This agreement marked the formal end of the Second Congo War.[7]

The *Accord* stipulated a transitional period of two years, beginning in 2003. It called for "one + four" governance: one president plus four vice presidents, representing different regions and interests.[8] Realizing that the transitional period would be timebound, those in positions of power lost no time in plundering state funds. According to a 2004 audit, within a year a half billion dollars had been embezzled, leading to the dismissal of six ministers. Some $13 billion – intended for investment in health, education, and infrastructure – "disappeared."[9]

The *Accord Compréhensif et Inclusif* brought no end to the political unrest in the east. The final phase of the Second Congo War began in late 2004 when President Kagame of Rwanda announced his intention to send troops into Congo to root out Hutu militants, whom he feared could threaten his government.[10] With no end to armed conflict, MONUC increased the number of peacekeeping troops.[11]

The year 2006 brought changes to the country that allowed both the international community and the average Congolese to cautiously anticipate a better future. It began with the adoption of a new constitution approved through a popular referendum.[12] The government also introduced a new flag with the now familiar colors of turquoise, yellow, and red.[13]

Yet the signature achievement of 2006 was the first multi-party democratic presidential election held since independence in 1960. The event had great symbolic importance, including to the average Congolese. For many, it was their first opportunity to vote. The international community invested a half billion dollars in this exercise in democracy, the most ever expended on a national election at that time.

In what external observers concluded was a generally fair election, Joseph Kabila emerged as president. In his inaugural speech, he pledged to reconstruct five sectors: infrastructure, water, and electricity, education, employment, and healthcare. Again, the West hoped this would bring a new dawn to a country decimated by war, political intrigue, and corruption. For a short time, he enjoyed new popularity among the populace.

Yet as Van Reybrouk observes, "How then could the West expect that particular method to magically transform a deep, rooted culture of corruption and clientelism into a democratic constitutional state in accordance with the

Scandinavian model? And then in a region that, during its pre-colonial, colonial[, and] post-colonial eras had known almost nothing but forms of autocratic rule."[14]

The Second Congo War finally ended in 2006, with Kabila regaining control of the four eastern provinces. Yet armed conflict had become endemic to this war-torn region. Child soldiers were cheap and easy to recruit. Guns flowed freely into the region. War was profitable and had become a way of life for many soldiers who had few alternative paths. The DRC army – lacking training and motivation – was no match for the multiple armed forces.[15] The MONUC troops maintained calm in some regions but had neither the mandate nor the numbers to root out the rebels in the east.

The DRC did not escape the negative impact of the 2008 global financial recession. With an acute shortage of cash, Kabila entered into a controversial infrastructure-for-minerals agreement with China. Under the Sino-Congolese joint venture signed in 2008, China would agree to build – even to advance funds – for the construction of the country's infrastructure – roads, railroads, houses, poly-clinics, hospitals, hydroelectric plants, and universities – in return for the rights to extract vast amounts of cobalt and copper. Negotiated by Kabila and his inner circle, the parliament had no say in the matter.[16]

After the lean years of the 1990s (*vaches maigres*), the DRC had one of the highest mortality rates in the world, attributable to a dysfunctional health system, insufficient access to healthcare, lack of prevention, poor quality of drinking water, and underlying levels of malnutrition.[17] According to the FAO (Food and Agriculture Organization of the United Nations), it was the most food insecure in the world, with 75% of the population undernourished. The health system was largely dismantled, owing to long-standing pre-war negligence and war effects, with the few exceptions being donor-dependent.[18] The DRC routinely ranked among the poorest in the world on other indicators of health, literacy (especially for females), and gender equality. Whereas the Kabila government would make major inroads in infrastructure toward the end of the decade, thanks to the Sino-Congolese agreement, it invested little to bring up the standards for the health and education of the population.

Prolonged armed conflict in the east brought another problem into focus: sexual and gender-based violence (SGBV). Although by no means limited to the DRC, the presence of rebels and other groups led to indescribable violence against women, most frequently in the form of rape. Legislation in 2006 attempted to address this issue, but laws passed in Kinshasa had little impact on the actions of undisciplined militants a thousand miles away.[19]

In the wake of the 2006 democratic elections, the international community cautiously reengaged with the DRC, gradually shifting from humanitarian assistance to developmental projects. International NGOs swept in to support health and education work to fill the void left by the government. Van Reybrouk argues that Kabila consciously underfunded health, education, and agriculture, knowing the international NGO community would fill the gap.[20]

These broad trends in the decade of the 2000s had direct implications for family planning in multiple ways. The government was at best distracted by the

prolonged armed conflict in the east, at worst unwilling to prioritize health, much less family planning. The inability to circulate freely in the four eastern provinces until 2006 created major logistic and security issues that hampered project implementation in those areas. And the continued struggle simply to survive made it hard for women to "plan" for their future; their more immediate concern was providing even a single meal a day to their children.

The willingness of international donors to engage with the DRC in the wake of the 2006 presidential elections gave new impetus to the development work in the country. For this reason, the narrative on the evolution of family planning in the 2000s (this chapter) begins with the situation early in the decade, then pivots later in the chapter to the situation in the second half of the decade.

UNFPA poised for leadership as the country reopens

In contrast to USAID which pulled out of the country after the 1991 pillage, UNFPA (United Nations Population Fund) kept its offices open, albeit with a skeleton staff. By 1996 they had posted a new representative Mme. Tamany Safir, an Algerian, and they were poised to revive activity to the extent possible in a very politically turbulent environment. From 1991–2001 UNFPA did not have a formal program for family planning, as it did from 1986–90. Rather, as of 2000, it was still funding relatively small, one-off activities such as scholarships for women and support for the Day of the Woman.[21]

Yet the pace of activity would increase in 2001 with the arrival of a new representative, Mr. Pierre Fokom. He wasted no time in spearheading two initiatives. The first was to develop a program aimed to reduce maternal mortality and increase contraceptive use. The second was to establish regional offices.

In the wake of the 1994 Cairo Conference, reducing maternal mortality became a major driver for family planning programming in countries worldwide, particularly in DRC. The case was even more compelling given the results of the 1998 study coordinated by the Kinshasa School of Public Health showing the maternal mortality ratio in the DRC to be 1,837 maternal deaths per 100,000 live births, the highest reported for any country at the time.[22] Also, preventing the death of a mother was far more culturally acceptable and politically palatable than limiting – or even spacing – births in a strongly pronatalist society. This program also included an emphasis on gender, HIV/AIDS prevention, and the role of population in development.[23]

Soon after his arrival, Pierre Fokom contracted with three well-respected demographers to develop a new strategy for addressing reproductive health in the country: Prof. Ngondo Seraphine and Prof. Nzita Kikhela Denis, both from the University of Kinshasa; and Mr. Mbadu Muanda Fidèle, Deputy Director at PNND/PNSR (National Program of Desirable Births/National Program for Reproductive Health). The report from their consultation provided a comprehensive overview of population/demography, gender, and youth, which informed UNFPA's funding decisions for the early 2000s.

UNFPA was not timid in defining its leadership role in reproductive health at the start of the 2000s. In the Second UNFPA Plan for Development Assistance in

the DRC: 2002–06, UNFPA claimed to be "so far the only partner of the DRC familiar with the specific population problems of the DRC and [that] has worked tirelessly with some success to promote national awareness of the existence of close links between population and the development process." In terms of comparative advantage, it cited its familiarity with the process of incorporating demographic trends into development plans and its work in elevating the legal status of women. In the field of health, UNFPA described itself as the main partner of the DRC addressing reproductive health using a holistic, life cycle approach, including interventions specific to the growing needs of adolescents in the country. Also mentioned was its role as the main supplier of contraceptives other than condoms, to meet the enormous and growing need in the DRC. Its regional multi-disciplinary teams were ready to provide technical assistance, and its management tools (for example, the logic framework) would facilitate participation by national counterparts.

Pierre Fokom set out to match these bold claims with action. The second UNFPA program in the DRC, which ran from 2002–06 (and was later extended to 2007) had a budget of $30M. In 2002, UNFPA established "antenna" offices in the seven provinces that were under the government's control: Kinshasa, Equateur, Bandundu, Bas-Congo, Katanga, Kasaï Oriental, and Kasaï Occidental.[24] UNFPA recruited a *chef d'antenne* (office director) in each province, to liaise with the Provincial Health Office (DPS, *Direction provinciale de la santé*) and Provincial Department of Plan (DPP). In each of the seven provinces, UNFPA supported two health zones: one in the provincial capital and a second in a rural area with poor health indicators. The support went to training service providers, rebuilding maternity wards, and providing equipment and supplies, including contraceptives. Most activities were implemented in government health facilities based on an annual workplan, at times in collaboration with ABEF (the Association of Family Wellbeing).

Dr. Jose Bora, the *chef d'antenne* in Bandundu, recalls that their educational outreach activities were generally well received in the local community, although the Catholics did not condone artificial methods. She recounts an instance when the team went to a military camp to talk with the wives. One of the military brasses welcomed her with the comment, "You arrived too late. Where were you when all those kids were being born at my house?"

With these initiatives in full swing, Pierre Fokom traveled to Brussels on business in February 2002. To the shock and sadness of all concerned, he unexpectedly died on this trip. Mr. Cheikh Tidiane Cisse stepped in as interim representative, while UNFPA recruited its next representative.

In 2003, Mr. Sidiki Coulibaly took over as representative, bringing with him renewed energy. He inherited the sizable budget that Fokom had secured from headquarters in New York, to which he added additional resources from Belgium and Canada. In contrast to Fokom's emphasis on reproductive health, Coulibaly redirected a major portion of the UNFPA portfolio to SBGV in the war-torn eastern region of the country. By 2006, the DRC government took back control of the four provinces in the east, and UNFPA opened offices in Orientale,

Maniema, North and South Kivu, for a total of 11 provincial offices, in addition to its headquarters in Kinshasa.

One of UNFPA's major contributions was to sign a five-million dollar, five-year project with PNSR in 2003 for reducing maternal mortality.

Programming for adolescents and youth was also gaining momentum in the wake of the Cairo Conference. UNFPA was one of the early supporters of DRC. In 2004 UNFPA hired Dr. Théophile Nemuandjare to lead a new program on sexual and reproductive health for adolescents and young people. In 2005, it awarded the recently established *Programme national de santé de l'adolescent* (PNSA) a contract for four million dollars for the establishment of three youth centers. In retrospect, this support to adolescent programming was nothing short of radical at a time when the country's political and religious leaders clung to the Christian ideal of purity for young women.

According to Dr. Jean-Claude Kamanda, one of the first *chefs d'antenne*, 2002–07 were the glory years for UNFPA in DRC. It had strong leadership, a healthy budget, and collaborative partner organizations to advance family planning. The agency had over 100 staff between its headquarters in Kinshasa and the six provincial offices, and each office had a staff member assigned to reproductive health. Yet Kamanda cited a problem that might not be readily evident to outside observers. Family planning was not a "paying business" for the health facilities providing it. In contrast to the fees that patients would pay for the delivery of a baby or the treatment of disease, family planning clients paid little or nothing for their contraception. There was little motivation to prioritize family planning.

Box 7.1 UNFPA's partnership with Gécamines

In September 2001, Pierre Fokom recruited Mr. Jean-Claude Kamanda in the role of *chef d'antenne* in Lubumbashi, the second largest city in the country. Once there, Kamanda considered possible partners: Gécamines (the mining company), SNCC (the railroad), and Tabac-Congo (cigarettes). Both PNSR and ABEF had offices in Lubumbashi. The PNSR regional coordinator even gave Kamanda his own office as a base of operations, complete with a depot and conference room.

Gécamines was an interesting case, being the most prosperous mining company in the country. For 85 years (1906–1991), Gécamines – previously *Union minière de Haut-Katanga* – was the main employer in the province of Katanga and the main contributor to foreign exchange in the country. It provided its workforce (numbering close to 25,000 in the late 1980s) with cradle-to-grave education, healthcare for family members, monthly food distribution, housing, water and electricity, recreational activities, retirement packages, and free burials. The monthly food ration was based on the number of children, thus incentivizing large families.[25] The company needed a strong work force, and large families were the societal norm. What greater

pride for a mother than to parade around on a Sunday with her ten children in tow, all supported by Gécamines.

But in 1991 with the collapse of the concessionary mines and the devastation from the first pillage, this system broke down. Gécamines production fell off significantly, bringing down other industries with it. The company could no longer provide these generous social benefits, and it began to realize the burden of large families on its workers.[26] When Kamanda arrived in Lubumbashi, he worked with ABEF and Gécamines staff to develop a program for the company. The PNSR would be responsible for supervising its implementation. Gécamines needed contraceptive products and refresher training for its staff in family planning service delivery. For demand creation, they recruited a local folkloric group, Zembela, to incorporate a pro-family planning message into the theater dramas that they performed around town.

Few Zairian workers lived as well as those employed by Gécamines before the fall. But this sad tale illustrates how external conditions came to affect the number of children a family could care for, and how couples previously uninterested in family planning faced a new reality.

According to UNFPA, the second program (2002–07) succeeded in improving the technical and managerial capacity of national partners and in developing policies in key areas (reduction of maternal mortality, contraceptive security, and adolescent reproductive health). It also rebuilt, equipped, and/or supplied 171 maternity centers, as well as establishing four youth centers. But it was not without problems. This work occurred against the backdrop of prolonged armed conflict. The country had a limited number of banks and frequent shortages of cash. Implementing agencies experienced problems in correctly utilizing UNFPA's procedures for project execution, and coordination of joint programs proved challenging.[27]

USAID reopens in the DRC

USAID/DRC had reopened for business in 1999. Health was a priority. Dr. Reggie Hawkins, previously with the CDC, had come on board to oversee its vaccination activities. In April 2000 he interviewed Dr. Lina Piripiri, a recently minted PhD from the Tulane School of Public Health and Tropical Medicine, for a full-time position in health. At the end of the interview, he asked: "Can you start tomorrow?" She appeared for duty the next day to begin what would become a two-decade career working in maternal child health at USAID. She recounts that when she arrived, "there was nothing, no division of health or education." The former technical divisions had closed in 1991.

New to USAID, Reggie and Lina took a self-administered crash course in USAID policies and procedures. Lina recalls burrowing through boxes of papers. Overwhelmed by the sheer volume of documents, Reggie told her to look for a secretary. Lina had recently met a woman who spoke good English and was serving as a translator, Amina Kayangambi. They hired her on the spot. "You are the

secretary, here is your computer." Together, the three of them formed a nucleus that would reconstruct the office of health. In those early days, the USAID staff was so small that they would regularly have lunch in the office with the acting mission director, Janet Schulman.

One of their early actions was to visit the minister of health to reestablish their presence in the country and determine his priorities. After a decade of inactivity, everything was a priority. "It was exhausting," recalls Lina. Hawkins proceeded to hire three other Congolese as technical specialists in HIV/AIDS (Dr. Nzila Nzilambi), malaria/TB (Dr. Emile Bongo), and water/sanitation (Dr. Baudouin Makasi), as well as a deputy director, Nancy Bolan.

Larry Sthreshley, a Presbyterian Church USA missionary, lost no time in knocking on USAID's door, with a request to mission director Ron Harvey for funding to reinstate SANRU (Basic Rural Health project). Harvey conferred with personnel from the Washington DC office, which resulted in a trip by Franklin Baer to the DRC in June 2000 to assess the feasibility of restarting a SANRU III project. In collaboration with Larry and Leon Kintaudi (Medical director of ECC – Church of Christ of Congo), they developed three possible scenarios for SANRU III: for $10M, $15M, and $25M.[28] Ron Harvey immediately opted for $25M for a project that would run from 2001–06, to be managed by ECC with funding channeled through Interchurch Medical Assistance (IMA). IMA then recruited Larry Sthreshley and Bill Clemmer – seconded by their respective churches – to help manage the SANRU III project.[29]

Ambassador Bill Swing felt strongly that USAID needed to extend its support across the country (not favor one region or province). SANRU III established a network based on 56 church-run health zones, with a cluster in every province. This geographically scattered pattern of health zones proved logistically challenging, as did working in parts of the country under the control of rebel groups. The Brooke amendment prohibited direct funding to the DRC government, but SANRU's partnership with church-run health zones was acceptable.

The first year of SANRU III operated under USAID's Office of Foreign Disaster Assistance (OFDA) and supported 56 health zones, but it did not include family planning.[30] The following year, USAID/DRC took over the project, and in 2003–04 family planning was added, albeit gradually.[31] Dr. Marie-Claude Mbuyi, previously MCZ at Vanga, was tapped in 2003 to head SANRU's family planning work. "After years of interruption, it was necessary to start up slowly," she recalls.

These were still hard times. SANRU staff were arrested twice under different pretexts. The SANRU project director Bill Clemmer was surrounded by Bemba rebels on a field trip to Nord Ubangi. In another incident, a plane providing supplies to churches in the east and its pilot, Dan Carlson, were held for a week. These hair-raising incidents only enhanced IMA's reputation as a development agency able to function in a challenging, post-conflict environment.

Mr. Tony Gambino served as USAID mission director from 1999–2004. He had been heavily involved since 1997 in analyzing the situation in the country, assessing the need for humanitarian assistance, and advising on strategy to reengage with the new Kabila government. When Gambino arrived in 1999, USAID/

DRC had only 30 staff, and it was a "no dependents" post. By the time he left, there were over 100 and dependents were allowed. According to Gambino, by 2004 the mission had returned to normal.

PNND struggles to deliver on its mandate

At the start of the 2000s, the PNND was still working to regain its footing after the lean years of the 1990s. Without USAID or another permanent source of funding, it depended on the government to pay salaries but had little in the way of operating expenses to run a national program. In the previous four years (1996–99), it had four different directors. The revolving door of leadership would continue from 2001–2007, with six different directors: Kwanzaka Izanza (interim), Mbotama Cecile, Tsheke Koy, Musuamba Mutombo Gertrude, Mandu Ekasi (interim), and Nzila Nzilambi.

Despite the financial and managerial difficulties, one positive activity was an agreement signed between UNFPA and the ministry of health (MOH) for "Support to Strengthen the Institutional Capacity of the ministry of health in the area of Reproductive Health" (RDC/01, known locally as "P-01"). This $480,822 project, executed through WHO, would run for 18 months. The purpose was to develop consensus for a national reproductive health policy, previously developed in 1999 by Dr Victor Muela, Mbadu Muanda, and Dr. Lina Piripiri, as well as to strengthen the technical capacity of MOH personnel in reproductive health. The P-01 project was seen as a means of reenergizing the PNND and clarifying its mission.

Dr. Victor Muela was selected as the lead consultant, charged with creating awareness and promoting buy-in to the draft reproductive health policy. Accompanied by PNND staff, Dr. Muela traveled across the country, organizing workshops with doctors, university professors, sociologists, anthropologists, members of civil society, and others to explain the contents of the policy. This activity was limited to the seven provinces under the control of the Kabila government, thus excluding the four eastern rebel-held provinces.

As a result of this work, in December 2001 the government established the (PNSR, National Program for Reproductive Health), under ministerial order number 1250/CAB/MINI/S/AJ/KIZ/009/2001 to replace the PNND. The PNSR was reorganized under nine services (departments), with the priority focus on reducing maternal mortality and increasing contraceptive use. The PNSR revitalized coordination offices in the 11 provinces of the DRC.[32] It hired back several well-known actors as division chiefs: Emmanuel Buhendwa (training), Mbadu Muanda (operations research), and Bitshi Mukengeshayi (supervision). But it was still operating in a war-torn country with limited resources.

PNSR got a new lease of life when in December 2003, UNFPA awarded it a five-year, five-million dollar project (ZAI/02/01/07–02/P07), making PNSR its major implementing agency for reproductive health. It was designed to enhance capacity-building and program operations in the seven provinces under government control, including Kinshasa. It also funded the production of communication materials, and it supplied PNSR with contraceptive commodities.[33]

Whereas this program gave a tremendous boost to safe motherhood initiatives, some complained that it gave too little emphasis to family planning. Those who had worked for years or decades under PSND/PNND/PNSR claimed that allocating human and financial resources to the multiple components of reproductive health diluted the historic focus on family planning. Mr. Bitshi was among the critics but circumvented this shortcoming by including family planning in the modules to be used for training providers countrywide. Later, the program ran into problems when there were insufficient stocks of contraceptives available to use in these training sessions.

With support from UNFPA, PNSR focused attention on a "new" aspect of family planning programming: contraceptive logistics and supply chain management. Although the problem of forecasting correct quantities of products, importing them, and distributing them to facilities across the country had always been a challenge in the Congo, the international family planning community was giving renewed attention to this set of problems under the catchphrase of "contraceptive security." In 2003, the MOH assigned Mme. Leonie Bola, the first female Congolese pharmacist trained in Belgium, to oversee the Office of Reproductive Health Commodities at PNSR. A 2003 situation analysis revealed problems at every level of the supply chain in the seven provinces where PNSR was operating and resulted in a strategic plan to address them.

Several problems surfaced in the UNFPA/PNSR relationship during the early 2000s. Financial management of the UNFPA funds intended for PNSR work in the provinces proved problematic. Audits showed periodic financial irregularities in the funds deposited in PNSR's central account but intended for the provinces. After several years, UNFPA switched to channeling its funding through the bank accounts of government authorities in each province. Within a year the auditors found similar financial irregularities with that system. UNFPA then reverted to a system of cost-reimbursement of specific activities, which persists to this day.

A second problem involved tensions over the management of project activities. Several years into the new agreement, some PNSR staff charged that UNFPA was attempting to implement the projects, not just fund them. When confronted with administrative transactions he was unwilling to accept, the widely respected Dr. Tsheke resigned from his position as PNSR director. Yet despite these interagency tensions, UNFPA continued as the only major donor for PNSR during the 2000s.

PNSA is created

In the mid-1980s, while he was studying demography at the University of Kinshasa, Mr. Mbadu Muanda took a course on family planning from Dr. Miatudila Malonga. Given Mbadu's clear aptitude for the subject matter, Dr. Miatudila recommended that he specialize in this subject. It was one of the more fortuitous happenstances in the history of family planning in Zaïre/DRC.

Mbadu Muanda had served two non-consecutive terms as deputy director at PNND/PNSR (1995–97 and 2000–02). The minister of health at the time, Mashako Mamba, contacted Mbadu. "You shouldn't still just be deputy director

at PNSR." Rather, he was prepared to create a new adolescent health service for him to direct. Mbadu demurred. The minister replied, "If you refuse, I'm firing you." Mbadu immediately found his way to yes. The following day, Mbadu appeared at the ministry for a formal interview, and within an hour, the minister presented him with a decree (N° 1250/CAB/MIN/S/CJ/001/2003) establishing the *Programme national de la santé de l'adolescent* (PNSA, the National Program for Adolescent Health) and a ministerial decree naming him as director. It was January 2003.[34]

Mbadu was now a director without an office. He rented a small space near PRONANUT (the Nutrition Planning Center) for $50/month and proceeded to recruit for the five persons that the ministry had authorized for the new center. One important screening criterion: did the candidate approve of modern contraception?

Within two years, his staff grew to 20 and he moved to larger quarters at the municipal building (*commune*) in Kinshasa. They purchased a bus and branded it with "MOH – Project to Establish Youth Centers," further increasing the visibility of the project. Soon, Mbadu began to experience a problem common for program directors in the DRC. The minister or secretary general began to send people to be added to the payroll, regardless of the program's needs or the individuals' qualifications. Mbadu was able to stand firm against this practice in Kinshasa, but he found he had little control when it happened in other provinces. He redirected several physicians for further training at the Kinshasa School of Public Health, with scholarships from USAID.

ASF/PSI benefits from first mover advantage

Despite life-threatening insecurity and logistical hurdles, the ASF/PSI continued to collaborate in promoting *Prudence* throughout urban and peri-urban areas in the country. By 2000, brand awareness for *Prudence* was sky-high and sales were bustling. On June 23, 2000, ASF was officially registered in the DRC (certificate of registration 1255/30 0002), and on 10 December 2001, ministerial decree #064 conferred on ASF the legal status of NGO (*association sans but lucratif* or ASBL).[35] In 2001, ASF signed a formal agreement with PSI to become its implementation arm in the DRC. Whereas the funding flowed through PSI, ASF was the face of the team in the DRC.[36]

In late 2001, PSI sent Alison Malmqvist from headquarters to Kinshasa as family planning technical adviser to assist in this rapidly growing and increasingly complex operation. The family planning department had six people based in Kinshasa, who collaborated with ECC and ABEF to handle the rapid expansion of project activity throughout the country.

When USAID/DRC reopened its offices in the late 1990s, it did not yet have a full-time population officer. Yet by 2003, it was able to reengage in family planning by adding funding for family planning including contraceptive procurement to the existing global AIDSMARK project through a mission buy-in, without having to rebid a new project. ASF/PSI initially worked in Kinshasa, then quickly expanded to Bukavu and Lubumbashi, where they already had offices that worked

Figure 7.1 Basketball legend Dikembe Mutombo brings star power to ASF/PSI campaign; with Johnny Loftin (left) and U.S. embassy official (right)

in other areas of health. The first order of business was to retrain service providers and furnish them with equipment (e.g., beds), supplies for contraceptive service delivery, and contraceptives.[37]

The operation represented a tripartite partnership: ASF/PSI, the *Direction des pharmacies*, and the *Direction médicale*, with a strong mandate from USAID to focus on urban areas. Soon PSI brought on Gaby Kasongo and Mado Baintape, to head up communication and training, and Willy Kabonga as their specialist for pharmaceuticals. Malmqvist recalls the enthusiasm, dedication, and collaborative spirit among the actors working in family planning: the ASF/PSI staff, their government counterparts at PNSR, and colleagues from SANRU and ABEF.

ASF/PSI combined the social marketing approach with the franchise model, whereby they created a branded network of health facilities and pharmacies and distributed contraceptives through these network partners. They maintained the brand name *Prudence* for condoms and continued to partner with clinics and pharmacies. With new funding in 2004, they developed a network of products and services around the name *Confiance* (Confidence), borrowing from PSI branding in Côte d'Ivoire. Contraceptives imported in generic wrapping would be repackaged in colorful wrappers with attractive designs and the *Confiance* branding.[38] The product line would expand to include pills, injectables, IUDs, and Cycle-Beads. They also counseled on lactational amenorrhea (LAM) and permanent methods. More basically, they were exposing couples to the idea of planning for their desired number of children.

After training the service providers and pharmacists and providing them with the necessary equipment, supplies, and contraceptives, ASF/PSI would award them a blue-and-white metal sign that read *Confiance* to post on the outside of the facility. Service delivery work was complemented by a robust social behavior and communications initiative, which included both mass media work to raise awareness and interpersonal communication/community mobilization. To monitor quality, they used a mix of supportive supervision and mystery client interviews.

Thanks to a grant from DFID (the British development agency) for malaria in 2003, PSI piggybacked family planning on the distribution of anti-malarial bed nets. With additional USAID funding, ASF/PSI expanded to eight provinces: Nord Kivu, Maniema, Orientale, the two Kasaïs, Equateur, and Bandundu. By 2005, ASF/PSI was operating in all provinces except Bandundu, in one to three urban areas per province (usually the largest cities). Because of funding constraints, ASF/PSI could not answer requests for expansion into other urban areas or into rural areas.

ASF/PSI collaborated with Pathfinder to train providers from multiple agencies – PNSR (national and provincial), ECC, and ABEF, as well as their own staff – in family planning and youth-friendly services. They also supported PNSR in updating family planning training materials.

Box 7.2 Life's little challenges

If these were heady times, they were fraught with difficulties over logistics and security. In the eastern provinces, rebels terrorized the local population and hindered development work. Although different rebel groups operated in the region, people tended to lump them together as "the Mai Mai."[39] Air travel was greatly limited. PSI and most of the international community relied on UN flights that crisscrossed the country, making multiple stops along the way and taking on passengers on a standby basis according to a priority list (diplomats and UN personnel first). A passenger with lower status might get on board for the first segment of the trip, only to get bumped in a small town with no hotel en route to their final destination. Despite its relative isolation from much of the country, contraceptives were generally imported only via Kinshasa, posing enormous logistical challenges to ASF/PSI to ship contraceptives from the PSI warehouse in Kinshasa to its regional offices.

To complicate matters, the country ran on a cash economy. Whereas organizations could have bank accounts, individuals could not.[40] It meant keeping enormous amounts of cash in the office and paying staff their salaries in blocks of Congolese francs. By the mid-2000s, ASF/PSI began paying their staff in dollars. Later, when the country authorized bank accounts for individuals, they paid salaries through this mechanism, though some staff remained distrustful of banks.

In late 2002, PSI relocated Alison Malmqvist to Goma, where she became the de facto PSI regional director for eastern Congo. The political situation remained very tense. Child soldiers would stroll down the main street with rocket launchers casually slung over their shoulders. The multiple NGOs working in Goma would have weekly meetings to exchange information on logistics, programmatic issues, and security conditions. In one such meeting in 2004, the meeting was interrupted by the cacophony of buzzing cellphones. Everyone had received the same message: "The rebels just attacked the market." As the market in Goma went up in flames, UN forces swooped in for a mass evacuation.

Dr. Bugini Nikita Robert recalls being recruited to work with ASF in South Kivu. He had learned little about family planning in medical school, nor did the *Hôpital general de Baguira* that he directed offer contraception. Rather, he received his first training in 2002 during a 28-day workshop conducted by ASF, after which he integrated family planning into his hospital and one other facility. When in 2004 he was named MCZ, he faced the larger challenge of incorporating family planning into health services for his health zone. To make the idea of paying for contraception more palatable to the local population, his staff would compare the price of a package of pills or an injection to one Fanta soft drink, and an IUD to a bottle of beer. In 2005, Dr. Robert would go on to become the PNSR coordinator for S. Kivu (a position he still holds today).

Box 7.3 "Get me to the church on time…"

Despite the insecurity of their environment, ASF/PSI plowed ahead with their activities. Malmqvist recalls the time when PSI needed to conduct both quantitative and qualitative research on its projects in the field. For this task, it sent its recently hired research director from Kinshasa to the rural town of Kindu (province of Maniema). Nicolas, the new staff member, was young and eager to get his feet wet with actual fieldwork, but he was worried. He was due to get married the week after his scheduled return to Kinshasa. Malmqvist assured him that she would get him back in time for his wedding.

As they prepared for the data collection, the Mai Mai invaded Kindu and set the UN buildings on fire. The PSI team took shelter in a monastery nearby, then Malmqvist got word to AirServe (the local private plane company servicing their trip) to evacuate them. By then several rebel groups had taken over the airstrips in Kindu. The PSI team found someone with a pickup truck to drive them to the airstrip; they hid under tarps in the bed of the pickup to avoid detection. Although soldiers were milling around the airstrip, AirServe was able to land. The PSI team raced from the pickup to the plane, which managed to take off before the soldiers could figure out what happened. It had been a harrowing experience for all concerned, but Nicolas made it home in time for his wedding.

Claude Disuemi, by then the social marketing sales and marketing manager, recalls one of their major challenges as selling condoms on the local market when other organizations (such as UNFPA and ABEF) were giving them away free of

charge. This problem was by no means unique to the DRC. They had to hope that their attractive packaging and creative advertising would convince potential users that *Confiance* products were of greater quality than condoms distributed free of charge by other organizations. Given the number of "knock-off" (fake) drugs and the proliferation of unfamiliar brands on the local market, *Confiance* gave users the assurance of getting the real thing.

When Jen Pope took over as PSI family planning technical adviser in 2005, she was struck by the lack of knowledge of contraceptive methods (besides condoms) in many parts of the country. When she would ask women what contraceptive methods they knew of the answer was often "none." Others mentioned Serena, which was the brand name for ASF's anti-malarial bed net, which they described as a barrier method. Also problematic, women who had fled Rwanda into the eastern DRC with implants or IUDs needed them removed, but the service providers in the DRC lacked the training to do so. At the time, many facilities lacked electricity and running water.

Yet it was an exciting time for those working on the front lines. There was so much to do, few organizations to do it, and far too few resources to meet the tremendous need. The country was struggling against massive problems, but in response, the service delivery partners working in family planning – ASF/PSI, SANRU, and ABEF – banded together in a pact of mutual assistance. The difficulties of operating in this environment created resilience among the staff and a can-do attitude that was special to that time. Commented Malmqvist, "If you needed a photocopy in the rainforest outside Kisangani, someone figured out how to hook up the photocopier to a car battery to make it happen." These years brought out the best in people.

ABEF perseveres

By 2002, ABEF had four provincial offices: Kinshasa, Bas-Congo (formerly Bas Zaïre), Bandundu, and Katanga. At this time, their "niche" areas were community-based distribution of non-clinical contraception and information-education-communication. They also had experience in counseling and community education for HIV/AIDS prevention.

UNFPA signed a three-year agreement for $154,900 with ABEF in June 2002 as part of a larger contract to support NGOs. ABEF continued to function with financial support from IPPF/Nairobi for salaries and small projects, as well as donations of contraceptives from UNFPA, for most of the 2000s. Yet in 2008–09, problems of financial management reemerged. Blame was cast on the volunteers, a large group that could influence decision-making, including financial decision-making, of the organization. Once again, ABEF was dragged down by the *mauvaise gestion* (poor management).

First National Conference to Reposition Family Planning held in 2004

Starting in the late 1990s and continuing into the 2000s, global health funding shifted dramatically to address emerging and reemerging epidemics, including

HIV/AIDS, malaria, and tuberculosis. Because of the urgency and levels of funding going to HIV/AIDS, the international family planning community was feeling underfunded and overlooked. In 2002, the USAID centrally funded project Advance Africa started working with the WHO/Africa regional office on a strategy to counter this shift and increase visibility for family

Figure 7.2 Pharmacy of hope, 2008, Equateur Province

planning. This collaboration led to the concept of repositioning family planning by revitalizing programs and ensuring a comprehensive approach to maternal and child health. Mozambique was the first to hold a repositioning workshop. DRC was the second.[41]

The first National Conference to Reposition Family Planning took place in 2004 under the auspices of the MOH, at the *Centre Catholique Nganda* on May 13–14, 2004, with over 150 participants in attendance. Advance Africa, directed by a Senegalese Dr. Issaka Diallo, provided technical assistance to the event.[42] Diallo enlisted Dr. Nlandu Mangani, the first director of PRODEF in Bas Zaïre, as a facilitator. UNFPA supported PNSR to play a major role in the conference, under Dr. Tsheke's leadership.

The conference issued a set of recommendations, including the importance of establishing an interagency committee of family planning stakeholders to monitor progress in carrying out the conference recommendations.[43] Given the difficult times, it is not surprising that little follow-up action was taken. With the significant setbacks to family planning in the 1990s and the limited number of organizations working in family planning in the early 2000s, it was laudable that there was a conference at all.

Political changes mid-decade brings new energy and resources to family planning

With a constitution and a legitimate presidential election in 2006, the international community became more willing to reengage in development work in the DRC.

By the second half of the decade, DRC had two main family planning donors, UNFPA and USAID; two government agencies operating in the realm of sexual and reproductive health: PNSR and PNSA; and three main service delivery projects: ASF/PSI that managed the Contraceptive Social Marketing/*Confiance* network in urban and peri-urban areas, AXxes supporting rural health zones, and ABEF in four provinces.

As the country began to inch back toward normalcy, family planning work gained increasing traction. New leadership at USAID and later at UNFPA contributed to an expanded portfolio of family planning work. The British DFID (later renamed FCDO) started to support efforts to reduce maternal mortality. The conduct of the first-ever DHS in 2007–08 provided greatly needed data to inform programming. And a Second National Conference on Family Planning in 2009 brought further visibility to this work.

With a new Population Officer, USAID/DRC sharpens its focus on family planning

By 2006, USAID/DRC had expanded its office of health in terms of the number of staff and levels of funding. Yet it still did not have a specialist in family planning. Using more formalized recruitment processes than were in place in 2000, USAID hired a population officer, Dr. Thibaut Mukaba. A physician by training, Thibaut

had worked in a wide range of health areas (HIV, water and sanitation, and maternal child health) and most recently and most recently mpox, known at the time as monkeypox. He also received his MPH from KSPH in 2004. Much as he liked his previous jobs, USAID provided the opportunity to get back into development and have a positive impact on people.

During his first years on the job, Mukaba participated in a joint annual review with the minister of health, in which maternal mortality was on the agenda. USAID offered to take the lead in family planning as one strategy for reducing maternal mortality. The minister of health gave nodding approval to family planning, encouraged that the donors were willing to return to the reputationally-challenged DRC. Given US regulations, USAID/DRC could not directly fund a government agency such as PNSR. Rather, Thibaut began to develop a portfolio of family planning activities through alternative mechanisms.

When Thibaut arrived in 2006, USAID/DRC had just rebid and (again) awarded the follow-on flagship project in integrated rural health to IMA World Health, with its partners ECC, Catholic Relief Services, and World Vision. Under the new name AXxes (the Integrated Health Services Project), the four-year, $60M project was designed to revitalize primary healthcare systems including family planning in 57 health zones in Kasaï, South Kivu, and Maniema provinces. It would run from 2006–11. Like its SANRU predecessors, the project worked on a broad range of health problems/areas. Yet family planning – named as a "key objective" of the project – had somewhat higher visibility than in the previous rounds of SANRU. The job was easier in health zones where SANRU had worked previously than in those where family planning was a new concept and there was little demand for it.[44]

With Dr. Marie-Claude Mbuyi continuing as the point person for family planning, AXxes worked to generate demand for family planning. In addition to providing the usual training, equipment and supplies, and contraceptives to health facilities in participating health zones, AXxes expanded into the community. In each health zone, they worked through community organizations – churches, women's organizations, youth clubs, men's groups – and identified a focal point for family planning. These leaders were trained and encouraged to integrate messages about family planning into their other activities. Each leader figured out what worked best for their circumstances, and the network of leaders helped all to approach the topic more boldly.

AXxes succeeded in increasing the number of new acceptors from 26,000 in year one to over 283,000 in year four. Much of the increase in family planning uptake corresponded to natural methods (lactational amenorrhea and fertility awareness methods). However, AXxes also introduced pills, condoms, Depo-Provera, and CycleBeads into communities across the country and met its targets on these methods. In Catholic facilities, providers could not promote modern methods themselves but were often willing to refer interested clients to services that would. The two major challenges for AXxes were ensuring a reliable supply of commodities in these remote facilities and contending with

socio-cultural barriers, such as the prestige of having a large number of children and the need for a partner's consent for family planning.[45]

Congolese staff who worked on both SANRU III and AXxes described the similarities between the two projects. Both focused on service delivery primarily through local health facilities; social marketing would come later. In both projects, the major challenge for family planning was community acceptance. Local communities still perceived family planning as a program to limit births – or even slow down the pace of childbearing. Dr. Adrien Nsiala explained that in this pronatalist society, "The purpose of marriage was to produce children, and if the wife didn't have a lot, there was a problem." Dr. Benoit Mibulumukina, who worked at the field level in both projects, described the highly patriarchal attitudes toward family planning. Husbands suspected that their wives might be unfaithful to them if they used contraception, and worse still if they tried to do so in secret. Women who used contraceptives were looked down upon as "easy." Whereas high parity women might have wanted to "take a rest" (between births), men tended to oppose contraception. And in those days and in that geographical context, husbands had to give their consent to their wives' using family planning.

Box 7.4 From SANRU III to AXxes: the sad fate of Vanga

In the transition from one donor-supported project to the next, certain health zones may be added, others dropped. Vanga provides a sorry tale of the negative effects that can occur when a previously supported health zone (under SANRU III) is excluded from the follow-on project (AXxes). The benefits of SANRU III became painfully evident when that support was withdrawn.

Mme. Alice Adombo – the pioneering nurse promoting family planning at Vanga in the 1970s – was witness to this transformation. Vanga had been the model of excellence for primary healthcare delivery in rural areas in the 1970s and 1980s. SANRU III ended, and Vanga was not included in the follow-on project, AXxes. Simultaneously, there was a change in management of the health zone that brought a decline in primary healthcare across the board. Mme. Alice – still managing the pharmacy at Vanga in 2022 – lamented that since the end of SANRU III, Vanga had experienced a shortage of contraceptives that continues to the present day. Those familiar with its storied past are left to wonder: in what world does Vanga – once synonymous with the best rural healthcare in the country – not have an adequate supply of contraceptives in stock?

In 2007, Thibaut organized a partners' group, consisting of the PNSR and agencies that received funding for family planning from USAID. At the start, this group of implementing partners included ASF/PSI, IMA, and Care International. Staff of other centrally funded projects would join before the end of the decade.

Thibaut was able to tap into the USAID mechanism of centrally funded projects to further strengthen family planning in the DRC. Such projects were funded by the USAID/DRC mission but benefited from the specialized expertise of organizations that were pre-qualified through competitive bidding in Washington, DC.

One such project was the DHS, on which USAID was one of multiple donors.[46] Mukaba arrived at USAID/DRC in time to join in the planning of the first national population-based survey that would provide data on many health topics, including family planning. Paradoxically, previous USAID project documents had specified the family planning objective in terms of increased modern contraceptive use, but until the 2007–08 DHS, there had never been a DHS conducted in the DRC to measure contraceptive prevalence.

USAID tasked Macro International under the DHS central mechanism to provide technical assistance to the National Institute of Statistics and help coordinate the DHS rollout under the leadership of the DRC Ministry of Plan. The data collection teams that deployed countrywide needed several months to complete the task.

In 2009, the results of the first DHS in the DRC became available, bringing the DRC out of "data darkness" vis-à-vis family planning. Almost overnight, the country went from dependence on small-scale studies and anecdotal evidence to having national family planning data available for strategic planning.

Figure 7.3 Meeting at USAID (2007): Left to right: Claude Disuemi, Arsene Binanga, Thibaut Mukaba, Jennifer Pope, Pelagic Saraza, François Kitenge, Ellen Lynch, Gisele Kasungi, and Marie-Claude Mbuyi

Of key interest, the DHS showed that only 5.8% of married women of reproductive age were using a modern contraceptive method. This finding put the DRC in the range of most francophone sub-Saharan African countries, but far below the countries with available data in Latin America (65%) or Asia (62%).[47] It revealed great disparities between Kinshasa (and some provinces in the east), in comparison to negligible use in much of the country. Among the rare users of modern contraception in the DRC, the leading methods were condoms and pills.[48]

Box 7.5 Chaos erupts over the reported decline in maternal mortality

DHS researchers presented the highlights of the 2007–08 DHS to an audience of more than 100 people attending the dissemination meeting at the Centre Nganda. Donors, program managers, and policy makers were eager to have updated, reliable national-level data on family planning and other health indicators for program planning purposes.. The sessions proceeded with the usual, fairly academic rendition of findings.

Midway through the program, one of the researchers presented the results for maternal mortality, announcing that the DHS showed 1,237 deaths per 100,000 live births. The audience erupted in opposition. The widely quoted statistic for maternal mortality was 1,837 deaths per 100,000 live births, based on a 1998 study.[49] This new statistic would put the DRC even lower (less bad) than Niger with 1,500 maternal deaths per 100,000 live births. Livid with outrage, participants jumped out of their seats screaming, "You don't know your data. You have it wrong! We have the worst maternal mortality in the world!"

They were furious that this finding would deprive them of the dubious distinction of being the worst in the world in maternal mortality, a claim that was very useful for fundraising in this domain. Undeterred by new evidence, some continued to cite the 1998 report in their requests for funding.

******

Under Mukaba's watch, Georgetown's Institute for Reproductive Health (IRH) established a program to promote natural family planning methods in DRC. Whereas mainstream family planning specialists often denigrated natural methods as being ineffective, a new fertility awareness method emerged in 2000 that promised to be more effective and more user-friendly. The Standard Days Method (SDM) – also known as CycleBeads – identified a 12-day fertile window during which women with regular menstrual cycles (26–32 days long) should abstain from sex or use a barrier method to prevent pregnancy. The MOH supported the introduction of SDM, which aligned well with the proclivity of women in the DRC to rely on natural methods.[50]

In 2008 IRH hired a young doctor, Arsene Binanga, to serve as their country representative. His job was to introduce program managers and service providers nationwide to CycleBeads and encourage them to incorporate this new method into existing family planning services. IRH subcontracted to ASF for the branding for CycleBeads, which was then incorporated into their *Confiance* product line. During this five-year project, Dr. Binanga succeeded in incorporating CycleBeads in over 250 different facilities, based on his persistence in advocating this new method to decision-makers at the central and provincial levels. IRH sent far more CycleBeads to DRC than to any of its other country programs. Because Arsene's position required him to knock on the doors of every family planning agency in the DRC and many service providers, he developed a network of contacts that would serve him well for the leadership role he would play during the next decade.

******

Another USAID centrally funded project that brought its expertise to the DRC in the 2000s was DELIVER, managed by John Snow Inc (JSI). The DELIVER project operated in 65 countries worldwide to strengthen contraceptive security and improve logistical systems for distributing commodities nationwide.[51] In the DRC, it joined forces with PNSR and UNFPA in 2004 to strengthen work that had begun earlier in the decade.

DELIVER provided technical assistance to an evaluation conducted in 2007 by the MOH of the first Strategic Plan for Contraceptive Security (2003–05). It identified the lack of a formal coordination mechanism among the different actors involved in family planning as a major shortcoming. As a result, PNSR – with technical assistance from the DELIVER project and financial support from UNFPA – established a contraceptive security working group that brought together representatives from the PNSR, UNFPA, USAID, and several governmental partners. It also developed a (second) Strategic Plan for Contraceptive Security (2008–2012).[52]

C-Change (Communication for Change)

C-Change – a clever play on words for "sea change," referring to a profound transformation – was USAID's prime vehicle for supporting behavior change communication activities in the DRC, from 2007–2015.[53] Originally managed by the Academy for Educational Development, the project provided technical assistance and support for a broad range of USAID communication and capacity-building activities in the DRC. In Kinshasa, it was USAID's most visible contractor for family planning work, although it also covered gender-based violence, water and sanitation, malaria, HIV prevention, and other areas of primary healthcare.

C-Change set up shop in Kinshasa in 2009, as the decade of the 2000s was coming to an end. The project brought Mme. Chirwisa (Flora) – former director of PSND in the 1980s – out of retirement from Bukavu to head up its family planning portfolio. As one of its first activities in family planning, C-Change

worked with PNSR, UNFPA, and others in organizing the Second Conference on Repositioning Family Planning in the DRC, held in December 2009.

UNFPA increases activity in the late 2000s

By 2006, UNFPA was operating at both the national level and through its 11 provincial offices. It continued to provide financial support to the PNSR and ABEF for maternal mortality/family planning and to the PNSA for sexual and reproductive health programming for youth and adolescents.[54]

Although much of family planning was couched in terms of reducing maternal mortality, UNFPA also remained active in the pioneering area of sexual and reproductive health for adolescents and youth. Dr. Théophile Nemuandjare was a key player in the creation of the African Youth and Adolescent Network (Afri-YAN) in Lusaka, Zambia, in 2005, and he participated in the General Assembly AfriYAN in Burkina Faso in 2008. Back at home, he supported the creation of a network of Adolescent and Young Congolese in Population and Development (*Réseau des Adolescents et Jeunes Congolais en Population et Développement*, RAJECOPOD) in 2006.

With branch offices in all 11 regions, UNFPA entered a phase where it became increasingly operational.[55] Its staff participated alongside PNSR staff in implementing activities according to a workplan. UNFPA would incentivize PNSR staff to gather and report on the service statistics from health facilities in the different regions and ensure that these statistics made it back to headquarters in Kinshasa. Frictions arose as some claimed that UNFPA had usurped the management of PNSR.

In 2008, UNFPA launched its third program in the DRC (2008–12), which sought to reduce poverty by improving access to high-quality reproductive health and HIV prevention services and by incorporating gender and population issues into sectoral development policies and programs. Whereas family planning was an important component of UNFPA, it was one of multiple aspects of reproductive health. Of some 24 output indicators in the results framework for this program, less than half linked directly to family planning.

With the departure of Sidiki Coulibaly in 2007, UNFPA/DRC experienced some serious road bumps. UNFPA headquarters in New York made a special appeal to Prof. Richard Dackam-Ngatchou, a Cameroonian, to assume the post of representative in the DRC and "rehabilitate" the UNFPA program in DRC, which was experiencing serious bottlenecks. When he arrived in 2009, he found its resources skewed toward SGBV. Also, UNFPA was expending vast sums of money to operate 11 provincial offices, with little to show for them. Dackam charted out UNFPA's immediate course: to provide some support to SGBV and the census but to redirect the focus primarily to reducing maternal mortality and promoting contraceptive use in defined health zones.

What Dackam found was a weak collaboration among the few organizations working in family planning. He envisioned UNFPA as the secretariat for actors in family planning. "*Tous les acteurs de PF sont les amis du FUNAP*," he touted. (All

actors working in family planning are friends of UNFPA.) At a time when few government officials spoke out in support of family planning, Dackam took every opportunity he could find to publicly promote its importance.

PNSR gains stable leadership

In late 2007, Dr. Marie Louise Mbo took over the reins at PNSR and remained in that position for seven years – one of the three directors in the history of PSND/PNND/PNSR to hold the position for that long (the other two being Mme. Chirwisa and Mr. Ngoie).

Dr. Mbo began her career after medical school as a clinician and she became the MCZ of the health zone of Kingabwa from 2002–07. In 2005–06, she got her MPH from the Kinshasa SPH, where she did her masters thesis on the determinants of maternal mortality in Kinshasa. She had always been interested in maternal child health, and she had experienced her personal obstetrical complications when she almost lost her life to an ectopic pregnancy. She was grateful to the people who saved her life and she wanted to help other women in return.

When she took over as director of PNSR in late 2007, she began by conducting a situational analysis of the causes of maternal mortality in DRC. She found qualified personnel and active partners, including UNFPA as a donor and ASF/PSI as an implementing partner. However, she identified a problem of coordination and management. At PNSR, she did not find any workplans, annual reports, trip reports, or minutes from meetings. The staff seemed to lack direction.

She did have the benefit of data from the DHS 2007–08, which had caused such a kerfuffle at the dissemination meeting. "All the reproductive health indicators from the DHS were red" (meaning, in an unacceptable range). The PNSR convened a meeting with other partners working in maternal mortality and family planning to see which partners could help. The result was an operational plan of action with fixed objectives to reduce maternal and child mortality. A series of *feuilles de routes* (roadmaps) were developed to chart the path. There was a call for greater collaboration among the partners working in this arena and increased contact with other ministries (including Gender, Plan, and Information). One of the first orders of business was to increase awareness of these problems through radio, TV, and other channels.

Although PNSR had gained a greater sense of mission and higher visibility under Dr. Mbo's leadership, some argued that the strong focus on safe motherhood diluted what should have been the principal focus of the PNSR: family planning. UNFPA would attempt to revive the emphasis on family planning with the arrival of its new representative, Richard Dackam, in 2009.

PNSR maintained its ties to *Conduite de la Fécondité*, the local NGO that promoted natural methods. Despite continued resistance of the Catholic Church to artificial methods, the PNSR and *Conduite de la Fécondité* worked in a complementary way.

Dr. Mbo cited multiple challenges during her tenure as director of PNSR: stockouts and expiration of contraceptive commodities, difficulty in managing the provincial offices from afar, the never-ending stream of clinical providers in need

of training, and incessant rumors that contraceptive methods caused cancer or sterility (not true but quick to circulate in local communities).

By the close of the decade, PNSR had some 90 staff on its payroll in Kinshasa, as well as seven to eight staff paid by the state in each of the 11 provinces.

PNSA launches youth-focused programming

In 2005 UNFPA awarded PNSA its first large project: four million dollars to establish three model youth centers: in Kinshasa, Matadi, and Bandundu.[56] The official launch took place in 2006 in the Youth Center of Matete. Mbadu and his team were eagerly preparing to begin this work, only to learn that the minister of health had decided to replace him as director – after Mbadu had mobilized the funds. The new PNSA director served for a year but was not up to the job. The minister of health that had removed Mbadu was not long for his position either, and his successor brought Mbadu back in March 2007 – exactly one year after his abrupt exodus. From 2007 to the current day, Mbadu Muanda has maintained his position as director of PNSA.

The experience of establishing youth centers in the DRC was like that of other developing countries: they were very expensive ($100,000 per center per year) without delivering the expected results. The WHO and PNSA agreed that the model was not sustainable. "It's like taking a Rolls Royce to Matadi when you can also get there by bus," observed Mbadu.

Instead, in 2007–08 they changed their approach to integrating youth services into existing health facilities in the health zones where they worked. They would create "youth corners" (*coins de jeunes*), where they would provide chairs and some materials, and where they could project films. The approach was further formalized when in 2009, the WHO came out with new guidelines, "Standards of health services adapted to adolescents and youth." Starting in 2009, they adapted these tools and introduced them into eight health zones in Kinshasa and Matadi (three funded by UNFPA, five by WHO).

These *coins de jeunes* were spaces within existing health facilities that opened their doors to adolescents and youth up to 24 years old on a pre-planned schedule, providing them a safe space to listen, learn, and discuss issues of importance to them, especially relating to sexual and reproductive health. The *coins de jeunes* also connected youth to a source of contraception, should they need it at the time or in the future, and it gave out free condoms. And they provided testing and referrals for treatment for HIV and other sexually transmitted diseases. The program encouraged these young people to actively participate in planning, conducting, and monitoring health-related activities. By the end of the decade, the PNSA had established some 150 *coins de jeunes* in ten provinces.

ASF/PSI struggle to keep pace with increased demand for family planning

By 2008, ASF/PSI had a staff of 40–50 in Kinshasa and another 150 in its regional offices, funded primarily by USAID. At the time, it was the major "nationally active"

service delivery program in the DRC, with offices in eight of eleven provinces. It still operated primarily in urban and peri-urban areas, using the combined social marketing/social franchise model under the umbrella branding of the *Confiance* network. Yet at the time that Jamaica Corker arrived in Kinshasa in 2008 as FP technical adviser at PSI, she felt that "we were still restarting [family planning in the DRC], picking up from where it left off 20 years ago."

By the late 2000s, ASF/PSI still faced major challenges. Although the largest family planning operation in the country, they still did not have sufficient resources to fully meet the needs of the population, even with a focus on urban areas. They constantly received requests that they were unable to fulfill to expand to new cities, and whereas their mandate from USAID was to focus on urban/peri-urban areas, the government was pressuring them to expand into rural areas. A nun from Kasaï once ended up on the Kinshasa office doorstep, pleading in a meeting with the FP team to give her contraceptives to take to the rural hospital where she worked. She had seen too many unwanted pregnancies and maternal deaths. USAID stipulated that ASF/PSI could only give contraceptives and equipment to pharmacies and health facilities within their social marketing/social franchise network, creating frustration for others seeking them.

A second problem was maintaining adequate levels of training and quality control. Whereas private health facilities paid relatively well and could retain personnel, the pharmacies had far greater staff turnover. Consequently, PSI revamped its initial three-day pharmacy training (expensive) into more frequent single-day training because – as Corker observed – "pharmacies were like a sieve."

A third challenge was the need to constantly replace equipment after years of use. Whereas earlier budgets had a line item to purchase and distribute equipment (for IUD insertions and later implants), these expensive purchases were often viewed only as start-up costs and subsequent budgets did not include funds for replacing them. Some clinics could only handle one to two IUD insertions a day because they did not have the additional capacity to sterilize the instruments or electricity to run the machines, leading to lost opportunities to provide services to women at high-demand clinics. With new Dutch government funding in 2009, PSI was able to replace critical FP equipment in its network clinics and expand its services to two additional provinces (Kasaï Oriental and Maniema), though it was still unable to keep up with contraceptive demand.

Box 7.6 Refusing to define "sufficient inventory" as a success story

It seems paradoxical to speak of the high demand for contraception in a country where such a small percentage of women wanted to use a modern method. Yet when one considers the total population of the country, the absolute numbers add up quickly.

Between 2007 and 2008, ASF/PSI increased the volume of injectables distributed from approximately 20,000 to 120,000. This caught the attention of the WHO, which in 2009 asked PSI if they could write a case study on

service delivery innovation and best practices related to this increase in injectable distribution. In discussions with PSI's headquarters on this request, Corker explained that there was nothing different that year around their approach to service delivery and that this was simply a result of a six-fold increase in injectables imported that year. She noted that providing 120,000 injectables was still a drop in the bucket for a country the size of DRC and expressed frustration at the limited amount of product the country had during those years. She added, "We could have distributed twice that amount if we'd had it," and declined to write up simply "having more product available" as an example of innovative service delivery.

Second National Conference on Repositioning Family Planning held in 2009

Five years after the First Conference to Reposition Family Planning in the DRC, the main actors in family planning – USAID, UNFPA, PNSR, PNSA, and implementing partners came together to organize the Second Conference.[57] It took place on December 8–9, 2009, at the Ministry of Foreign Affairs under the patronage of the First Lady Mme. Olive Lembe Kabila. The objectives of the conference were to expand family planning/reproductive health efforts; to create a cross-sectoral forum of government, donor agencies, and civil society to advance family planning programming and policy; and to garner necessary resources.

The government outlined its underlying rationale for promoting family planning: to reduce maternal mortality. The paths for revitalizing family planning included increasing coverage, developing an integrated communication program, ensuring a constant supply of contraceptives, advocating repealing unfavorable provisions of the law (e.g., the Law of 1920), and involving the community in its actions.

The organizers reviewed the recommendations that had been issued from the first national conference and concluded that none had been implemented. The recommendations of the second conference again called for the creation of a family planning stakeholder group. Although the Multisectoral Permanent Technical Committee (CTMP) did not become operational until three years later, this recommendation can be seen as the most consequential outcome of the conference. The CTMP would come to play a major role in bringing cohesion and coordination among the different donors, government programs, NGO and iNGO partners working in family planning.

Reflections on the decade of the 2000s

The decade of the 2000s was, at best, a struggle to return to normalcy for the DRC. After the assassination of Laurent-Désiré Kabila in 2001, hope surged that his son Joseph – appointed as his successor – would bring widespread systemic reforms and improve the quality of life for the average citizen. It did not materialize.

The tense political situation in DRC at the start of the new decade hampered but did not halt the resurgence of family planning programming in the DRC. In 2001, SANRU III came roaring back, reintroducing contraceptives to selected health zones across the country by 2003. In 2002, USAID/DRC funded ASF/PSI to incorporate family planning into its active HIV/AIDS prevention program, making it the largest service delivery operation in the country for the rest of the decade. UNFPA provided institutional support to PNSR and the newly established PNSA.

The difficulties of operating in this environment were immense. Kabila's government had control of the western provinces, but armed rebels controlled the east. The degradation of the transportation system across the country made the shipping of supplies a major challenge. Even during the difficult days of the 1980s, SANRU was able to get assistance and supplies to all regions of the country by boat, truck, or airplane. By the early 2000s, they had to use other entry points: Central African Republic for Equateur Province, Kenya for eastern Congo, and Zambia or South Africa for Katanga Province.[58]

In the second half of the decade, both USAID and UNFPA welcomed dynamic new leaders who intensified the focus on family planning in their respective agencies. PNSR regained stability in its leadership, and PSNA launched programming for youths and adolescents. USAID tapped into the specialized expertise of centrally funded projects – DHS, IRH, JSI, and C-Change – to work in specific areas. UNFPA through its global program UNFPA Supplies regularized contraceptive procurement. AXxes continued the work of SANRU III, and national conferences on family planning in 2004 and 2009 paved the way for the family planning stakeholder group in the following decade.

The 2007–08 DHS showed that only 5.8% of married women of reproductive age used a modern method, although in the capital city of Kinshasa it was 14.1%. Countrywide, far more women (14.9%) reported using a traditional method (rhythm or withdrawal) than modern contraception. The DHS confirmed that the DRC had one of the highest fertility rates in the world: 6.3 births per woman.[59]

Yet the problems plaguing family planning at the end of the 2000s had less to do with family planning and more to do with the political, economic, and social problems confronting the country. Despite Independence some 50 years previously, the country was striving to recover from the 32 years of Mobutu's repressive leadership, followed by the regimes of Kabila *père* and *fils*.

Accepted practices in government did not help to support development programs, including family planning. The selection of program directors based on region or ethnicity rather than technical credentials further weakened government institutions. The expectation of frequent turnover in positions of leadership encouraged the incumbents of high positions to take whatever advantage they could, while they could. The practice of successful men (and they were almost always men) taking care of their extended families further encouraged the tendency to look out for personal interests rather than the greater good of the public at large. The concept of a "public servant" was virtually unknown in the DRC government bureaucracy. Meanwhile, public employees at lower levels limped by on meager salaries that forced them to find other gigs, further diminishing their contribution to government.

Demand for contraception was still limited. Given that urbanization favors smaller families, Kinshasa had a higher level of modern contraceptive use among married women than the rest of the country, but it was still low by international standards: 14.1%. Access to contraception, especially free contraception, was limited, and social norms continued to favor large families, even among the educated. In a society where advancement was based on familial or ethnic ties rather than merit, the argument of investing more in a smaller number of children (the quantity-quality tradeoff) did not resonate. The dominance of men in household decision-making also kept some women from becoming users.

Yet several points boded well for development projects, including family planning. Tremendous strides were made in developing a managerial cadre within public health in the DRC, both through training abroad and at the Kinshasa School of Public Health. Through SANRU and AXxes, the organization of primary healthcare in rural areas advanced. ASF/PSI had demonstrated the demand for contraception in cities nationwide. Two major donors (UNFPA, USAID) and two national programs (PNSR, PNSA) were well established, creating the necessary institutional infrastructure for a program that would mature in the 2010s.

Notes

1 Marysse, Stefaan, and Catherine André. "Guerre et pillage économique en République démocratique du Congo." *L'Afrique des Grands Lacs, Annuaire* 2000–2001 (2001): 307–32
2 Crossette, Barbara. "Death Toll in Congo's 2-Year War Is at Least 1.7 Million, Study Says," The *New York Times*, June 9, 2000. https://www.nytimes.com/2000/06/09/world/death-toll-in-congo-s-2-year-war-is-at-least-1.7-million-study-says.html, p 1
3 Van Reybrouk, David. *Congo: The Epic History of a People*. London: Fourth Estate, 2014, p 440
4 Kisangani, Emizet F. *Historical dictionary of the Democratic Republic of the Congo*. Fourth ed. London: Rowman & Littlefield Inc., 2016, p xliii
5 Van Reybrouk, 2014, p 466
6 Kisangani, 2016, xliii
7 "Inter-Congolese Political Negotiations the Final Act – United Nations." United Nations Peacemaker, April 2003. https://peacemaker.un.org/sites/peacemaker.un.org/files/CD_030402_SunCityAgreement.pdf
8 UN Peacemaker, 2002, p 7
9 Kisangani, 2016, p 357
10 "Democratic Republic of Congo – Rwanda Conflict." Human Rights Watch, December 4, 2004. https://www.hrw.org/news/2004/12/04/democratic-republic-congo-rwanda-conflict
11 Kisangani, 2016, p xliv
12 Van Reybrouk, 2014, p 505
13 "DRC: Congo Gets New Constitution, New Flag – Democratic Republic of the Congo." ReliefWeb, February 20, 2006. https://reliefweb.int/report/democratic-republic-congo/drc-congo-gets-new-constitution-new-flag
14 Van Reybrouk, 2014, p. 500, 511–512
15 "DR Congo: Transition without Military Transformation – Democratic Republic of the Congo." ReliefWeb, December 14, 2007. https://reliefweb.int/report/democratic-republic-congo/dr-congo-transition-without-military-transformation
16 Van Reybrouk, 2014, p 450, 529

17 Michael, Markus, Veronique Thouvenot, Thomas Hoerz, and Laura Rossi. "Evaluation of Echo's Actions in the Democratic Republic of Congo (DRC)." European Commission, August 2004. https://ec.europa.eu/echo/files/evaluation/2004/drc_report.pdf, p 8
18 Michael, *et al.*, 2004, p 10, 8
19 Lauro, Amandine. "Women in the Democratic Republic of Congo." Oxford: *Oxford Research Encyclopedia of African History*, 2020. https://doi.org/10.1093/acrefore/9780190277734.013.544. p 17
20 Van Reybrouk, 2014, p 474–475
21 Fonds des Nations unies pour la population (FNUAP/ UNFPA) "Deuxième programme d'assistance au gouvernement de la R.D. du Congo, 2002–2006," issued in March 2001
22 République démocratique du Congo, Ministère de la Santé publique, "État des lieux du secteur de la santé en RDC 1998." École de santé publique de Kinshasa, May 1999. https://espkinshasa.net/etat-des-lieux-du-secteur-de-la-santé-en-rdc-1998/ p 39
23 FNUAP/ UNFPA, 2001, p 3
24 FNUAP/UNFPA, 2001, p 13, 23, 14–5
25 "Democratic Republic of The Congo Poverty and Social Impact Analysis : Mine Sector Reform" (Washington, DC: World Bank Group, June 2007), https://documents1.worldbank.org/curated/en/750411468019743700/pdf/405050SR0Congo1al0Final0Final0No0TG.pdf.
26 Tambwe, Nyumbaiza, Michael Rudolph, and Ran Greenstein. "'Instead of begging, I farm to feed my children:' Urban Agriculture: an alternative to copper and cobalt in Lubumbashi." *Africa* 81, no. 3 (2011): 391–412. https://doi:10.1017/S000197201100043X, p 391
27 Rep. *Fund: Country Programme Document for the Democratic Republic of the Congo*. United Nations Population Fund (UNFPA), 2007, p 2–3
28 Baer, Franklin. Rep. *Feasibility and Design of an NGO-Umbrella Project to Assist Health Zones in DR Congo*. USAID-Funded Tulane Project in the Congo, 2000, p 19
29 Metzel, Dan. "Final Performance Report SANRU III Phase; Emergency Response Services December 1, 2000 through December 1, 2001." Interchurch Medical Assistance (IMA) and Église du Christ au Congo (ECC) Eglise du Christ au Congo (ECC), February 14, 2002. https://pdf.usaid.gov/pdf_docs/PDABU855.pdf, p. 1
30 Rosenweig, F and I Moise. "Developing a Hygiene Promotion Program: Summary of Assistance to SANRU III in the Democratic Republic of the Congo" Environmental Health Project, July 2004, p.1–2
31 DR Congo Program Rapid Contraceptive Increases in a Post-Conflict Setting Integrating Services through Local Partners, 2003–2005, Advance Africa, 2005, p 4
32 République démocratique du Congo, Ministère de la Santé publique & Programme national de santé de la reproduction *Politique nationale de santé de la reproduction (PNSR)*, July 2008, p 7–9
33 FNUAP/UNFPA, 2001, p 17
34 *République démocratique du Congo, Ministère de la Santé publique, Secrétariat général à la santé, Politique nationale de santé de l'adolescent, n.d., p 7*
35 "Rapport de stage effectué chez PSI/ASF Congo à Goma." Memoire Online, n.d. https://www.memoireonline.com/07/07/541/m_rapport-de-stage-psi-asf-congo-goma1.html
36 Rep. *2005 Annual Report: Reproductive Health Project Democratic Republic of the Congo*. Population Service International (PSI), 2005, p 2
37 Rep. *AIDSMark: Year Four Annual Report (October 2000–September 2001*). USAID/PSI, 2001, p 13
38 PSI, 2005, p 3
39 "USAID Field Report DR Congo Dec 2005 – Democratic Republic of the Congo." ReliefWeb, December 31, 2005. https://reliefweb.int/report/democratic-republic-congo/usaid-field-report-dr-congo-dec-2005

40 "African Economic Outlook 2008." *African Economic Outlook*, 2008. https://doi.org/10.1787/aeo-2008-en, p 243
41 Cobb, L, G Bowers, N Frankel, M Mamlouk. Assessment of Advance Africa and the Catalyst Consortium. Poptech under USAID HRN-C-00-00-00007-00, 2004, p 30
42 DR Congo Program Rapid Contraceptive Increase in a Post-Conflict Setting Integrating Services through Local Partners, 2003–2005. Advance Africa. June 25, 2005, p 8
43 Cobb, *et al.*, 2004, p 32
44 Project AXxes Final Report (September 2006–September 2010). IMA World Health. Integrated Health Services Project (Project AXxes) USAID Cooperative Agreement No: 623-A-00-06-00058-00. Democratic Republic of Congo, 2011, p 1
45 IMA World Health, 2011, p 26–7, 3, 8–9, 36–7
46 *Demographic and Health Survey 2007: Democratic Republic of the Congo (DHS-DRC)*. Calverton, MD: Macro International and Ministry of Planning, 2008, p i
47 "World Contraceptive Use 2007 Wall Chart." United Nations Department of Economic and Social Affairs Population Division, 2008. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2020/Jan/un_2007_worldcontraceptiveusewallchart.pdf
48 DHS-DRC 2007, 2008, p 203
49 République démocratique du Congo, Ministère de la Santé publique, 1999, p 39
50 FAM Project. Scale-up of Standard Days Method in DR Congo FAM Project. IRH. 2013. https://www.irh.org/resource-library/country-briefs-scale-up-of-standard-days-method/, p 2–4
51 "Developing Innovative Solutions That Help Countries Improve National Health Supply Chains." JSI DELIVER, 2023. https://deliver.jsi.com/
52 Programme national de santé de la reproduction (PNSR) and UNFPA. Rapport d'évaluation du Plan stratégique de sécurisation des produits de santé de la reproduction 2008–2012 de la République démocratique du Congo. République démocratique du Congo, Ministère de la Santé publique, Secrétariat général, 2011, p 28, 11
53 "C-Change Final Report." Washington DC: C-Change/FHI 360, March 2013. www.c-changeproject.org/sites/default/files/C-Change-Final-Report.March2013.pdf
54 *Rep. Country Programme Document for the Democratic Republic of the Congo 2008–2012.* United Nations Population Fund (UNFPA), 2007, p 2
55 PNSR and UNFPA, 2011, p 10
56 République démocratique du Congo, Ministère de la Santé publique, Programme national de la santé des adolescents (PNSA). Plan stratégique national de la santé et du bien-être des adolescents et des jeunes 2016–2020. March 2016, p 23
57 Conférence nationale pour le repositionnement de la planification familiale en République démocratique du Congo, Rapport final. Comité technique, December 2009, p v-vii, 8–9
58 Baer, 2000, p 16
59 DHS-DRC 2007, 2008, p xxiii

8 The 2010s

The DRC Experiences the Second Golden Decade of Family Planning

Plus ça change…

For the average Congolese citizen, the 2010s brought more of the same: widespread poverty, unending armed conflict in the east, Presidential elections with contested results, foreign control over much of the country's minerals, and another Ebola outbreak in 2018–20.[1] Add to this the Covid-19 pandemic that spread worldwide in early 2020.

Joseph Kabila, appointed president after the assassination of his father Laurent Kabila in 2001 and then elected to the post in 2006, would be reelected in 2011. As his second and final term came to an end, levels of corruption within the government increased and Kabila attempted to delay the next presidential election that would put him out of office. By 2018, a new presidential election was held in which Félix Tshisekedi came to power, in the first-ever peaceful electoral transfer of power. Amid protests from the rival opposition candidates and an uneasy power-sharing arrangement with Kabila, Tshisekedi announced a 100-day emergency program that would prioritize the social sector: roads, drinking water, electricity, health, and education. Yet, the implementation of this program fell far short of the aspiration.[2]

Armed conflict continued unabated in the mineral-rich, agriculturally fertile, and densely inhabited provinces of the east. The situation with the neighboring countries of Uganda, Rwanda, Burundi, and Angola remained volatile.[3] MONUC – renamed MONUSCO (United Nations Organization Mission in Democratic Republic of the Congo) in 2010 to reflect a new phase of operations – had become (and continues to be) one of the largest and longest-running peacekeeping operations in history.[4]

An unhappy by-product of the never-ending conflict is the extreme level of sexual and gender-based violence (SGBV), especially in the east. The DRC was voted to be among the world's worst places to be a woman, with rape, mutilation, and other forms of violence inflicted on toddlers, the elderly, and those in between. In addition to the pain experienced from SGBV, victims are highly stigmatized in their communities.[5]

The country continues to depend on its mineral resources, accounting for 95% of its exports and 20% of its GDP. In addition to its vast quantities of copper, diamonds, zinc, tin, and gold, it produces 80% of the world's highly coveted

DOI: 10.4324/9781032718897-10

supply of cobalt, used in electric car batteries, and 80% of the world's coltan, essential for manufacturing cellphones and laptops.[6] One outcome has been the large numbers who expose themselves daily to the extreme dangers of artisanal mining, a practice that has found its way to the headlines of the *New York Times.*[7]

Yet the country's vast resources continue to serve the personal interests of the politically powerful elite. Although President Tshisekedi vowed to root out corruption, his chief of staff was arrested for embezzlement of funds a mere 14 months after he ascended to office. A large portion of the country's wealth has passed into the hands of Chinese companies, who now control about 78% of the mines in the Congo.[8] Meanwhile, issues of insecurity, corruption, and the unpredictable regulatory environment have deterred other foreign investors from doing business in the Congo.[9]

The Catholic Church continues to play a vital role in the life of the country. From the days of the Belgian Congo when it was closely allied with the colonial government, the Church has evolved to become the conscience of the country, speaking truth to power: pressuring Joseph Kabila to hold elections, disputing the electoral count in 2019, and criticizing President Tshisekedi for failing to improve the conditions of the Congolese population. It continues to uphold the educational system of the country. While the government "oversees" the educational sector, the Catholic Church manages 80% of the private schools in the country.[10] In terms of followers, the Catholic Church has had to compete with the growing number of evangelical churches that have sprung up in the DRC, especially popular among the youth. By the mid-2000s, there were 3,000 *églises de reveil* in Kinshasa alone.[11]

Figure 8.1 Boulevard du 30 juin in contemporary times
Photo credit: (Zute Lightfoot)/Alamy

In 2010, the population of the DRC had grown to 62 million people, 40% of whom lived in urban areas. As of 2022, the country numbered 95 million with 42% of the population urban.[12] The rural areas lag far behind the cities in access to resources and opportunities.

By 2012, 69.9% of the population was earning under two dollars a day.[13] As of 2023, the DRC ranks as the fifth poorest country in the world with an estimated 62% of the population living under $2.15 a day.[14] An estimated 80% of the population depends on the informal sector for survival.

As of 2015, the National Assembly passed a law that increased the number of provinces from 11 to 26. Four provinces remained unchanged: Bas-Congo (renamed Kongo Central), Maniema, Nord-Kivu, and Sud-Kivu. A lack of adequate funding for new administrators and operating expenses was felt most acutely in the spinoff provinces.

The healthcare system – already in dire straits across much of the country – further suffered from the Covid-19 pandemic starting in 2020. Its impact was both direct, by limiting access to health facilities, and indirect, by weakening the economy, making it harder for Congolese to feed their families.[15] With nearly 70% of the population lacking access to an adequate food supply, one in every four children is malnourished.[16]

Educational opportunities, while improved, still reflect the decades-long lack of investment in this sector. Between 2000 and 2017, primary net enrollment increased from 52% to 78%, although only 75% complete primary school. As of 2020, less than half (46.2%) finished their secondary education and only 6.6% completed tertiary education. For every 100 boys in primary school, there are 90 girls, but for secondary schools, the number of girls drops to 6 in 10.[17] Data from 2016 indicates that 88.5% of men could read and write, compared to only 66.5% of women.[18] Lack of education directly impacts fertility, as women with no education have twice as many children on average (7.4) as those who have studied beyond secondary school (2.9).[19]

Women remain relegated to the role of second-class citizens. Only half as many women (16.8%) as men have completed secondary school. Some 62% of women participate in the labor force, though primarily in agriculture or the informal sector.[20] Those in the formal labor force earn far less than men. Although the occasional woman is selected as a minister within the government, she is by far the exception to the rule.

Against the backdrop of these statistics, one finds an irrepressible *esprit de vivre*. A headline from France 24 on the eve of Pope Francis' 2023 visit to the Congo captured this paradox: "Poverty, but also rumba and resilience."[21] In the face of harsh conditions and daily challenges to survival, much of the population keeps going in the hope that tomorrow will bring a better day. Those with deep religious convictions depend on their faith to remain strong in the face of adversity. The rapid rise in evangelical churches within Kinshasa and elsewhere reflects the quest of the population for a better future. Many have given large portions of their meager resources in hopes of salvation.

The development community has witnessed several positive changes. In a trend that has been evolving for over a decade, Congolese (as opposed to expats) hold the vast majority of top management positions within iNGOs working in the country. The gap in salaries at the management level between Congolese and their Western counterparts – while still a reality – has narrowed. With the growing call for "decolonialization" and power shifting from the Global North to the Global South, donor funding will increasingly flow directly to local organizations, with a decreasing portion transiting through iNGOs headquartered in the US or Europe. Although statistics to support this observation are elusive, the percentage of women working in family planning has steadily increased over the past two decades. And in 2020, Pathfinder International was the first Kinshasa-based family planning iNGO to appoint a female Congolese country director, Dr. Marie-Claude Mbuyi.

Family planning does not occur in a vacuum. The DRC is considered one of the most difficult environments for development work, for all the reasons outlined above.[22] Yet against this backdrop, the country experienced its second golden decade of family planning.

The family planning movement gains momentum

Unaware that the golden decade was to begin

As of 2010, the family planning community was still working to gain back some of the ground lost in the 1990s. USAID and UNFPA both had strong advocates and able managers in their key family planning posts. With support from UNFPA, the two governmental agencies – PNSR (*Programme national de santé de la reproduction)* and PNSA (*Programme national de santé de l'adolescent)* – had stable leadership. ASF/PSI (*Association de santé familiale/*Population Services International) had the

Figure 8.2 Dr. Marie-Claude Mbuyi, one of the female pioneers in family planning

most far-reaching program in terms of contraceptive service delivery. IRH/Georgetown was making inroads in introducing CycleBeads to programs across the country. John Snow Inc's (JSI) DELIVER project was working with UNFPA and PNSR to improve contraceptive security. C-Change provided intermittent support for family planning events. PROSANI (P*rogramme de santé intégré de l'USAID en République démocratique du Congo)* – the successor to SANRU and AXxes as USAID's flagship project – was continuing to make contraceptives available in 57 of the rural health zones of the country. The UK's DFID Access to Healthcare Program included family planning in 20 health zones.

Yet in 2010 all the movers and shakers for family planning in the DRC could sit around a single conference table. Their efforts – however meritorious – were a drop in the bucket in a country that now had an estimated 66 million people. Given the low priority that the ministry of health (MOH) placed on family planning, most "did what they could," resigned to the difficulties of operating against the chronic challenges of weak management systems, unreliable transportation networks, and the constant threat of fraud. Those committed to making change pushed the rock of Sisyphus uphill as they worked to get contraception to the millions of women with unmet needs.

Few sitting around that imaginary conference table realized that they were on the cusp of a major surge in family planning activity. The proverbial train was about to leave the station for what would be the second golden decade for family planning in the DRC.

The MOH publicly embraces family planning

Given the lukewarm enthusiasm of many francophone sub-Saharan countries for family planning at the start of the decade, it was unusual for a ministry of health to take the lead in forcefully advocating for family planning. But Dr. Thomas Kataba, a MOH adviser in the *Direction des études et planification* (DEP, Direction of Research and Planning) who was standing in for the minister, defied this expectation when he got up to speak on behalf of the ministry in 2012.

At a mini conference organized at the Hotel Sultani in June 2012 to reinforce ties among different actors in the family planning network, Dr. Kataba opened the meeting with a rousing endorsement of family planning that left many in the audience frankly stunned. He explained in clear language, with effective visuals, that family planning was one of six pillars for lowering maternal mortality, and if the DRC was serious about attacking this problem, it needed to invest more heavily in family planning.[23] With compelling arguments, Dr. Kataba brought a new urgency to this work. Only afterward did it emerge that the minister of health had recently attended a global meeting on accelerating progress to meet the Millennium Development Goals. Given that the DRC was among the highest contributors to the global count of maternal deaths, the ministry was under pressure to improve its performance. The invitation to speak at this mini conference allowed Dr. Kataba to voice the ministry's newfound interest in family planning and to actively seek collaboration with those already working in this field.

This strong endorsement of family planning was music to the ears of the organizations working in family planning that had previously felt a passive acceptance bordering on disinterest from the ministry. Even better, the DEP was a group of technical advisers to the MOH that would not rotate out with each new administration or minister. The group of family planning stakeholders realized they had a well-placed ally.

Dr. Kataba was a busy man, responsible for a large portfolio of health issues extending well beyond reproductive health/family planning. Years later, when asked why he had embraced family planning so fervently over the years, his answer was clear. Of the different groups to which he had given this call to action, the only "pillar" to respond with concrete plans and donor-funded activities that could move the field forward were those in family planning. (In 2020, Dr. Kataba was named director of the DEP).

Two keynote speakers at the same meeting were Dr. Jean-Pierre Guengant, a renowned demographer specializing in sub-Saharan Africa, and Dr. Sahlu Haile, regional representative of the Packard Foundation. Both would continue to play important roles in advancing family planning. Guengant presented the DRC fertility rates and contraceptive prevalence in the global context and described the implications of continued high fertility for the country. He would serve as a consultant on the two strategic plans for family planning subsequently developed (2014–2020 and 2021–2025 with a vision toward 2030). Haile detailed the experience of training community health workers in Ethiopia as the basis for accelerated progress in contraceptive use, and Packard would subsequently fund community-based distribution in Kinshasa.

London Summit brings attention to Family Planning

In the late 1990s, HIV/AIDS became the most critical and best-funded sector on the global public health agenda. In 2002, countries in the Global North came together to create the Global Fund to fight the deadliest pandemics confronting humanity: HIV/AIDS, malaria, and tuberculosis.[24] In 2003 under the administration of President George W. Bush, the US government launched the President's Emergency Plan for AIDS Relief (PEPFAR), the largest commitment ever by any nation to address a single disease.[25]

Against this tsunami of funding for HIV/AIDS, international family planning had all but fallen off the global health agenda. Whereas it enjoyed a small spike in donor investment after the 1994 International Conference in Population and Development in Cairo, this escalation was short-lived.

To increase a sense of urgency for family planning, several major players – Melinda French Gates of the Gates Foundation, USAID, UNFPA, and DFID – joined together to organize the London Summit in July 2012. It served to launch a new global movement known as FP2020, to empower women and girls by investing in rights-based family planning. It set as its goal that an additional 120 million women and girls would have access to effective family planning information and services by the year 2020.[26]

Although DRC did not participate in the London Summit, it became a direct beneficiary. With the FP2020 goal to reach 120 million additional women and girls with family planning, the Gates Foundation would support different aspects of service delivery in a number of large countries that could potentially contribute to this number. Moreover, it would favor countries that demonstrated their interest in family planning in two concrete ways: publicly committing to the goals of FP2020 and producing a costed strategic plan.[27] This ticket to play was not lost on the DRC.

CTMP brings cohesion to family planning stakeholders

Both the 2004 and 2009 National Family Planning Conferences had called for the creation of a permanent multisectoral technical committee (known by its French acronym as CTMP) to coordinate and monitor the work of government agencies, implementing partners, and donors in family planning. The mini conference in 2012 created an opportunity to make it a reality.[28]

The few organizations working in family planning tended to pursue their own project objectives, independent from others doing similar work. As the idea for a mini conference emerged in 2012, lead staff members from several Kinshasa-based implementing partners came together for planning purposes. Previously stymied by a lack of government participation in such meetings, the C-Change project paid the transport fees that allowed government staff to attend. Whereas one organization could have paid for the entire event, the group decided collectively to share the expenses across organizations. This decision created a precedent that would define the CTMP: it was not a project with a budget, nor did it have any paid staff. Rather, it operated through contributions from different organizations. Members of the CTMP attended meetings and participated in events as part of their respective jobs with family planning organizations. This arrangement proved very provident because the CTMP remained mission-oriented. Members were not vying for their piece of the *caisse* (bank account) because there was not one.[29]

In 2012, following the mini conference, members met and elected Dr. Arsene Binanga as coordinator. His contract with Georgetown University to promote CycleBeads came to an end in 2013, at which time he accepted the position of country director for family planning projects at Tulane International. Fortuitously, the Bill and Melinda Gates Foundation (BMGF) saw the value of the CTMP mechanism and, through its grant to Tulane, supported his work in this role, through 2018.

Membership of the CTMP was voluntary and attendance at meetings was optional. However, within a year, the membership included representatives from government agencies (PNSR and PNSA), international and national NGOs (most of those listed in Box 8.3), and donors USAID, UNFPA, DFID, WHO, and the World Bank.

The CTMP became the clearinghouse for multiple family planning activities. One of its first tasks was to assist in drafting the DRC government pledge to family planning at the 2013 International Conference for Family Planning (ICFP)

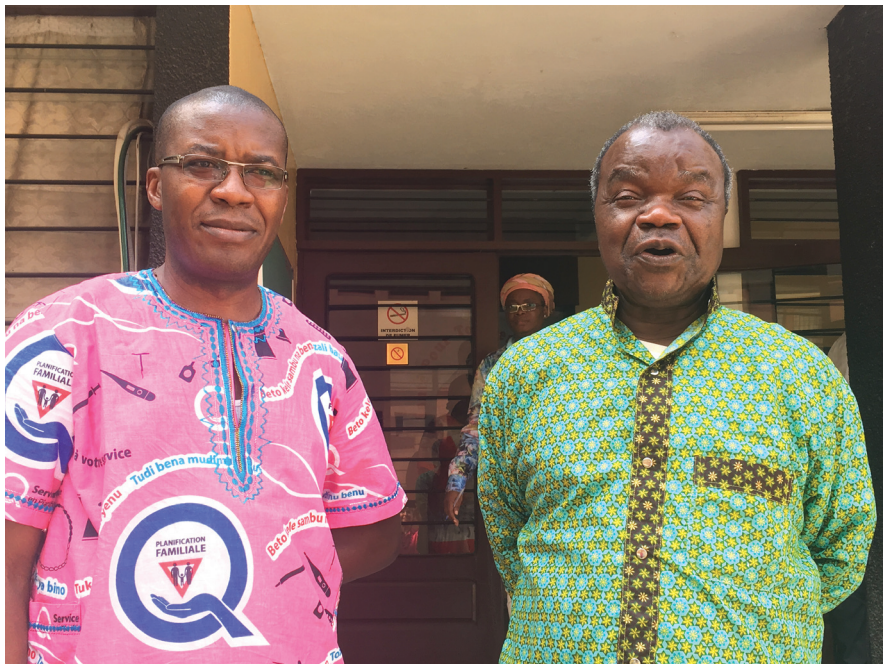


Figure 8.3 Dr Arsene Binanga, CTMP coordinator, with Dr. Miatudila Malonga, President of SANRU Board of Directors, in 2018

in Addis Ababa. Members also played a key role in developing the first Strategic Plan for Family Planning. When decisions needed to be made about the indicators to be included in the national health information system, the CTMP organized for the family planning community to speak with one voice. When visitors from donor agencies came to Kinshasa, they were able to connect with potential partners through this mechanism.[30]

The initial work of the CTMP focused entirely on Kinshasa, the headquarters of most government and partner agencies. Yet in 2015, efforts began to develop the CTMP into a national network. The selection of provinces was opportunistic. Where there was a donor-funded agency working in family planning and willing to support the expenses of occasional meetings, this organization worked with the national CTMP to establish a provincial CTMP. The rollout was gradual. Four provinces were added in 2015, six in 2016, two in 2017, one each in 2018 through 2020, four in 2021, and one in 2022.[31]

In 2015, with momentum growing for family planning, Prime Minister Matata Ponyo Mapon conferred official status on the CTMP through a ministerial decree (n°15/003).[32] The by-laws specified that an iNGO ("partner organization") would take the lead role of coordinator, while the PNSR served as secretariat for the group. For six years, this arrangement worked very effectively, with regular meetings attended by members from diverse sectors: government, NGOs, and donors.

The advocacy work early in the decade benefited from the technical and financial support of Advance Family Planning, a project funded by the Gates Foundation and managed by Johns Hopkins University. A second advocacy project became active in 2018, managed by Options in the DRC under the WISH (Women's Integrated Sexual Health) project funded by DFID.[33] It worked with the provincial CTMPs to obtain line items in the provincial budgets for contraceptive procurement. By 2022, seven provinces had obtained such a line item: Lualaba, Haut Katanga, Lomami, Tshopo, Nord-Kivu, Sud-Kivu, and Kinshasa. Kwilu was added in 2023. Only one – Lualaba – succeeded in obtaining the release of these funds, but they were subsequently reallocated to cover "more pressing" expenses.[34]

DRC commits to FP2020 objectives

The DRC had missed the boat for the 2012 London Summit, not surprising since family planning remained low on the government's priority list and the local actors had limited ties to initiatives at the global level. To sustain the momentum of FP2020, the organizers arranged for countries absent in London to pledge their commitment to FP2020 at the ICFP held the following year in Addis Ababa.

In the months leading up to ICFP 2013, the CTMP had joined forces with Dr. Thomas Kataba of the DEP to strategize on developing a statement of commitment and coordinating with the office of the prime minister to deliver this statement in Addis Ababa. Fortuitously, during this same period, the AFP Project began its support for advocacy activities in the DRC. Beginning with a workshop on the use of the SMART advocacy tool,[35] the CTMP/AFP team developed its strategy for bringing this issue to the attention of the prime minister and securing his agreement to make this pledge of commitment at Addis Ababa.

The CTMP/AFP team contacted the prime minister's adviser for health, Mr. Dieudonné Kwete. He became the critical liaison to the prime minister, who was sympathetic to the cause of family planning as a means of decreasing maternal mortality and boosting economic development in the country. In the weeks leading up to ICFP 2013, numerous drafts of the text changed hands and late-night meetings were convened to further wordsmith the document. Once in Addis Ababa, the team continued to tweak the document, calling back to the office of the prime minister until the final minutes leading up to the presentation. Then on November 15, 2013, Mr. Kwete took the stage in the cavernous auditorium of the African Union building to present the DRC declaration, as an international audience including over 30 Congolese looked on. In it, the government pledged to revitalize family planning services by implementing and financially supporting the DRC's recently developed national strategic plan for family planning, reforming laws that posed barriers to birth planning, and empowering women.[36]

The Strategic Plan provides a shared roadmap

It was in the interest of the country to develop a strategic plan – to articulate a common mission, streamline interventions, and boost funding prospects. Many

countries, especially those with strong funding support already, opted to call on a major consulting firm such as McKinsey to take the lead in developing the plan. Whereas this approach worked in some cases, in others it resulted in a slick, well-designed document that had little local buy-in.

The DRC took a very different approach. Rather, the CTMP took a leadership role in developing this document, with a strong emphasis on inclusion and consensus building.[37] In 2012–13, four different meetings were convened – three at the ENVRAC conference center on the outskirts of Kinshasa, and a fourth at the Sultani Hotel – with different interest groups. Initially, the discussions began with the main family planning stakeholders: the staff of organizations working in family planning. Once the document was drafted, a session was convened with government representatives from all the provinces.

To a Western observer, the discussions in these sessions seemed interminable. They frequently ran overtime as participants passionately rehashed issues far after the scheduled hour for adjournment. Following each of these sessions, a core group would work to package the main ideas into a coherent document that evolved with each new consultation. Also, the team had technical input on the setting of the objectives (an increase of modern contraceptive prevalence from 6.5% in 2013 to 19% by 2020) and budgeting from Dr. Jean-Pierre Guengant.[38]

By the fall of 2013 (coinciding with the 2013 ICFP), a final draft of the Strategic Plan was released and circulated for comment. The official launch occurred in February 2014, sponsored by the minister of health at the Grand Hotel (now the Pullman). The glossy cover with the DRC colors of turquoise, red, and yellow, and high-quality graphic design made for a very attractive document with strong substantive content. The rousing endorsement from Minister of Health Dr. Félix Kabange Numbi – who spoke eloquently without notes on the importance of family planning – was a high-water mark for those working in this sector.[39]

The *National Multisectoral Strategic Plan for Family Planning: 2014–2020* became a roadmap for the work of organizations in this field. It was not an operational plan of who would do what and where. Rather, it outlined six main areas where work would be completed: advocacy, service provision, service quality, demand generation, contraceptive logistics, and evaluation. Organizations could then "find themselves" within this plan and use it to justify their own work to donors and home offices.[40]

The single greatest value of the strategic plan was the pride that most members of the family planning community felt in having a document to which they had contributed. As a result of the protracted periods of consultation and interminable discussions of the issues, a large number of people had a sense of having participated in the process. They saw themselves and their organizations in this document, and they felt a sense of ownership of it.

The government demonstrates commitment through the purchase of contraceptives

Governments can make favorable statements toward family planning and approve donor funding for new projects but "talk is cheap." One marker of government commitment is its willingness to use money from the national treasury for family

Figure 8.4 Annoucing the availability of contraceptives at a community outreach event

planning. In countries worldwide – especially those with weak political will for family planning – one marker of commitment is the purchase of contraception for use in its programs. In contrast to paying for meetings or travel, the purchase of contraception is tangible and provides a visible result. Even better, a photo of high-level officials receiving the boxes of contraceptives that have arrived sends a clear and visible message of their support to this sector.

In its commitment at Addis Ababa to FP2020, the DRC government had pledged to contribute financially to the purchase of contraceptives for use in the national program. There was precedent for this type of procurement since the government had done so for immunizations. In connection with the 2013 pledge by DRC officials to FP2020 at Addis Ababa, the government gave $300,000 toward the purchase of contraceptive commodities, which were delivered in 2015. The government subsequently disbursed $1M for contraceptives in 2017. After a lull of several years – due in part to the troubled 2018 elections and the Covid-19 pandemic – the government again paid $2.1 M in 2021 for contraceptive procurement. Whereas these amounts only covered a fraction of the cost for the volume of contraception needed in a given year, these government disbursements have been extremely important for their symbolic value.[41]

The Law of 1920 prohibiting contraception and abortion repealed

President Mobutu's historic speech in 1972 authorizing *Naissances Désirables* gave a greenlight to providing contraception through existing health services, but it did not serve to repeal the Law of 1920 that remained in effect, prohibiting the promotion or provision of contraception to the population. Organizations and individuals committed to family planning worked diligently to expand the services but were dogged by the nagging apprehension that they were not protected by law.

The law – originally conceived by the French and later adopted by the Belgians – served multiple purposes: to maintain high moral standards, to replenish the population diminished by the brutal measures of King Leopold II and then the Belgium government against the native population, and to ensure a strong work force to further exploit the riches of the country.[42] Dr. Miatudila Malonga had tried his hand to get this law repealed in 1982 but with no success.

In 2012, the advocacy subgroup of the CTMP joined with CAFCO (a civil society organization comprised of female politicians, lawyers, and other professionals) to ensure that women of reproductive age would have legal access to contraception. They drafted a Reproductive Health Law that a female parliamentarian submitted for consideration in 2014. The draft ricocheted between different bodies and multiple reviews for several years before the president of parliament recommended to CAFCO that they fold their Reproductive Health Law into a Public Health Law being promoted by the MOH. Doing so meant decreasing the visibility of reproductive health as a priority issue, but it increased the chances of passage. Wisely, the group took this approach with the result that the Public Health Law of 2018 passed, stating that "All persons of reproductive age – after benefiting from counseling – have the right to voluntarily use a reversible or irreversible contraceptive method" (article 81).[43] Cleverly, they had not specified that adolescents had access to contraceptives, which could have triggered a negative response among more conservative sectors; yet adolescents – being "persons of reproductive age" – would be covered by this provision of the law.[44]

The reproductive health advocates went further – to slip in a clause that legalized abortion. The same penal code that restricted access to contraception also penalized abortion performed under any circumstance. Abortion providers and patients convicted of this offense could spend 5 to 15 years in prison (Code Penal RDC, 1940b). Yet, in 2008, the DRC was the first francophone country to ratify the Maputo Protocol, a charter adopted by the African Union to uphold equal rights for girls and women, despite opposition from the Catholic Church.[45] In addition to provisions related to women's economic and political empowerment, health, and wellbeing, the Maputo Protocol explicitly recognized abortion as a human right in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother.[46]

The tug of war over the inclusion of abortion in the Public Health Law of 2018 continued until hours before the final vote. When the law finally passed, it failed to include the provision legalizing abortion, though the Maputo Protocol would later be published in the National Gazette, superseding national law.

Traditional donors increase their support for family planning

As of 2010, the DRC was still donor-dependent across all sectors of health. Whereas the government was responsible for the salaries of personnel and the provision of buildings, the vast majority of funding to support health programs including family planning came from international donors: multi-lateral, bilateral, private foundations, and occasionally private philanthropists.[47]

The pillages of the 1990s had caused donors to withdraw from the country or greatly scale back their activities. In the decade from 2000–2009, the large family planning donors – USAID, UNFPA, and DFID – had begun to reengage.[48] By the 2010s, multiple other donors felt the time had come to invest in the DRC.

USAID expands its family planning portfolio

As of 2010, over half the family planning funding for the country came from USAID. During the decade of the 2010s, USAID continued to expand its portfolio of health programming, including family planning. Many of these projects were financed through a centrally-funded mechanism; that is, USAID/Washington selected an organization or consortium through competitive bidding for its expertise in a specific area, after which a USAID country office could use its own funding ("buy-in") to obtain its services in-country. In addition, USAID/DRC maintained its flagship project that delivered family planning as part of a broad-ranging project to strengthen the health system and increase access to a broad range of health services, including family planning. As shown in Box 8.1, USAID/DRC relied heavily on centrally-funded projects.

Box 8.1 USAID-funded projects in the DRC with a family planning component*

Active as of 2010:

- **Comprehensive social marketing project:** promoted contraception and other health products in urban areas, managed by ASF/PSI (through 2017).
- **C-Change:** technical assistance and capacity building in behavior change communication across a range of health topics (through 2015).
- **AXxes*:** flagship project for integrated health service delivery in 57 health zones (though 2010).
- **PROSANI*:** successor flagship project in 78 health zones in nine provinces; operated (2010-15); later extended as PROSANI+ through 2018; operated by Management Sciences for Health.

New projects starting between 2010-19:

- **Flex-FP:** tested various approaches to family planning provision in South Kivu (2008–13), then scaled up to 15 rural health zones in three additional provinces (2014–18) under the E2A (Evidence to Action) project; managed by Pathfinder.
- **SIFPO (Support for International Family Planning and Health Organizations):** promoted family planning using a private sector/social franchising model focusing on urban areas of nine provinces (2014-19); managed in DRC by PSI.
- **Global Health Supply Chain – Procurement and Supply Management project (GHSC-PSM):** forecasted and procured contraceptives for USAID-funded projects in DRC, provided technical assistance to government entitles working in supply chain management, and embedded advisors in regional warehouses; managed by Chemonics (2015- present).
- **USAID Integrated Health Program*:** provided family planning as part of a sprawling effort to strengthen health services, improve access to quality services and increase the use of healthy behaviors across multiple health topics in nine provinces (2018–2023); implemented by Abt Associates.
- **Data for Impact (D4I):** worked with KSPH to evaluate USAID's Integrated Health Program and conduct health system research (2019-24); managed by the University of North Carolina/Chapel Hill.

Other centrally funded projects relevant to family planning:

- **Systems for Improved Access to Pharmaceuticals and Services (SIAPS):** 2011–2016, MSH
- **Health Finance and Governance:** 2011–2016, Abt Associates
- **Health Policy Plus (HP+):** 2015-22, Abt Associates,
- **Integrated Youth Development Activity (IYDA):** 2018–22, EDC
- **Breakthrough Action**, 2017–24, CCP

Projects starting since 2020:

- **Momentum:** Safe Surgery in Family Planning and Obstetrics, EngenderHealth (2020–25); focuses on prevention and surgical repair of obstetric fistula, and to increasing access to long acting and permanent methods in Kinshasa and Ituri.

**Except for those marked with an asterisk, all others form part of a centrally-funded project.*

By 2022, the DRC had the largest USAID budget of any francophone SSA country in support of family planning, and it tied for sixth place in USAID family

Figure 8.5 Mr. Bitshi Mukengeshayi and Mme. Rachel Vacka supervising fieldwork

planning funding worldwide, with an annual budget of $20 million. Yet USAID's role in the DRC has extended far beyond funding this alphabet soup of projects. As the leading donor worldwide in family planning, it has significant influence.

Having joined the agency in 2006, Dr. Thibaut Mukaba remained USAID's family planning and reproductive health adviser as of 2023. Mukaba rose through the ranks to become one of the highest-level Congolese nationals in the USAID/DRC health office. His institutional memory – a rarity in a country with frequent turnover – helped to guide the emergent family planning movement.

According to Mukaba, in the two-plus decades since USAID reopened its doors (1999), two trends have emerged: USAID has increasingly moved from vertical programs (only family planning) to funding it as one component of integrated health programming. Second, USAID/DRC no longer sees itself as the dominant player in family planning, as it was in 2010 when it supplied over half of all funding for family planning for the country. With the arrival of new donors and implementing partners, USAID remains a valued agency but others have joined the charge. Rivalries exist among implementing partners bidding on a limited number of projects, and conflicts arise between government agencies and the far better-funded international NGOs. But according to Mukaba, there is magic in the collaboration that has formed among the agencies – donors, government, iNGOs, and others – resulting from years of working together toward a common cause and fostered by the CTMP that created a sense of belonging among major players.

UNFPA intensifies its focus on family planning and contraceptive procurement

In contrast to USAID which operates on a system of competitive bids, UNFPA is mandated to support governmental and other national agencies working in reproductive health/family planning (primarily PNSR) and sexual and reproductive health for youth and adolescents (primarily PNSA), without recourse to competitive bidding. The IPPF member association ABEF-ND also receives UNFPA funding through an agreement at the global level between the two agencies. UNFPA funds national NGOs, community associations, as well as universities, often through competitive processes. At the start of the decade, UNFPA was mid-cycle through its third program (2008–12), which was followed by the fourth (2013–17, extended to 2019) and fifth programs (2020–24). These five-year programs are designed to align with government planning cycles for the health sector.[49]

By 2010, UNFPA's representative Dr. Richard Dackam had been at the helm for over a year. To increase efficiency and productivity, he phased out the 11 provincial offices but retained three decentralized regional offices in Kinshasa, Lubumbashi, and Goma. He reprioritized family planning and safe motherhood over gender-based violence, naming Dr. Théophile Nemaundjare to the post of national family planning program officer. He worked to improve the flow of contraceptive commodities into the country for use by PNSR, ABEF (*Association de Bien-Être Familial*), and other implementing agencies, as well as to track service statistics (a continual source of great frustration among donors).

Figure 8.6 Dr. Théophile Nemuandjare at UNFPA outreach event, 2014

One of UNFPA's most visible and important roles in the DRC involves contraceptive logistics. As the number of organizations active in family planning service delivery has increased through the 2010s, so has pressure on UNFPA to accelerate contraceptive procurement on the international market via its global program UNFPA Supplies (renamed UNFPA Supplies Partnership in 2021). Under this global mechanism, UNFPA hired Dr. Ali Wanogo in 2015 to manage its contraceptive logistics work in the DRC (forecasting, ordering, warehousing, and monitoring through the supply chain). UNFPA collaborated with the PNSR and several iNGOs involved in contraceptive logistics (Chemonics, Village Reach, CHAI) to build local capacity and improve the flow of contraceptives into the country to service delivery points. UNFPA also worked with PNAM, the national program responsible for the procurement of essential medications (well beyond family planning), which oversees the regional warehouses across the country.[50]

UNFPA has faced an uphill battle in procuring sufficient quantities of products in a timely fashion to meet the needs of implementing agencies. It has an annual budget for contraceptives for in-country distribution, based on a plan approved by the PNSR. In addition, several organizations use UNFPA as their purchasing agent, paying them with project funds. In this role, UNFPA remains critical to the success of family planning in the DRC for a significant portion of family planning service delivery.[51] (USAID-funded projects are excluded from this agreement since USAID procures and imports contraceptives on behalf of its own recipient organizations.)

Since Dackam's departure in early 2013, UNFPA has had three resident representatives: Dr. Diene Keita (2014–17), Dr. Sennen Hounton (2017–21), and Dr. Eugene Kongnyuy (2021–present). Others who served as interim representatives include Mr. Keita Ohashi (2013 and 2017), Edwin Huizing (2013), Victor Rakoto (2020), and Cheikh Tidiane Cisse (2021).

Dr. Diene Keita was only the second female UNFPA/DRC representative in two decades. Under her leadership from 2014–17, UNFPA increased its efforts to mobilize resources from bilateral donors, becoming the lead office in the east and UNFPA's East and Southern Africa Regional Office regional office. A forceful advocate for family planning and reproductive health, Dr. Keita worked with the top levels of government, including the prime minister, parliamentarians, and other members of government to ensure their commitment to reproductive health. From 2018–20, Dr. Sennen Hounton strengthened UNFPA/DRC's role in humanitarian assistance. His tenure as representative coincided with the deadly clashes between the Kamuina Nsapu militiamen and the armed forces of the DRC, which led to massive destruction and displacement of populations. Furthermore, it took place in the wake of the 2016 World Humanitarian Summit in Istanbul, which emphasized the links between development, humanitarian work, and peace.

When Dr. Eugene Kongnyuy arrived in 2021, he had the benefit of perspective, having worked in DRC from 2012–16. In the decade since his previous posting, he saw a marked increase in the demand for contraception on the part of the population; family planning is no longer taboo. Yet the agency's priorities have shifted. Funding for safe motherhood/family planning – previously higher than for

SGBV during his previous posting – is now similar for the two. UNFPA strives to meet the demand for contraception from different partners, which far outstrips the budget available to UNFPA/DRC. He recognizes the sizable gap but notes a similar gap in other "big countries."

DFID/FCDO prioritizes family planning through multiple projects

DFID (subsequently merged with and renamed the Foreign, Commonwealth, and Development Office, FCDO, in 2020) joined the fight to lower maternal mortality in 2008, through its Access to Healthcare Program in 20 health zones in Kasaï, Kasaï Central, Maniema, Tshopo, and South Kivu.[52]

In 2012 DFID/DRC put out to bid a large project that would support integrated health services in rural health zones, while also working to strengthen the public sector health system. IMA World Health, still smacking from its loss of the successor project to AXxes in 2011, wasted no time in organizing a bid for this work, and in 2013 the IMA-led consortium won this new project, known as ASSP (the French acronym for Access to Primary Health Care). Whereas in other projects family planning gets lost in the large range of topics covered by integrated health projects, it was in fact a priority in ASSP. The contractual agreement read that if by mid-project, ASSP was not hitting its numerical targets for family planning, the project leadership would rework the budget to further prioritize activities in that area.[53]

Dr. Larry Sthrestley served as the director of ASSP. The family planning component of the project was managed by Pathfinder, under the direction of Dr. Marie-Claude Mbuyi, assisted by Yvette Mulongo (who had worked with the Browns during the difficult years of the 1990s). DFID staff closely monitoring the family planning work at different points across the decade, including Drs. Sarah Goldsmith, Daniel Carter, Lizz Yocum, and Florence Vojak, as well as their Congolese colleague, Dr. Albert Mudingayi.

The rollout of this project occurred as the contraceptive implant was gaining popularity in countries across sub-Saharan Africa, and it quickly became a preferred method among contraceptive users supplied by this project. ASSP exceeded its numerical goals for the volume of contraception distributed (measured as CYP, couple-years of protection),[54] and the impact evaluation of the project showed increased contraceptive prevalence in one of the three clusters evaluated.[55] (Management irregularities had derailed the project in a second cluster, while political unrest precluded data collection for the evaluation in the third cluster).

In anticipation of a rebid of the project, in April 2019 DFID extended the project for 18 months under a new name ASSR (the French acronym for Support to the DRC Health System), working in four provinces: Kasaï, Kasaï Central, Maniema, and Nord Ubangi. In terms of family planning, ASSR reached 107% of its CYP target.[56]

In 2021, FCDO decreased its overseas development assistance by 21% because of major financial constraints for the British government linked to Covid-19 and later support of Ukrainian refugees in the UK. As a result, FCDO limited the geographical

expanse of its follow-on project to the province of Kasaï. Scheduled to run from 2022–25, the SEMI project (French for Essential MCH Services) again prioritizes family planning as one component of a larger integrated health services delivery.[57]

DFID/FCDO also supported family planning through WISH, a centrally managed program (£292.5M, 2017–2024) working across 17 countries in sub-Saharan Africa. Its objective is to allow women to safely plan their pregnancies and improve their sexual and reproductive health. Approximately £3M per year has gone to the DRC, the second largest recipient after Nigeria. MSI Reproductive Choices leads the consortium, which also includes DKT, Options, ABEF-ND, and Ipas. Options and Ipas work on policy issues: domestic resourcing for family planning and safe abortion, respectively.[58]

With this consistent record of project support, DFID/FCDO has been the second largest bilateral donor of family planning in the DRC in the 2010s, after USAID. Starting in 2020, it took a lead role in encouraging the reinstatement of a Population Council (CONAPO) and the development of a national population policy through the *Ministère du plan*.

Global Affairs Canada supports policy work, adolescent programming, and SGBV

Like other bilateral donors, Canada halted assistance in the DRC with the onslaught of the pillage in 1991.[59] It was not until the early 2000s that Canada returned to the DRC to fund development work, and not until 2010 that it funded family planning. Since 2010, Global Affairs Canada has supported policy work for gender equality and incorporated family planning in programming for adolescents/youths, and for SGBV in the DRC. Whereas several expat program officers have rotated through the Kinshasa office, Dr. Marie-Jeanne Bokoko has remained the face of Canada's reproductive health work in the DRC for more than a decade, providing continuity to its work.

In the area of policy, Canada has supported Ipas to work on the Feminist International Assistance Policy (adopted in 2017) and contributed to the legalization of contraceptive use and safe abortion (Public Health Law of 2018).

In terms of service delivery, Canada has supported initiatives combining SGBV and family planning, including the TO SUNGANA project (2021–24 in Kinshasa), the TUSEME KWELI project in South Kivu and Burundi (2022–27), and the Jane Goodall Institute (20 villages in Lubutu and Walikale) (2016–20). It has also contributed to UNDP's "Project Justice, Autonomy, and Dignity for Women" in seven provinces (2018–22).

Canada Global Affairs has been a stronger supporter of adolescent/youth initiatives. It funded the Population Media Center (2014–18) to produce a radio drama on sexual and reproductive health, broadcast in multiple languages and provinces, and Save the Children (2018–21) to promote sexual health and the rights of adolescents in Kinshasa. It supported UNFPA in 2017–19 for contraceptive procurement and programming aimed at adolescents and youth, and in 2021–23 for "Improving the Resilience of the Health System to Ensure Sexual

and Reproductive Health and Rights." In addition, it has funded two multinational programs: "The Power to Choose" (2021–28) and "Project SMART" (2021–2025) which addresses sexual and reproductive health and rights for adolescents in seven countries.

New donors invest in family planning in the DRC

The Gates Foundation plays a catalytic role in expanding family planning

By 2010, the Gates Foundation was expanding its family planning work throughout sub-Saharan Africa. Whereas many donors shied away from the DRC in the tumultuous decade of the 1990s and the uncertain 2000s, the Gates Foundation felt it could no longer overlook the DRC.

Knowing of Tulane's previous work in family planning in Zaïre, Monica Kerrigan contacted Jane Bertrand to discuss the prospects of conducting a "landscaping" of family planning work in Kinshasa: who was doing what, and where were these opportunities for expansion? The Gates Foundation funded Tulane's unsolicited proposal. During this initial three-year project, Tulane conducted a survey of every family planning outlet in Kinshasa, including a crude rating of quality, and shared findings with the facility administrators. Tulane collaborated with partner organizations to plan the 2012 mini conference, used to showcase the family planning work of the few existing partners to each other. And Tulane staff converted what might have been a final report to a website on family planning in the DRC that gave access to a far wider audience on the status of the family planning situation in the country.

Tulane's seed grant in the DRC demonstrated to the Gates Foundation that the country was open for business. Moreover, in the wake of the 2012 London Summit, DRC was of particular interest because of its large population and high levels of unmet need. By 2013, the country had committed to FP2020 and was finalizing its strategic plan.[60]

In April 2014, the Gates Foundation sent a delegation to explore an expansion of its family planning activities in the DRC. Members of the delegation – Papa Sarr, Monica Kerrigan, Jude Uzonwanne, and Perri Sutton – along with Tulane staff met with Prime Minister Matata Ponyo Mapon in his office along the Congo River. The delegation seated around the conference table felt the imposing gaze of the previous Congolese heads of state, whose portraits hung on the walls of his office. The visit led to the rapid expansion of the Gates Foundation portfolio in the DRC, under the leadership of Perri Sutton.

Between 2014 and 2022, BMGF funded 54 investments across 31 grantees, for a total of $80M.

To monitor the work of so many different organizations, the Gates Foundation created a project known as FP CAPE (Family Planning Country Action Process Evaluation) in the DRC and Nigeria. The lead organization – UNC/Chapel Hill – did a masterful job of synthesizing the accomplishments, measurable progress, and challenges across this large portfolio of projects. Twice a year, FP CAPE would organize a two-day meeting in collaboration with the PNSR to present an

easy-to-understand slide-deck of results, which allowed members of the FP community to remain updated on recent findings and trends.[61] The collegial atmosphere of the meetings also fostered solidarity among this group of health professionals working toward a common goal, many of whom knew each other from the CTMP meetings. FP CAPE brought additional value in that its country representative – Dr. Jean-Lambert Chalachala – was seen as a neutral broker who had easy contact with this group of organizations. When the idea emerged to define "*Qui fait quoi ou*?" (a mapping exercise to determine "Who is doing what, where?"), FP CAPE was the ideal organization to take the lead in this exercise.

The effect of the Gates Foundation funding was immeasurable. It increased the number of organizations working in the domain of family planning. It fostered specialization in different aspects of family planning programming: advocacy, service delivery, social/behavior change, population-based surveys (PMA), health information systems, and youth programming, among others. The result was one of the most effective on-the-job training programs in family planning history in sub-Saharan Africa, yielding a cadre of specialists experienced in implementing a full range of family planning programming.

The David and Lucile Packard Foundation promotes youth programming, quality, and safe abortion

Dr. Sahlu Haile, the African regional representative for the David and Lucile Packard Foundation, had attended the 2012 mini conference on family planning in Kinshasa and could see the potential for project work among this very engaged group of participants. At that meeting, he presented the highly successful model of community health workers that had increased coverage for primary healthcare, including family planning, across Ethiopia, significantly increasing contraceptive use.

The Packard Foundation chose to test the waters with a small project that Tulane was preparing to undertake. In 2013, Dr. Tamara Kreinen, head of the population and reproductive health division of the foundation, agreed to support a small study to survey, geo-code, and map all family planning outlets in Kinshasa. Dr. Julie Hernandez, a faculty member at Tulane and geographer by training, introduced the idea of mapping as a management tool for family planning which quickly caught the attention of local program managers.[62]

The following year the Packard Foundation sent a team consisting of Lester Coutinho and Sahlu Haile to explore additional investments in the Congo. Based on the success of the Ethiopia model, the foundation funded Tulane to establish a large-scale CBD program in Kinshasa as a means of increasing access to contraception. The Packard Foundation funding enabled the launch of AcQual I (*Accès et qualité*, Access and Quality) in 2014. Gates joined in financing AcQual in 2015 (expanding it to cover Bas-Congo as well), and both supported AcQual II and III through 2021.[63] The Center for Communication Programs/Johns Hopkins spearheaded the demand creation work.

By 2017, the Packard Foundation had significantly expanded its investment in the DRC, under the leadership of Temple Cooley. Consistent with its focus on

youth programming, it began support to DKT International for the project *Batela Lobi Ya No* (meaning "Protect your future" in Lingala), scheduled to continue through 2024.[64] It also started the first of four cycles of funding to *Médecins du Monde*/France for youth programming.

In contrast to the Gates Foundation, which does not fund abortion-related activity, safe abortion is an institutional priority for the Packard Foundation. In 2017, it funded Ipas, a global leader on this issue, to begin working through local organizations on research and advocacy related to safe abortion. It financed the ground-breaking survey on the incidence of abortion in Kinshasa, which aided with advocacy for safe abortion.[65] In two subsequent funding cycles, it supported the establishment of an Ipas office in Kinshasa and activities that increased access to safe abortion, legalized in the DRC in 2018.[66]

In 2018, Packard added Marie Stopes International (renamed Marie Stopes Reproductive Choices in 2020) to its list of grantees, to support research to understand women's pathways to abortion care, public and private sector provider training, and partial support for the establishment of a call center and MSI clinic for comprehensive reproductive healthcare.[67]

In recent years, the Packard Foundation has placed new emphasis on supporting local organizations, in particular the *Fonds pour les femmes Congolaises* (the Congolese Women's Fund). And its most recent grant to Tulane is to support the local NGO SANRU, in strengthening its capacity to implement and evaluate existing comprehensive sex education models in high schools and contraceptive provision at community based events, a project led by Dr. Lisa Mahoya.

Between 2013 and 2022, the Packard Foundation awarded 41 grants to 13 different international and local NGOs for over $26M. Along with the Gates Foundation, this funding contributed to developing a cadre of committed leaders and middle managers experienced in implementing reproductive health initiatives in the DRC.

The World Bank becomes a major donor for family planning and SRH

In the PARSS project (*Le projet d'appui à la réhabilitation du secteur santé*, the French acronym for the Sector Rehabilitation Support Project) approved in 2006, the World Bank had signaled its intent to support family planning as part of a "well-defined package of quality essential health services to cover 83 health zones in five provinces in the DRC." However, the family planning component never materialized.[68]

By the mid-2010s, the World Bank sharpened its focus on family planning, delivered in the context of integrated health programming. The PDSS project (the French acronym for Health System Strengthening Project), weighted heavily toward MCH, was scheduled to run from 2015–2022. Due to administrative delays, it started in 2016 but was extended through 2024. The project supported training, supply, and purchase of contraceptives.[69] Problems in purchasing and delivering commodities to the provinces delayed the family planning component by two years. But by 2020–21, the PDSS was operating in 13 provinces and 169 health zones, with contraceptives available in most project-supported health zones.

PDSS used an approach known as results-based financing (RBF), whereby health zones were reimbursed for specific results achieved across multiple indicators. For family planning, these included the number of new or continuing users of long-acting methods (such as implants and IUDs) and reversible methods (pills or injectables). A randomized control trial compared health zones with RBF versus those that received comparable funding without strings attached. This evaluation showed positive results for family planning (more so than for maternal and child health indicators): increased use of modern contraceptives, an increased likelihood of women discussing family planning with health providers, and increased availability of contraceptives at health facilities.[70] The downside of RBF was the labor-intensive process of reporting, evaluation, and verification of the service statistics, to thwart *tricherie* (fabrication of numbers). But the World Bank persisted with its exercises of verification and counter-verification, to the point where they considered the system functional.

In 2017, the World Bank initiated a pay-for-performance system for the PNSR, PNSA, and the provincial health offices (DPS) in four provinces. For the PNSR and PNSA, part of the bonus is fixed, intended to support the operations of the agency; the other is based on a quarterly evaluation of performance of key staff (e.g., productivity, attendance, length of time in the organization, and attitude). Extra points are awarded to leadership for the completion of big-ticket items, such as the strategic plan. The system has brought salary relief to chronically underpaid government officials and incentivized them to accomplish certain tasks. Its limitations have been the additional paperwork entailed in scoring the performance of several key persons in each organization, a certain subjectivity to the personnel scoring mechanism, and delays in the system of reimbursement. And it begs the question of sustainability: what happens when the *primes* end?

In 2019, the World Bank further signaled its support for family planning in announcing a $502M PNMS (French acronym for Multisectoral Nutrition and Health Project), which included a $10M grant from the Global Financing Facility.[71] This five-year project was subsequently extended to 2026. Whereas the main focus is on nutrition and child stunting, the project aims to provide family planning services to 200,000 women in four provinces. The World Bank awarded funding to international and local NGOs – SANRU/Pathfinder for Kwilu and Kasaï Central, ASF for Kasaï, and Save the Children for South Kivu – for work including both community-level activities and clinical service delivery.[72]

To stimulate demand creation in the context of PDSS, the World Bank granted the Center for Communication Programs (CCP)/Johns Hopkins $500,000 to research nutrition and family planning, and to create programs to reduce malnutrition, stunting, and other health issues in the country. The work has focused on social and behavior change interventions and scaling up high-impact practices for nutrition and family planning at the community and primary care levels in the provinces of Kasaï, Kasaï Central, Kwilu, and South Kivu in 2021–2022.[73]

A major obstacle for the World Bank – and others in the DRC – has been the difficulty of obtaining sufficient contraceptive commodities to meet the needs of their projects. The problem is further aggravated by the fact that regional warehouses tend not to reorder as their supplies diminish. On the demand side, their projects –

especially those based in rural areas – face the deep-seated societal preference for large families. Recounts Dr. Baabo Kuyuba, manager of PDSS for the MOH, the population considers that "*les enfants sont notre richesse*" (children are our wealth). Even with the new law that gives women the right to use contraception, if they so desire, most women depend on the men in their lives for their survival and that of their children. In such a situation, the cost of going against the husband's wishes is very high.

Anonymous donors support post-abortion care and contraceptive procurement

In contrast to other private donors that channel their funding through iNGOs, a foundation that prefers to be known as the "large anonymous donor" wanted to give more leadership to the MOH. In 2018 it began supporting the MOH for a five-year project designed to integrate family planning and post-abortion services using a pay-for-performance scheme. Initially, project staff defined the criteria used to assess performance, trained "verifiers" who would visit services each trimester to assess performance, and developed a matrix of hospitals and health centers to participate. Just as the World Bank was giving bonuses (*primes*) to government workers, the large anonymous donor intended to do so. Yet mid-project the funding was no longer available. The MOH had instead used it for the Ebola outbreak. As a result, in late March 2020, the donor withdrew from the project and the country, several years before the expected completion date.

Tulane and DKT International both benefited from funding from a Boston-based anonymous donor who wanted to get contraception into the hands of the largest possible number of interested users as efficiently as possible. To this end, they supported the scale-up of the nursing school model to additional schools in Kinshasa and the city of Matadi between 2016–18. Starting in 2019, they invested funding in the purchase of contraception, to be used in programming run by Tulane and DKT, with DKT serving as the procurement agent. Because some donors do not cover the purchase of contraceptives and UNFPA is generally stretched beyond capacity to fulfill the needs of the DRC, this funding provided particularly useful to fill important gaps in contraceptive procurement.

CAFI and FONAREDD supports family planning with environmental funding

Mr. Jostein Lindland was first posted to the Norwegian embassy in Kinshasa in October 2011 as climate and forest envoy. When he returned to the Norwegian Ministry of Climate and Environment in Oslo in 2015, he was instrumental in creating and implementing the Central African Forest Initiative (CAFI), a multi-donor initiative designed to protect the massive forests in Central Africa and improve resilience to climate change. Whereas much of CAFI's work involved agriculture, rural development, alternatives to charcoal, land use planning, sustainable forest management, land tenure, governance, national forest, and climate strategies, the DRC agreement signed in 2016 also referred to demographic pressure as an important underlying cause of deforestation.[74] As early as 2011,

Lindland had started to educate himself about family planning. He was keenly aware of the complex ways in which growing populations, entrenched poverty, and lack of alternative livelihoods, particularly for women, contributed to environmental degradation: through extensive slash-and-burn agriculture and deforestation for charcoal production to fuel an ever-increasing urban demand. Family planning, through its direct and indirect effects on health, education, and access to economic opportunities was seen as a means to offset these negative dynamics.

When the CAFI-DRC agreement came out in 2016, some 6% of the $190 million CAFI investment was earmarked for family planning. Yet only multilaterals (e.g., UNFPA) or bilaterals (e.g., USAID) were eligible to bid on this funding.[75] After two rounds of open tender with no bidders, Lindland proposed CAFI-DRC take a different approach: identify existing family planning organizations with a track record in family planning service delivery to bid on these funds. Once awarded, a UN agency would manage the project. Family planning funding further increased when program managers found unexpended funds in other parts of the FONAREDD budget that risked being lost if not spent.

With $33M at stake, the MOH did not want to see this funding go to international NGOs. Yet the donors were hesitant to channel this funding through government entities, given previous financial irregularities and a weak record in contraceptive service delivery. In a chicken-and-egg situation, the government argued that the funds should go to strengthening the weak health systems in the country, which would then be able to provide better family planning services. Yet strengthening health systems is a long and expensive process, with little expected output in terms of family planning. After much discussion, a compromise was reached whereby the government would at least have some involvement in the project (e.g., training, supervision visits to the provinces, and the construction of a large warehouse in one of the provinces).

Thus, was born the PROMIS project, the French acronym for the Project to Scale up Family Planning in the DRC, implemented by Tulane (as the Technical Lead), DKT, and Marie Stopes, with financial oversight by UNOPS; UNFPA received funding for procuring, importing, and distributing contraceptives. Each of the implementing partners used different community approaches for increasing access to contraception in 11 of the 26 provinces between 2019–22 (with an extension through 2023). This project was designed unapologetically to generate CYP (large quantities of contraception distributed to clients in the selected provinces).[76] In its first three years of operation, it produced over 5 million CYP, by far the largest quantity of any project in the DRC. In the one year with reliable national data (2022), PROMIS was responsible for 41% of the total CYP generated in the country.

The Swedish International Development Cooperation Agency supports youth programming and safe abortion

The Swedish International Development Cooperation Agency (SIDA) began supporting other areas of development work in the DRC in 1998.[77] In the 2010s, it committed to assisting the DRC in achieving the Sustainable Development Goals (SDGs), in particular SDG 3 (good health and wellbeing) and SDG 5

(gender equality). With a strong focus on gender, its funding has gone primarily to integrated SRHR projects with a youth focus and to safe abortion.

From 2010–12, SIDA granted $800,000 to Columbia University to implement the RAISE (Reproductive Health Access Information and Services in Emergencies Initiative), which worked to address SRHR through technical and financial assistance for advocacy, training, and monitoring and evaluation in North and South Kivu.[78] From 2015–2020, it channeled $8.3M through UNFPA for a project to improve the integrated quality of services for sexual and reproductive health, maternal and newborn health, and family planning, with an emphasis on training community health workers in ten health zones of Kinshasa; implementing agencies were Pathfinder International and *Médecins du Monde*. Due to Covid-19 and other problems, these donors reprogrammed unused funds ($1.5M) to other areas of sexual and reproductive health and rights.

SIDA funded DKT International for social marketing in sub-Saharan Africa from 2019–23, with $1.2M for use in DRC. This funding went to support *Batela Lobi Na Yo* ("Protect Your Future" in Lingala) which combined social media and a television show to cover an array of topics including menstruation, abortion, STIs/HIV, and a variety of contraceptives. This regional funding increased its reach to 14 cities, whereas additional support funded activities in North and South Kivu.

SIDA was also among the donors supporting safe abortion. Explained Tamara Jonsson, Program Specialist/Health at the Swedish embassy in Kinshasa, "It is challenging to work in humanitarian settings because humanitarian organizations don't fund abortion and the demand is very great." Following the legalization of abortion in 2018, SIDA provided financial assistance to Ipas (2020–24) to assist the PNSR in developing provider guidelines for the implementation of abortion services in the DRC. The collaboration among several donors, government agencies, and iNGOs has contributed to the DRC being one of the first francophone African countries to have a full range of comprehensive abortion care.

The Netherlands Organization for International Development Cooperation works in humanitarian assistance and safe abortion

While not a family planning donor per se for the DRC, the Netherlands has funded humanitarian initiatives for over a decade. Dutch funding to the DRC on family planning is limited, though its work in security and the law, humanitarian aid for displaced persons, and women's rights and gender equality is closely associated with family planning.

Since 2010, the Netherlands has channeled its major DRC health funding to the Great Lakes Regional Program, a multi-country initiative that targets the root causes of conflict in eastern Congo. One of the five themes of the Great Lakes Initiative is sexual and reproductive health and rights; funding supports victims of sexual violence with medical and legal assistance and psychosocial care.[79] Although the project involves four countries – DRC, Uganda, Rwanda, and Burundi – three-quarters of the funding went to the DRC as of 2022.

In addition, the Netherlands Cooperation has been a strong supporter of safe abortion, which it views as closely linked to sexual violence, especially rape. Following

ratification of the Maputo Protocol by the DRC authorities in 2018, it provided funding to a consortium led by Ipas to establish three "one-stop centers" for safe abortion in Kinshasa, specifically in Makala, Kimbanseke, and Kintambo. This intervention is currently being extended to other provinces in the DRC, mostly in the east.

New organizations join the established government and NGO partners

PNSR continues as the lead government organization in family planning

In contrast to the 1980s when USAID funded PSND to manage the provision of service delivery in 14 cities nationwide, the role of PNSR had changed by the 2010s. Although lacking the financial or human resources needed to operate a national program, it has remained the voice of the government in all matters related to family planning. The PNSR focuses on three technical areas: establishing service delivery norms and guidelines, managing contraceptive logistics in collaboration with other partners, and training clinicians in family planning service delivery. The *Clinique Libota Lilamu* still operates in the same building as the PNSR but has never evolved to become the model clinic it was designed to be.

As of 2010, Dr. Marie Louise Mbo had directed the PNSR for three years and would continue to do so for four more. Then one day in 2014, she received a phone call from the minister, informing her that she would be replaced. "You never know when the call will come or why the change is being made," she explained. "It's simply how it's done."

Dr. Marie Thérèse Kyungu would serve as PNSR director from 2013–17. She was originally appointed as the deputy director of PNSR. As a practicing Ob-Gyn, Dr. Kyungu was very familiar with the clinical aspects of service delivery for family planning, management of pregnancy, and obstetric complications, but less experienced in managing family planning programming at the population level. She set about to increase her knowledge of the field.

Like her predecessors, she learned by surprise – via the radio – that the (new) minister of health had named her to the post of director. When she began, she was not sure the staff would fully accept her, but she pushed ahead with the tasks at hand. Several activities were in full swing: the strategic plan, the Public Health Law, and emergency obstetric care. If less experienced in family planning programming, her clinical work proved highly relevant for the PNSR portfolio of safe motherhood activity.

As she worked to expand her knowledge of different aspects of family planning, she developed constructive relationships with the donors and the iNGOs working in this space. Realizing that she had a limited budget, she collaborated with partner organizations to design and implement a series of activities that advanced the field. Her greatest satisfaction from the position came from witnessing the results of work she had supported: the launch of the strategic plan, the successful execution of the 2014 National Conference on Family Planning, and the release of government funds for contraceptive procurement. When asked about her relationships with the implementing partners, she replied, "They were always very positive."

Yet a change in minister would bring another turnover in the position of PNSR director. When Dr. Kyungu returned from traveling abroad, she learned of the change, not from the minister but from her replacement. Although disappointed that some work was left unfinished, she lost no time in returning to her clinical activities, and PNSR staff continued to consult her on certain problems, indicating that she need not have worried about being accepted.

In November 2017, a group of colleagues was preparing for a dissemination meeting of research findings at the Pullman Hotel. The presenters were milling around the podium on the stage when Mr. Mbadu Muanda arrived, uncharacteristically late and out of breath. He explained apologetically, "The minister called me into his office this morning." Later that day, the minister announced that Mbadu would replace Dr. Kyungu as the new director of PNSR and that he would retain the same title at PNSA. Although many thought it odd that a single individual would be asked to do both jobs, most welcomed the prospect of having such a seasoned manager in the position.

Mr. Mbadu lost no time in implementing a new mandate. In the absence of partner funding, he convened a meeting of donors and implementing partners to present his vision and outline priority activities. Within months the PNSR received sizable grants – from UNFPA to renovate the offices and purchase computers, from UNICEF to support training activities, and from PATH to purchase office equipment. PNSR staff developed and submitted a budgeted work plan (PTBA) to the World Bank through the PDSS project, which made the agency eligible for funding, including performance bonuses, to the tune of $1M a year. Directeur Mbadu also sought out technical collaboration and financial support from ABEF, DKT, MSH/PROSANI, SANRU, and Tulane. He obtained funding from the African Development Bank to support two consultants to develop software to digitalize the records of the *Clinique Libota Lilamu*. In less than a year, the PNSR became a vibrant organization, in step with partners who shared the collective drive to advance family planning in the country.

As director of both PNSR and PSNA, Mbadu solicited contributions from partner organizations and succeeded in building a new office space for PNSA adjacent to PNSR in the Kintambo Maternity compound. The partners – Elizabeth Glazer Pediatric AIDS Foundation (EGPAF), DKT, EngenderHealth, Pathfinder, MSH/PROSANI, Tulane, UNFPA, and the World Bank – were eager to further the work of this dynamic leader. Later, Mbadu would greet his visitors from one of the partner organizations, acknowledging their donations: "Pathfinder, these are your bricks," or "Tulane, these are your wooden doors."

Yet Mbadu's tenure was short. In less than a year (July 2018), the same minister who hired him informed him that he was to be replaced as director of PNSR but retain the directorship of PNSA. Ironically, on the day of his departure from PNSR, the staff received their very first performance bonuses from the World Bank project. Mbadu took great satisfaction in having facilitated those payments for staff whose motivation to work had been revitalized under his leadership.

The new PNSR director was Dr. Lis Lombeya. A physician by training, her previous experience was largely in HIV/AIDS programming. In contrast to her two immediate predecessors – Dr. Kyungu and Mr. Mbadu – she had not worked

previously on family planning programming. Moreover, she arrived at a time when the different partner organizations were already very active; the proverbial train that left the station in 2012 by now had gained tremendous momentum. Dr. Lis had the challenging task of establishing her brand of leadership within a community that had far more experience in the subject matter than she did and had developed an effective mechanism for collaboration through the CTMP.

During Dr. Lis' tenure, she worked on domestic resource mobilization with members of the CTMP, attending a conference of the Mining Society in Kolwezi in September 2019, in which they spoke to the then-President Joseph Kabila about the need for family planning. The PNSR also oversaw the Fourth National Conference to Reposition Family Planning in December 2019. Yet her two years in office were turbulent, and multiple parties brought pressure on the minister of health to remove her from the post.

After resisting this pressure for months, the minister of health resolved the situation by switching the position of two directors. He transferred Dr. Lis Lombeya from PNSR to workplace health, and named Dr. Anne Marie Tumba, director of workplace health, as director of the PNSR. In October 2020, Dr. Tumba received an unexpected call from the minister, informing her of her new position. When asked how she became involved in family planning, she replied "by chance."

Dr. Tumba took the reins of PNSR as the Covid-19 pandemic paralyzed daily life in countries worldwide. In the DRC, the MOH did not close health facilities or programs working in public health. Rather, it called for strengthening prevention activities (e.g., masks and handwashing), and it reduced potential exposure by imposing restrictions on the number of persons in a meeting room or the percentage of staff who could be in the office on a given day. As elsewhere, Covid-19 was a great disruptor, but organizations found workarounds to keep their activities going.

Dr. Tumba was soon confronted with at least two major challenges: overseeing the development of the second strategic plan for family planning and drafting the commitment that the DRC government would present at the International Conference on Family Planning (which in the end was postponed several times because of Covid-19). Professor Dosithée Ngo Bebe and Dr. Jean-Pierre Guengant served as consultants on the strategic plan, working under contract with EngenderHealth with different members of the family planning community. Given a change in the dynamic among the family planning stakeholders, it was more difficult to arrive at a consensus on different aspects of the plan, but by August 2022 the *Plan stratégique national à vision multisectorielle de la planification familiale 2021–2025 avec regard sur 2030* was issued.[80]

Over this decade of changing leadership, the government continued to pay the salaries of PNSR staff and provide the office buildings for their work. Most of the funding that supported the activities of the PNSR came from donors, with UNFPA and later the World Bank as its primary source of institutional support. It also conducted multiple activities (training, workshops, and supervision visits) in collaboration with iNGO partners that financially supported the activities. PNSR continued to play the role of lead agency for the DRC government in all aspects of family planning, though not without tensions among the stakeholders beginning in 2018.

Figure 8.7 Dr. Anne Marie Tumba and Directeur Mbadu Muanda, outside the Clinique Libota Lilamu

PNSA grows in capacity and visibility

Whereas the PNSR rotated through ten different directors or interim directors in less than a decade, the PNSA had a single director – Mr. Mbadu Muanda – for all but one year of its history. As explained Muanda, ministers look to see which programs are well-funded by international donors. Especially in the early days, PNSA was protected by having far fewer partners than larger programs in HIV, malaria, or even family planning. He also admitted that having strong management skills and good donor relationships had helped him to hold onto his job.

To his formal training in demography in the early 1980s, Mbadu added a master's degree in management in 2021, specializing in development, from the Catholic University of Congo. His management acumen, combined with several decades of field experience, has allowed PNSA to expand.

The PNSA has attracted considerable donor funding in two areas: sexual and reproductive health and applied research. The World Bank (through the PDSS project), WHO, UNICEF, and UNFPA have been its main donors. With this support, the PNSA expanded the WHO-endorsed model of *coins de jeunes* (youth corners) within existing family planning services.[81] The PNSA, in collaboration with iNGOs that had funding for this type of activity, set up 74 youth corners in the city of Kinshasa: 45 supported by Save the Children, ten by UNFPA, nine by WHO/UNAIDS/CORDAID, six by Pathfinder, and four by *Médecins du Monde*/France. By 2022 it boasted activities in 19 of the 26 provinces.

Because of Mbadu's own training as a demographer and in-depth experience in conducting research, PNSA has a research capacity that far exceeds what one would expect in a government agency with a programmatic mandate. It is a one-stop-shop, capable of instrument design, data collection, data processing, analysis, report writing, and public presentation of the results. Frequently, partner agencies subcontract with PNSA for specific studies or evaluations.

Since 2010, PNSA developed three strategic plans, supported by UNFPA and UNICEF.

In 2014, the PNSA spearheaded a Round Table on Youth and Adolescents SRH, which brought a new level of visibility to this still-controversial topic. It served to introduce different organizations working in this space to each other. And it established the leadership role of PNSA among this subgroup of family planning stakeholders.

As of 2017, PNSA also benefited from the World Bank pay-for-performance funding, whereby its staff received *primes* based on the completion of specific activities or tasks. These bonuses have improved staff attendance and the quality of the work produced. A drawback to this system is the amount of paperwork required each trimester to justify these bonuses, resulting in delays in their payment.

New international and national NGOs join the family planning movement

In 2010, a dozen international NGOs headquartered in Kinshasa worked in family planning. Several more worked almost exclusively in the east. By 2020, the number would be close to double, as shown in Box 8.2.

Box 8.2 International and local NGOs working in family planning in the DRC

Already active by 2010:

Kinshasa-based iNGOs:
Academy for Educational Development/AED (which would become FHI360)
Care International
DKT International
IMA World Health
Institute of Reproductive Health/Georgetown
IntraHealth
International Rescue Committee
Management Sciences for Health
John Snow Inc
Pathfinder International
Population Services International (PSI)
Save the Children

iNGOs providing family planning integrated in HIV services
PATH
Elizabeth Glaser Fund for Pediatric AIDS (EGPAF)

iNGOs working primarily in the East
Care International
Merlin
Columbia University
Médecins sans Frontiers
International Committee of the Red Cross (ICRC)

Local NGOs working in family planning:
Association Bien-être Familial – Naissances Désirables (ABEF-ND)
Association Santé Familial (ASF)
Conduite de la Fécondité (Catholic)
Maman Ansar (a Muslim group)

New NGOs working in family planning since 2010

Kinshasa-based iNGOs:
Tulane International (2011)
EngenderHealth (2013)

Center for Communication Programs/Johns Hopkins (2014)
i+solutions (2014)
The University of North Carolina/Chapel Hill (2015)
Clinton Health Access Initiative/CHAI (2016)
Jhpiego (2017)
Chemonics (2017)
Abt Associates (2018)
Ipas (2018)
Marie Stopes International (2019) (renamed MSI Reproductive Choices in 2020)

Local NGOs working in family planning or sexual/reproductive health since 2010
Action Santé et Développement (ASD)
HPP-Congo (Humana People to People)
REEJER (*Réseau des Éducateurs des Enfants et Jeunes de Rue*)
SANRU
Si Jeunesse Savait

iNGOs working primarily in the East
Cordaid
i+solutions
Caritas
Health Africa

These organizations became the engine behind a wide-ranging number of projects designed to advance family planning in the DRC.

Social marketing: PSI withdraws, ASF falters, DKT expands

At the start of the decade (2010), ASF/PSI was at the apex of its work, operating in 10 of the 11 provinces, with a network of 93 clinics and 327 pharmacies. Although it focused primarily on urban areas, its reach was unparalleled by any other service delivery organization. Even with steady funding from USAID and the Dutch government (for contraceptive procurement), ASF/PSI could not keep up with the demand for contraceptives. Reflects Jamaica Corker, the PSI adviser for family planning, "We were so proud of our 93 clinics and 300 plus pharmacy partners, but that was barely a drop in the bucket for a country of 70 million."

ASF/PSI had developed the social franchising model based on the *Confiance* model, whereby clinics with trained personnel could brand their facility with a *Confiance* sign. By 2010, the *Confiance* product line included pills, condoms, injectables, CycleBeads, and IUDs. With the influx of funding for malaria and HIV/AIDS, ASF/PSI had grown exponentially.[82] As had been the case for over a decade, PSI obtained and managed the funding, which financed the work of ASF

in implementing a host of different projects. Within the country, ASF was the face of their operation.

In 2010, a second internationally recognized social marketing organization – DKT International – arrived in Kinshasa to set up shop. Curiously, PSI and DKT were founded by the same individual, Phil Harvey, who used the profits from the Adam and Eve store (that advertises itself as "the #1 source for adult toys") in Raleigh, North Carolina, to finance social marketing in the developing world.[83] Traditionally, they had "divided up the world" in terms of the countries selected: DKT tended to work in the larger countries (India, Mexico, Philippines, and Brazil), and PSI in smaller ones. But in 2010, this distinction began to blur. In the DRC, PSI did not exactly welcome DKT with open arms, but their staff did acknowledge that "marketing is based on competition."

In 2010 DKT set up an office in Kinshasa, began to hire staff (poaching some from ASF/PSI), and worked on developing its own product line. Its first director, George Simpson Jr., was replaced in 2011 by Sandra Gass, who lost no time in adding to the number of contraceptives to be marketed and developing a new brand. DKT had previously decided to import "OK Condoms," a brand that it had used in other countries, to jump-start activities in the DRC. DKT promoted OK Condoms with a positive spin on fun, in contrast to the more conventional messaging about "protection." Gass directed the development and pretesting of the brand name for DKT's new product line: Aleze, a non-word that conjures up "being at ease" in French. It appeared on the attractively designed packaging of pills, emergency contraception (pills), and later on IUDs. DKT also trained pharmacists, clinical providers, and community health workers, with an emphasis on IUDs and implants for clinical providers.[84] Before leaving in 2016, Gass secured funding for what would become DKT's signature initiative, *Batela Lobi Na Yo* (Protect your future).

By 2015, a friendly rivalry existed between the two social marketing groups. Because of its longer history in the country, ASF/PSI distributed considerably more units of contraception than DKT.

In 2017, the floor fell out from under the ASF/PSI operation in the DRC. As PSI's CEO Karl Hofmann candidly explains, PSI had received $170M from the Global Fund for a nationwide insecticide-treated bed net campaign that ASF was responsible for implementing. The project had shown impressive results in distributing over 25 million bed nets and lowering the rate of malaria. But in 2016, a routine audit suggested irregularities in the procurement process.[85] As the investigation of this situation was underway, local members of the ASF board of directors became increasingly vocal in their desire to break away from PSI and become an independent entity, able to directly receive funding from donors. Hofmann described it as a "unilateral declaration of independence." When the findings from the audit revealed systematic irregularities in procurement (phantom companies and inflated prices), PSI lost confidence in the ability of ASF to execute projects at this level. PSI could not stop ASF from breaking away, but it was no longer willing to continue with a joint enterprise. PSI was required to repay $7M to the Global Fund for this fraudulent activity, at which point they informed the

Global Fund that they could no longer deliver on this work in the DRC and withdrew from the project.[86] PSI considered registering in-country as a separate iNGO, but when they were unsuccessful, they realized it was no longer practical to have PSI staff in-country and finally withdrew in 2018.

The late Professor Payanzo Nsomo recalled the events differently. ASF was formed in the late 1980s (well before PSI entered the country) to promote HIV/AIDS awareness and prevention, and it would later expand to other areas of health, including family planning. In 2000, it was formally registered as a local NGO. Prof. Payanzo was a founding member of ASF and president of its board of directors. In 2012–13, ASF developed a strategic vision that would allow it greater autonomy. Specifically, ASF requested that PSI allocate a certain percentage of overhead (even 1%) to ASF for its own institutional development and allow it to receive funding directly from donors, independent of PSI. It set 2016 as the year to implement this vision. Prof. Payanzo remembered receiving approval of this proposal from the CEO of PSI in May 2014. The two organizations continued to work in lockstep as they had for years until 2016, and they passed multiple audits required by funding agencies. "It was a period of great love, with outstanding performance," according to Payanzo.

However, the lovefest ended in 2016, according to Prof. Payanzo, when ASF asked PSI to honor its previous commitments: for PSI to provide ASF with some discretionary funding (overhead) and allow it to receive funding directly from donors, independent of PSI. In Prof. Payanzo's version, the CEO of PSI refused, and PSI ordered the 2016 audit of ASF as a punitive measure designed to tarnish ASF's good name. As for the $7 million that PSI was required to reimburse to the Global Fund, Payanzo considered it incomprehensible, based on results of the audit that he described as "assumptions and allegations." The entire incident brought into question the legal status of PSI's registration as an iNGO working in the country (which had not been formalized), and the government withdrew its support of PSI to continue working in the DRC. In short, after three decades of working together seamlessly in a highly productive collaboration, PSI withdrew from the DRC, and ASF was left to fend for itself.

Unsurprisingly, ASF soon encountered financial difficulties, since almost all its funding had come via PSI. From 2018–22, it continued to exist, operating through the social marketing of the water purifier Aquatabs, as well as self-funded projects. In 2022, it received a new lease of life, when it began to receive family planning funding from the World Bank to operate in Kasaï, as well as smaller amounts from others.

The departure of PSI from the DRC cleared the stage for DKT to significantly scale-up contraceptive social marketing activities. Three consecutive executive directors – all male, all European, all with a strong private sector background – brought a renewed energy to the task. Quipped Jacques-Antoine Martin, "We were doing penitence for the years we worked in marketing tobacco."

During the tenure of Jacques-Antoine Martin from 2016–18, DKT created a new platform for its social marketing of contraceptives: a youth-oriented project named *Batela Lobi Na Yo*. From 2018–19, Ian Kreutzberg took the helm as

country director for some 17 months, introducing MIFEPACK in late 2019 to increase access to safe abortion. He also opened a DKT office in Mbuji Mayi, Kasaï, a province where family planning needs were very high. His successor, Jean-Christophe Carrau (from 2020), expanded geographically to cover more provinces (22 of the 26 as of 2023) with new depots in Kolwezi and Goma. He increased DKT's efforts to address the needs of the hard-to-reach by incentivizing providers in the community-based distribution model. And he diversified the product line, adding five new items by 2023.

Family planning in the eastern provinces of the DRC

Much of the family planning work in the DRC is based in Kinshasa, where government ministries reside and international NGOs are headquartered. It is easy to lose sight of the family planning work taking place in the eastern regions of the country for several reasons: it occurs some 1,600 miles from Kinshasa; it often involves iNGOs that specialize in humanitarian assistance; this portion of the country continues to pose security problems, making it an inhospitable environment for exploratory visits; and in recent years, some of these projects are multi-country initiatives administered from Rwanda or Burundi.

Several organizations – ASF/PSI, Care International, Columbia University, and International Rescue Committee (IRC), among others – were undeterred by the volatile conditions of the east and continued to deliver family planning services, even before the central government of Joseph Kabila reclaimed control of the provinces of North Kivu, South Kivu, Maniema, and Orientale in 2006.[87] Family planning often has been coupled with interventions on gender-based violence, prevalent in this worn-torn region to this day. As a minor part of their work, these projects pioneered emergency contraception (EC) in the DRC, with somewhat lackluster results. One unexpected consequence was that professionals in Kinshasa and elsewhere viewed EC as a "post-rape" method and assumed its use should be limited to the east. As commonly occurs, many confuse EC with the abortion pill.

Jessica Kakesa, regional manager for the Great Lake/Reproductive Health for IRC, first worked in family planning in the east in 2009. At the time, IRC shared the perception of the government that family planning would not be a priority. In such an unstable setting, it would be necessary to focus instead on life-saving interventions. A few faith-based organizations provided family planning, albeit passively with a limited range of methods. To her surprise, over time, community acceptance – even among men – began to increase. Jessica left that job and returned to family planning several years later. She found that far more women had started to accept contraception. Over time, they gravitated toward longer-acting methods, in particular the implant, "but not the *sterilet*," the unfortunate French translation of the IUD with the mistaken association to sterilization. (The RAISE project had a different experience; IUDs became an accepted part of the method mix.)

Dr. Emilio Mashant, reproductive health adviser for IRC from 2010–13, echoed the sentiment on the acceptance of family planning among men in rural

areas. To his surprise, in the district of Kalehe (South Kivu), a considerable number of men came to get a vasectomy because they could not provide for any more children – sometimes against the wishes of their wives. Explained Mashant, the women were opposed because the birth of each new baby further cemented their marriage and was the occasion for them to receive a gift, such as a *pagne*.

The presence of these organizations working in family planning resulted in heightened interest and commitment to family planning from the government – at different levels of the health pyramid. In contrast to their distinct disinterest in the past, personnel in the health zones began to besiege IRC with requests for contraceptive commodities to fill the growing need in these populations. Especially for the population of displaced persons who live in a constant state of trauma and must scratch for survival on a daily basis, the burden of another child can be heavy.

Working in family planning brings its own set of challenges in eastern Congo. The presence of the military keeps everyone on high alert, and with reason. The pillages by armed groups are not necessarily focused on health centers or family planning providers. But when they occur, everyone suffers. Staff must move to another location for safety. Many remember the tragic fate of Mme. Elysée Kalemwa, national community health officer for IRC, who was doing health education work in the health zone of Rwanguba, near Bukavu, in 2019. Upon her return home, armed groups ambushed her vehicle; she was shot and killed. Such incidents create a constant source of stress for health workers who leave home, not knowing if they will return. At times, these humanitarian agencies can develop close working relationships with local health zone officials that provide some degree of protection. Still, the danger is ever-present.

Frank Roijmans of i+solutions recounts the challenges of implementing projects in war-torn areas in North Kivu. Training on supply chain management and contraceptive logistics was conducted in "safe areas" and only after contact with the UN Peacekeeping force, MONUSCO. iNGOs working in the area shared information on routes that were secure versus those to be avoided. The CTMP in South Kivu formed a logistics committee consisting of i+solutions, Cordaid, and PSNR South Kivu (among others) that redeployed contraceptives from health zones that were overstocked to those with stockouts. They also assisted in supplying the so-called "orphan health zones," those without support from an iNGO partner.[88] In Beni, their work was further complicated by the outbreak of Ebola in 2019.[89] i+solutions reverted to training conducted by trainers already living in the area. Follow-up of stock reporting and supportive supervision were all done remotely and where feasible through the internet from the health zone level.[90]

Prisca Ntabaza of the Dutch Ministry of Foreign Affairs touts the importance of donors remaining flexible and in touch with the realities on the ground. They must be willing to update a budget and reallocate funding to adjust to constantly changing circumstances. Her organization does conflict sensitivity analysis, checking in with its partners monthly to get a sense of the community's reaction to specific programs and working to avoid potential conflict, such as sending in personnel of the wrong ethnicity to a given community. Those working in the east lament that their work is often governed by policies established in Kinshasa, by persons unaware of the daily realities where intermittent conflict persists.

Innovative, impactful work advances the field

Over the decades, most family planning funding was expended on the basics: training, supervision, equipment and supplies, contraceptive commodities, demand creation, and monitoring and evaluation. These fundamentals represent the cornerstone of family planning.

Yet countries benefit from innovative work that accelerates progress toward the objective of improved access to services. Examples include the following.

Testing and scaling up the nursing school model for community-based distribution

In 2014, the DMPA subcutaneous injection – known by the brand name Sayana® Press – emerged as a potential game changer for family planning programs in low- and middle-income countries. Because of the pre-sterilized single-dose injection device and ultra-thin short needle, it could be administered by trained community health workers or even self-injected by the user.[91]

However, in DRC, the medical convention held that only doctors and nurses could perform injections; task-shifting the provision of DMPA-IM (intramuscular) or DMPA-SC (subcutaneous) to community health workers or others without clinical training was a non-starter. Yet Arsene Binanga of Tulane International identified a potential loophole. Medical and nursing students were authorized to give injections if trained and supervised by their instructors. The model was inspired by the clinically-trained network of community providers in Ethiopia, with one important difference. In Ethiopia, the government paid a salary to these workers, which would not be possible in the DRC. Thus emerged the concept of using medical and nursing students as clinically-trained community-based distributors. Instead of salary, these students would receive valuable field experience as part of their training, as well as occasional perks (e.g., money for transport on campaign days).

With buy-in from the relevant government agencies (PNSR and PNSA) and other stakeholders, Tulane designed a pilot test in 2015 to assess the feasibility and acceptability of using medical and nursing students to deliver DMPA-SC (along with pills, condoms, and CycleBeads) at community outreach events. The students and their instructors would assemble in a central location, such as the courtyard of a health facility or a public meeting place. Health zone outreach staff (*relais communautaires*) and the students themselves would announce the availability of family planning services for interested women, often with songs and chants through a bullhorn. The pilot test revealed high levels of satisfaction on three counts: acceptors liked DMPA-SC, acceptors trusted and appreciated the service they received from the young providers, and students were gratified to be giving back to the community.[92]

The more far-reaching discovery was the potential of this cadre of students to increase access to low-cost contraception in the short run while improving the quality of service delivery for future generations of healthcare providers.[93]

The leadership of the DESS (*Direction de l'Enseignement des Sciences de Santé*, responsible for a network of over 600 nursing schools nationwide) – Mr. Komba Djeko André (2015–2016) and Mr. Désiré Bapitani (2016–2023) – embraced this opportunity to update the quality of training in their schools.

At the December 2015 dissemination meeting of these results that included key MOH decision makers, the audience not only supported this approach but called for the piloting of additional strategies to increase access to contraception at the community level. Within a year, two other pilots began: one to test the feasibility and acceptability of using nursing students to insert Implanon NXT (a single-rod implant inserted directly under the skin on the inside of the upper arm using an all-in-one applicator) and a second, to train interested clients to self-inject DMPA-SC. Both studies yielded positive results for these new strategies. With authorization from the MOH, Implanon NXT immediately became part of the range of methods offered by nursing students. The MOH also authorized nursing students to train clients to self-inject DMPA-SC.

In retrospect, the "game-changing" innovation in the DRC was the use of nursing students – who through the piloting of the approach – became authorized to administer Implanon NXT, increasingly the most popular method for women in the DRC.

In 2016, Tulane worked with the DESS to update and incorporate a ten-day course of family planning into the routine training of nurses. After the classroom portion, students would obtain field experience, counseling and providing contraception to interested clients in community settings. Given the didactic nature of much classroom instruction in the DRC, these students appreciated the competency-based training. Because these students were of high school age, they had an easy rapport with the adolescents and young people the project aspired to reach.

In 2016–18, the nursing school approach was scaled up within Kinshasa and extended to the adjacent province of Kongo Central. From 2019–2023, the program expanded to a total of seven provinces under the PROMIS project, which Dr. Franck Akamba managed for Tulane International. In 2022, three additional donors – USAID, FCDO, and the World Bank – funded projects in other provinces that used the nursing school model.[94]

In many countries, training nursing students to deliver family planning would hardly be an innovation. In the DRC, it has succeeded as a workaround to address the lack of accessible, affordable contraception through fixed clinics. The value of the nursing school model has been the dual benefit of increasing access to contraception in the short run while building capacity for service delivery in the long run. The experience with this model in the DRC aligns with a broader trend in sub-Saharan Africa of effectively using community health workers for contraceptive outreach and service delivery as a vehicle for increasing the modern contraceptive prevalence rate (MCPR).[95]

Figure 8.8 A nursing student counsels a young mother on contraceptive use

***DKT takes a fresh approach to reaching adolescents and youth with* Batela Lobi Na Yo**

When Jacques-Antoine Martin took over from Sandra Gass as DKT country director in 2016, DKT/DRC had funding from the Gates Foundation for programming to reach adolescents and youth. Coming from the private sector (big pharma and cosmetics), he applied an innovative marketing technique to the social marketing of contraceptives. In partnership with the California-based human-centered design company, IDEO, their audience research indicated that young people aspired to a better future and wanted to feel involved in doing something good for their lives. Working with TEK, a talented and innovative local ad agency in Kinshasa, DKT branded the marketing campaign *Batela Lobi Na Yo* ("Protect your Future" in Lingala). It would become a widely-recognized brand name nationwide that is still used to promote sexual and reproductive health.

Eschewing generalities and platitudes, DKT was intent on bringing a strong yet playful message to this youthful audience, to "inform and inspire." At the time, contraceptive implants were gaining in popularity, and Jacques-Antoine wanted them prominently featured in their ads. Playing on the Rosie the Riveter "I can do it" images, the ad agency developed a series of posters with young girls from the local community – not models – in "power poses." Superimposed on their arm or lower abdomen was an image ("white tattoo") of a contraceptive method: the

implant, injectable, or IUD. DKT was convinced that this was the type of hard-hitting message needed to break through to its audience of young people in neighborhoods across Kinshasa.

When Jacques-Antoine met with the PSNR management to vet the campaign, they did not share his enthusiasm for these posters. PNSR promoted full abstinence among young girls. And in light of prevailing social norms – influenced by the Catholic Church – these posters could provoke a major outcry if plastered around Kinshasa. Jacques-Antoine countered that 14-year-olds were already having sex, often the victims of sexual violence. They deserved to be protected against a pregnancy that would derail their future. Moreover, he argued, the PNSA had approved them. Finally, the two compromised. A new, less controversial poster showed a big red bubble promoting abstinence, "but if that doesn't work…" and the tattoo of the implant on the girl's arm was removed.

The campaign *Batela Lobi Na Yo* was launched in July 2016 to great fanfare at the Bolingo clinic in the Masina district of Kinshasa. In attendance were health officials, sponsors of the campaign, the press, and the Gates' representative. In the weeks after the kick-off, several high-profile events attracted large audiences, such as "Live from Kinshasa," with team competitions for singing, dancing, music, and performances. DKT organized small church gatherings labeled "Trusted Voice" and peer conversations with youth ambassadors. Sensing the immediate success of this initiative, the PNSR dropped its objections to the poster. Soon the red bubble on abstinence disappeared from the posters, and the contraceptive "tattoos" reappeared in the power poses.

Batela Lobi Na Yo expanded to multiple channels. To engage more young people, DKT organized a contest to produce a popular song with the campaign themes. They recruited community mobilizers to circulate in local neighborhoods, their backpacks filled with contraceptives. Youth ambassadors visited schools and universities to promote contraception. DKT converted a white stretch limousine into a mobile condom depot that never failed to draw attention at large events. To promote the expansion of their OK brand to include colored condoms, they

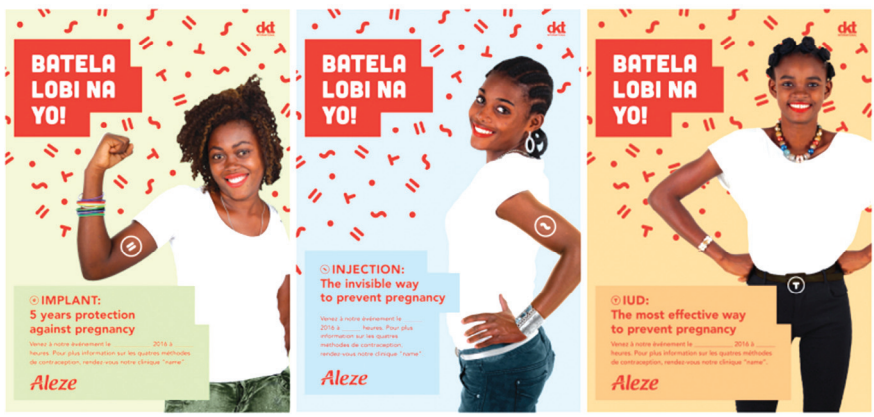


Figure 8.9 DKT's "power poses" to encourage contraceptive use

staged a 6 km road race at which a new color was revealed at each kilometer; banners for "six colors, six pleasures" appeared along the route. A Shared Pleasure Brigade of young hostesses with chic outfits circulated in Kinshasa's night spots on weekends, encouraging young men and women to have safe sex.

It was not all fun and games. DKT knew that government buy-in was essential and worked closely with the PNSR, PNSA, and UNFPA. It developed partnerships with clinics and pharmacies, which they branded as *Batela Lobi Na Yo*, providing commodities and training staff in counseling and contraceptive delivery.

Batela Lobi Na Yo has successfully reached audiences in provinces spanning the DRC with radio, TV, digital media messages, T-shirts, and word of mouth. Its success is also measured in terms of the volume of contraception distributed in the wake of these campaigns. Within a year of the launch, the number of CYP topped one million. Still today, it remains the flagship project of DKT in the DRC and contributes to its being the largest distributor of contraceptive methods in the country.

Advocates for safe abortion bring comprehensive reform to the DRC

The issue of abortion remains controversial in the vast majority of low- and middle-income countries, with its legal status varying from "available on demand" to "prohibited in all circumstances, including threat to the mother's life."

Although abortion was illegal in most African and all francophone sub-Saharan countries in the 20th century, a major turning point occurred in 2003 at the African Union Summit in Maputo, Mozambique. The heads of state issued a document – which became known as the Maputo Protocol – that formally recognized women's sexual and reproductive rights, particularly the right to safe abortion. It authorized abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangered the mental and physical health of the mother or the life of the mother or the fetus.[96] In 2008, the DRC was one of the first countries to ratify the Maputo Protocol, but the Catholic Church raised fierce opposition to its becoming law.

As shown in a 2016 study, abortion was common in Kinshasa, estimated at a rate of 56 abortions per 1,000 women of reproductive age.[97] According to a MOH survey in 2017, roughly one-quarter of health centers across the country reported offering abortion services.[98] A national-level assessment of commodities and facility readiness in 2017–18 indicated significant resource limitations: only one-third of health facilities had the necessary resources to perform pregnancy terminations.[99] In short, many women needed abortion services, but they were in short supply.

Confusion reigned in the DRC for the decade following the 2008 ratification of the Maputo Protocol. Existing legislative texts were contradictory, ranging from total abortion bans outlined in the Congolese Penal Code to allowance of therapeutic abortions per the Code of Medical Ethics. Yet the conditions outlined in the latter were so restrictive that it was nearly impossible for physicians to meet them, let alone ensure quality of care.

Advocates began to push for the legalization of safe abortion.[100] Initially, they tried to insert language from the Maputo Protocol into the Public Health Law in 2018, but their efforts failed during a tense electoral period. However, the publication of the Protocol in the National Gazette superseded national law, and these same advocates succeeded in getting it published there in 2018. As such, the DRC became the first country in francophone Africa to have implemented sweeping changes to broaden access to abortion care.[101]

Even after the National Gazette publication, policymakers and providers remained uncertain about the conditions under which abortion was allowed. Not all providers – especially outside of Kinshasa – were even aware of this change in the law. Others may have learned of the new regulations but for personal convictions refused to perform the procedure. Many health centers – especially in rural areas – did not have the necessary equipment and supplies to safely perform abortions.[102] One of the largest obstacles to increased access to safe abortion was the deeply engrained stigma, which caused many women to opt for unsafe, clandestine measures to avoid public scrutiny.

In December 2020, the MOH developed, published, and distributed a document entitled "*Normes et directives des soins complets d'avortement centrés sur la femme*" (Women-centered Comprehensive Abortion Care Standards and Guidelines). In addition to clarifying the language of the Maputo Protocol, the guidelines defined quality standards for facilities and healthcare providers to perform abortion, necessary equipment and commodities, medical and surgical techniques for pregnancy termination, and the role of community health workers.[103] The document authorized mifepristone-misoprostol medication abortions and added mifepristone to the list of essential drugs. (Only misoprostol had been included prior to the Maputo Protocol). Considered progressive, these standards and guidelines emphasized women's agency and choice, reflected adolescent and youth-specific needs, and anticipated barriers. Evidence of rape, parental authorization for teenage girls, and marital approval for married women or couples were no longer required for a woman or girl to obtain an abortion.

Several national and international NGOs were behind the push to legalize abortion and increase access to the procedure in the DRC. The *Coalition de lutte contre les grossesses non désirées* (Coalition Against Unintended Pregnancies) consisted of eight organizations. The four local organizations were ABEF-ND, *Si Jeunesse Savait* (a youth-led organization), AFIA MAMA, and CAFCO (a group of women leaders). They were supported by four international NGOs: Pathfinder, Care International, IRC, and *Médecins du Monde-France.* [104] Ipas, the leading NGO for safe abortion at the global level, began working with local organizations in 2015 and established an office in Kinshasa in 2018.[105] Professional societies – Ob-Gyn (SCOGO), midwives (SCOSAF), and female lawyers AFEAC – and KSPH made important contributions. Particularly influential was the work of two widely-respected University of Kinshasa scholars: Professor Nguma Alois, a gynecologist who gave testimony and provided clinical case studies, and Professor Patrick Kayembe, the lead researcher on the study of the incidence of abortion in Kinshasa.

Other organizations provided crucial support. *Médecins Sans Frontières* collaborated with Ipas to introduce safe abortion care in their humanitarian response in the eastern region of DRC.[106] Marie Stopes International became an active partner in safe abortion after opening an office in Kinshasa in 2019.[107] DKT International introduced the combination of misoprostol and mifepristone into their product line after registration on the essential drug list in 2021.[108] Donors supporting this work included the Packard Foundation, the "large anonymous donor," DFID/FCDO, SIDA, the Dutch government, and Global Affairs Canada.

Although safe abortion remains beyond the reach of many women in the DRC – especially those living in extreme poverty and/or rural areas – the DRC is at the forefront of francophone sub-Saharan countries that have legalized abortion and developed guidelines for its introduction into hospitals and health centers nationwide.[109]

Major events showcase DRC work

DRC delegates participate in five international conferences on family planning

After the Cairo Conference in 1994, there had been no international conferences on family planning until 2009, when the Bill and Melinda Gates Institute (renamed the William H. Gates Sr. Institute in 2023) at Johns Hopkins, directed by Dr. Amy Tsui, decided to regenerate interest in such an event. The Institute joined forces with the major population donors in organizing a conference in Kampala, Uganda, in 2009. Whereas the organizers expected some 300 participants, over 1,000 attended, demonstrating the pent-up demand for this type of event. Thibaut Mukaba of USAID/DRC convened the key FP stakeholders – who still fit around a single conference table at the time – to identify and support several participants in the inaugural meeting in 2009. Among the DRC representatives attending the conference was the PNSR director.

The DRC then sent a delegation to each of the subsequent conferences, held every two years, and its members played active roles in these events. Dr. Arsene Binanga spoke at a plenary in Dakar, Senegal (2011). Mr. Dieudonné Kwete gave the speech pledging the country's commitment to FP2020 at Addis Ababa, Ethiopia (2013). The 2015 ICFP in Indonesia was postponed when a volcano erupted near the airspace of Bali's airport, canceling international flights for weeks. When the ICFP did occur in early 2016, the DRC was particularly well represented. The prime minister gave a keynote speech via video at the closing plenary session, highlighting the importance of the demographic dividend. The DRC was the only country with three ministers in attendance (Health, Plan, and Gender). And country representatives organized a parallel/satellite session to showcase notable accomplishments in its work. In 2018 in Kigali, Rwanda, the DRC delegates presented recent findings on DMPA-SC and the nursing school model, in addition to promoting greater involvement by the private sector in mining in the DRC. And in Pattaya, Thailand, 2022, the DRC sent some 30 delegates, including the ministers of Health and Gender. The minister of health presented the DRC commitment to FP2030.[110]

These international meetings provided opportunities to present the findings from research studies and share innovative programmatic approaches. Even more importantly, they allowed DRC participants to recognize that their work formed part of the global movement. To many laboring under daily challenges, a celebration of this type reenergized them to continue the good fight.

Third and Fourth National Family Planning Conferences (2014 and 2019) raise visibility

As 2014 approached, members of the CTMP began discussing plans for the third National Conference to Reposition Family Planning, planned to occur in 2014 (once every five years). The term "reposition" was a carryover from the 2004 conference when it was in vogue and proved to be a catchphrase hard to discard.[111]

The existence of the CTMP provided the necessary organizational structure that could aspire to a larger, more elaborate conference in 2014 than in 2009. The first two conferences consisted of a series of speakers giving talk after talk to the assembled participants in one large auditorium. The organizers wanted instead to hold a conference with both plenary sessions (everyone in a large room) and parallel sessions (where speakers could present to a smaller audience on a more specialized topic, with more opportunity for dialogue). Also, as is done at many international conferences, there would be space set aside for booths, where different organizations would decorate the walls and tables with attractive visuals and staff could converse with participants who visited the booth. The social marketing organizations invariably won the prize for the most attractive booths and best swag.

The Third National Conference took place on December 3–5, 2014, in the newly opened Beatrice Hotel at the end of the Boulevard du 30 juin.[112] The headline topics were the demographic dividend, faith and family planning, programming for young people, and family planning in the private sector. The plenary sessions were conducted in a ballroom that could seat 500 people, and most days it was nearly full.[113] The hotel was not well-designed for parallel sessions, with only two conference rooms suitable for this purpose. Yet the collective scramble to get seats in these sessions reflected the genuine interest of participants to be part of the exchange.

The conference was proceeding on track, with over 95% of the audience Congolese. On day three, the theme of the plenary was "Family Planning and Faith," at which representatives of different religious confessions each had the opportunity to speak. During the Q&A, one of the 50 youth participants – invited to participate in their own pre-conference as well as the main conference – asked the speaker: "What is the best contraception for adolescents to use?" Without hesitation, the speaker replied "abstinence." The auditorium erupted in shrieks of disapproval, especially from the group of 50 youth at the back of the auditorium. Any audience control that had existed to that point was lost, as other participants volubly stated their views on the subject to those sitting next to them or to no one in particular. By the time the moderator got the room under control, time had mercifully run out for that session.

Box 8.3 So much for the quantity–quality trade-off

At the Third National Conference on Family Planning, some 20 participants attended a session on the topic of contraceptive logistics. In the Q&A following the presentations, one topic that emerged was the quantity-quality trade-off: a well-recognized concept among economists and demographers. Jane Bertrand briefly explained the concept: that fertility rates begin to fall as couples make the trade-off between quantity **(**more children**)** or quality (more resources invested in a smaller number of children). This phenomenon partially explains the sharp decline in fertility rates in Latin America in the 1970s and 1980s, where families of all socioeconomic strata began to view small family size as their ticket to a better future. With fewer children, they could feed them, send them to school, and provide other benefits that would allow them to attain a higher standard of living than their parents.

Conscious of being the only *mundélé* (white person) in an audience of Congolese, Bertrand couched her description of the quantity-quality trade-off as a phenomenon that had influenced societal norms in other countries. Several colleagues nodded – if not in agreement, at least with recognition of the potential benefit of this phenomenon. Finally, the representative from the ministry of plan raised his hand. "Madame, thank you for your explanation, but here in Congo, this won't work. We just love children too much."

Maintaining the five-year schedule, the Fourth National Conference to Reposition Family Planning was scheduled for December 2019. The PNSR wished to take the lead in organizing the conference but lacked the experience, staffing, and access to finances needed to do so. Several organizational meetings in early 2019 went nowhere, and by August 2019 the PNSR director gave technical control of the program to the group that had organized the 2014 conference.

In January 2019, President Félix Tshisekedi assumed office, and the program committee aspired to his public endorsement of family planning in the most visible way possible: attending the conference in person.[114] By September 2019, the budget for this event had already been set, and different organizations had agreed to cover different costs for the conference. The two main private donors – the Gates and Packard Foundations – also provided additional support to the event. Yet as the negotiations with the president's office advanced, it became clear that his endorsement of the event would come with a stiff price tag (extra security and support for his planning detail). Nonetheless, the program committee continued to pursue this option on the belief that securing the president's in-person attendance would be worth whatever it took to get him there.

Meanwhile, planning advanced for the less politically charged aspects of the program. The event would take place at the Fleuve/Kempinski Hotel, by far the most expensive and elegant in Kinshasa. It had sufficient space to comfortably hold parallel sessions and allow ten organizations to set up booths in an adjacent area. A technical

committee of 15 academics and program managers reviewed some 80 abstracts and assembled the parallel sessions based on the strongest submissions.

To the great disappointment of the program committee (but unsurprisingly to other observers), President Tshisekedi did not attend in person despite the expenses incurred by the organizers to get him there. He did allow his image to be used on the banners and flyers produced for the event, which was an "advocacy win" in its own right. And the First Lady hosted a gala dinner for VIPs in conjunction with the event.

The conference came off without major incident. The physical setting of the Fleuve Hotel lent a certain prestige to the event, and participants acknowledged the organization that had gone into the parallel sessions. Over 140 participants from across the DRC and international visitors attended.

Yet the conference did not take place without some hiccups. It did not go unnoticed that at the opening ceremony, there was not one woman on the stage of six luminaries. The representative from FP2020 later commented that his organization would not have allowed him to attend and present at the conference had they known this would be the case. For all the lip service to the topic of gender, especially in the context of family planning, the organizers had not anticipated the negative optic that this caused, at least among Westerners – largely female – who attended.

The conference ended with a sigh of relief. Overall, it could be considered a major success in updating participants on recent advances both in DRC and internationally, fostering networking across diverse organizations, and revitalizing commitment to working in the field of family planning. Only afterward did the disputes begin when efforts began in earnest toward financial reconciliation of conference expenses.

Research reinforces a culture of evidence-based programming

Evidence-based programming has become a watchword within the field of public health, and international family planning is no exception. Different types of evidence include formative research to learn what audiences want and need, process evaluation to monitor the strengths and weaknesses of program implementation, and impact evaluation to determine the effectiveness of an intervention, among others. This research uses a mix of data collection methods: population-based surveys, facility-based surveys, focus groups, key informant interviews, observation of clinical technique, mystery client surveys, and monitoring of service statistics. Since 2010, the DRC has made remarkable progress in conducting a wide range of research and building the capacity of local researchers.

The DHS and MICS surveys track modern contraceptive use at the national level

Some might wonder if a woman would disclose to a perfect stranger (the interviewer) whether she is using a contraceptive method, especially in countries where family planning is controversial. The global experience over 40 years indicates that the answer is yes. The Demographic and Health Survey (DHS) – conducted

among a nationally representative sample of women – has yielded reliable data on contraceptive use from over 90 countries worldwide since 1986. Although it produces hundreds of variables, the most-widely used indicator to gauge progress in family planning in a given country is the MCPR: the percentage of women of reproductive age using modern contraception at the time of the survey.[115]

The first DHS survey in 2007–08 revealed a very low MCPR: only 5.8% of married women. Six years later, the DHS 2013–14 showed that MCPR has increased very little: to 7.8% of use among married women in the DRC. In both DHS, the main modern methods used were male condoms, injectables, and pills. In contrast to most countries, the use of traditional methods (rhythm, withdrawal, folkloric) was almost twice as high (14.9% in 2007 and 12.6% in 2014) as for modern ones in the DRC.

A second survey that contributes to understanding family planning dynamics is the Multi Indicator Cluster Survey (MICS), developed and conducted by UNICEF and other donors with a strong focus on monitoring child health indicators. The survey also includes contraceptive behavior but often produces results that are different from the DHS, given the different purposes and methodologies used in conducting the two. The three MICS surveys conducted to date that collected information on MCPR showed a gradual increase – 4.4% (2001), 5.4% (2010), and 17.6% (2017-18) – among married women.[116]

When the MICS 2017–18 showed that 17.6% of married women were using a modern contraceptive method, those monitoring progress against the strategic plan – calling for 19% MCPR by 2020 – were elated.[117] But the eureka moment was short-lived, as data analysts looked more closely at the composition of the modern methods used. Of the 17.6%, almost one third (5.9%) corresponded to the lactational amenorrhea method (LAM), known locally as MAMA and often confused with breastfeeding. Had LAM been removed, MCPR would have been closer to 12%.[118]

The MICS results led to an uncomfortable tug of war between the researchers ("purists") who refused to accept that the DRC had an MCPR of nearly 18% and some government officials who wanted to show progress toward the country's goal of 19% by 2020. The project Track20, administered by Avenir Health, provided a convenient technological fix – not only for the DRC but for countries worldwide. Rather than judging the reliability of the data from each national survey, they use the data from all available surveys to simulate the most probable level of MCPR for a country by year.[119] In recent years, the convention has moved from reporting MCPR based on women married or in a union to all women of reproductive age. According to the FPET simulation, the MCPR for the DRC as of 2020 was 14.8% among all women and 15.1% among married women.[120]

PMA surveys provide annual data for two provinces

The DHS and MICS survey programs provide data at approximately five-year intervals. They are primarily household surveys without a parallel facility-based survey that provides data on the service delivery points available to women in the communities (enumeration areas) surveyed. This interval was too long for those

evaluating progress toward the objective of the 2012 London Summit: to provide access to 120 million new users of contraceptives (women and girls) by 2020.[121]

The response came in the form of PMA2020 (Performance Monitoring and Accountability 2020), a survey program that would yield population-based data (on households and women of reproductive age) as well as facility-based data from the same communities on an annual basis in selected countries.[122] The PMA2020 questions mirrored the family planning questions on the DHS to the extent possible, to increase comparability between the two. Starting in 2013, PMA2020 conducted surveys in 11 countries and produced data annually.[123]

DRC was the second of the 11 countries to be included in the PMA2020 program, again reflecting its rising star as an African country on the move for family planning. The Kinshasa School of Public Health led the operation in the DRC, under the direction of the late Professor Patrick Kayembe and Professor Pierre Akilimali. The survey allowed KSPH to pioneer the use of data collection using smartphones in the DRC. With technical assistance from Johns Hopkins and Tulane, the KSPH researchers became increasingly proficient in data collection, analysis, and presentation of results. The colorful "two-pagers" summarizing key results were easy to grasp and proved valuable in advocacy efforts.[124]

Because of the size of the country and the exorbitant cost of collecting data in all provinces, PMA2020 in the DRC was limited to two provinces: Kinshasa and

Figure 8.10 PMA data collector using innovative smartphone app for survey interview

Kongo Central. The survey results provided an annual report card for contraceptive uptake. Although impossible to link the work of any given organization to a change in MCPR, the collective programming of all groups was expected to result in increased contraceptive use.

The results of PMA showed a small but steady increase in MCPR in Kinshasa between 2013–14 (the first year in which it was conducted) and 2020. In 2022 MCPR plateaued around 30% among married women and around 25% among all women of reproductive age. In Kongo Central (which started a year later), the trend vacillated but rose from 21% in 2016 to 28.6% in 2022 among married women.

PMA2020 revealed important changes in the contraceptive method mix (the distribution of methods used by the population). Condoms had been the leading method in almost all surveys since the method mix was first measured. Yet by 2021, in Kinshasa, it was surpassed by emergency contraception (misleadingly called the "morning-after" pill), a method that was virtually unknown in 2014, among all women of reproductive age. Following closely behind was the implant. Unmarried sexually active women were more likely to be using contraception than their married counterparts, and among contraceptive users, the unmarried were far more likely to rely on emergency contraception and condoms than their married counterparts.[125]

PMA2020 (renamed PMA for Performance Monitoring for Action in 2019) also included a module on a sample of health facilities and pharmacies in the

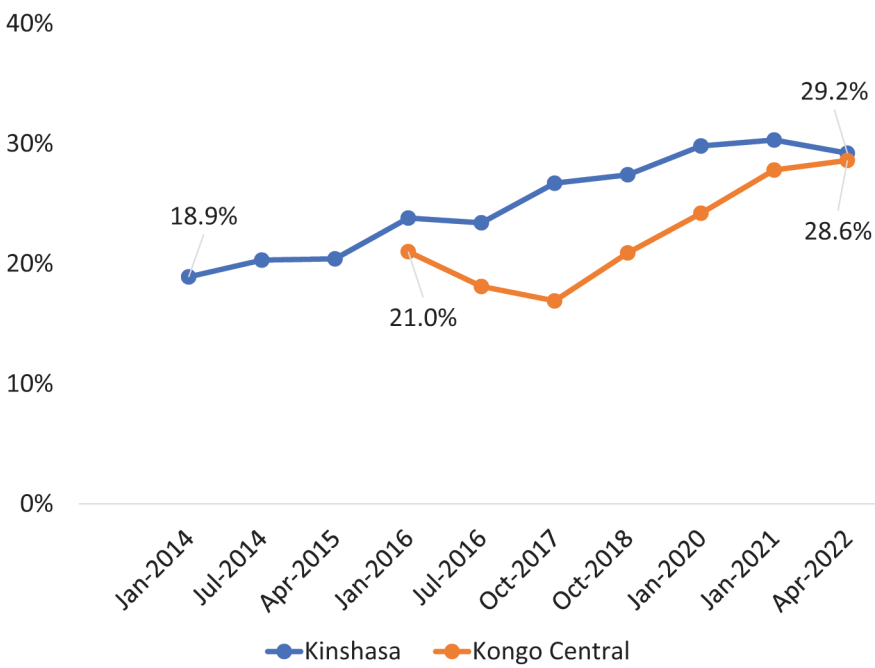


Figure 8.11 Trends in modern contraceptive prevalence: Kinshasa and Kongo Central (2014–22)

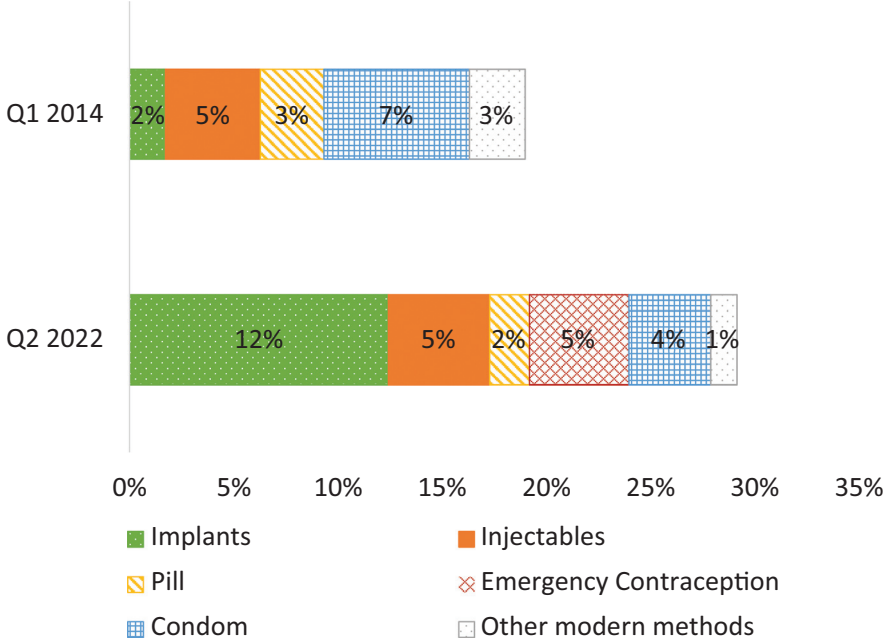


Figure 8.12 The distribution of methods reported by married users of modern contraception aged 15–49, Kinshasa, 2014 vs 2022

communities (enumeration areas) of the women randomly selected to participate in the survey. These data allowed researchers to assess the family planning supply environment for these women (what services were available to them) and its effect on patterns of use. It also helped to identify shortcomings in service delivery, such as frequent stockouts or facilities that lacked trained personnel.[126]

PMA2020 had its limitations, in particular that it only covered two provinces in the DRC. Yet this on-the-job training brought research capacity at KSPH to a new level, and the rapid turnaround time and attractive graphics used to present the results contributed substantially to a culture of evaluation among the family planning community.

Other facility-based surveys measure the supply environment

Although less well-known, three other facility-based surveys provided data on the service delivery environment (i.e., what was available to clients seeking contraception).

In 2012, UNICEF contacted PNSA (Mbadu Muanda and team) to conduct a facility-based survey entitled *Cartographie de la PTME compréhensive en RDC*, which inventoried PMTCT (prevention of mother-to-child transmission of HIV) and family planning service delivery in all 8,266 health areas (subdivisions of health zones) in the country.[127]

From 2015–2022, excluding 2021, UNFPA supported a series of facility-based surveys, based on a random sample of urban and rural health facilities (FOSA) in all 26 provinces known to offer family planning.[128] In collaboration with the MOH, PNAM, and PNSR, Professors Pierre Akilimali and Luc Kilabi from KSPH directed the data collection and analysis. The survey monitored numerous variables, including the range of methods available and the frequency of stockouts.

Although not as common as its population-based surveys, the DHS program also supports a facility-based survey known in English as the "SPA" (Service Provision Assessment). In 2017–18, the KSPH conducted the first-ever *EPSS* in DRC (the French acronym for *Evaluation des prestations des services des soins de santé*).[129] A nationally representative survey, the EPSS 2017–18 provided critical evidence of the widespread shortcomings in the availability of family planning services throughout the nation. When judged on a readiness index to provide services, family planning rated 68%, compared to MCH (96% for prenatal care, 90% for infant vaccination), malaria treatment (100%), and STI treatment (96%).[130]

Impact evaluations measure the effectiveness of key interventions

Consistent with its increasing visibility in family planning and sexual reproductive health, the DRC participated in cutting-edge evaluation work, both as a country partner in global initiatives and in research specific to the DRC. While formative research and communication pretesting became standard processes across multiple implementing partners, the DRC also demonstrated its capacity to conduct state-of-the-art impact evaluations. In the cases described below, faculty at the Kinshasa School of Public Health played a key role in the research.

Growing up Great! focuses on young adolescents

Growing up Great (GUG!) was part of the USAID-funded multi-country Passages project, led by the Institute for Reproductive Health/Georgetown and implemented by Save the Children. Dr. Pierrot Mbela served as project director. Particularly innovative was the focus on very young adolescents (VYAs), aged 10–14. Implemented in 2017–18 in the DRC and known locally as *Bien Grandir!*, this project included a nine-month intervention that engaged VYAs and adults to shift priority norms, aiming to increase knowledge around puberty and reproductive health, gender-equitable attitudes and behaviors, and self-efficacy of children aged 10–14. To accomplish this, the intervention package featured a multi-level, multi-layered set of activities with VYAs, their caregivers, teachers, health providers, and other influential community members.

The impact evaluation of *Bien Grandir!* formed part of the Global Early Adolescent Study, directed by Johns Hopkins University in collaboration with local university researchers in each country. In DRC, the researchers used a longitudinal, quasi-experimental design to evaluate the relationship between evolving social and gender norms and a range of key health outcomes across the adolescent period, and between intervention and non-intervention (control)

groups, including both in-school and out-of-school adolescents. This research ran from 2017–2022. After the untimely death of Professor Patrick Kayembe in 2020, Professor Eric Mafuta assumed the research lead for KSPH, with Professor Aimé Lulebo as co-lead.

The evaluation demonstrated that *Bien Grandir!* had significant effects in building reproductive health knowledge, caregiver connectedness, and gender-equitable attitudes and behaviors among VYAs. Several sustained intervention effects included greater knowledge about menstruation among in-school girls and higher levels of caregiver connectedness. among both in- and out-of-school VYAs, there was higher agreement that boys and girls should be equally responsible for household tasks in the intervention group compared to the control group.[131]

Based on the results of the evaluation, the Ministry of Education fully integrated GUG! into its comprehensive sex education program, including all pre- and in-service training documents and teaching aids. At the end of the pilot phase, the *Bien Grandir!* project was scaled up to over 200 schools from 2019 to 2021 with funding from USAID and the Gates Foundation. In addition, with funding from Global Affairs Canada, *Bien Grandir Plus!* launched in 2018 with a target of both younger and older adolescents.[132]

Impact evaluation: Momentum focuses on first-time mothers

Not to be confused with the previously mentioned USAID-funded, multi-country project with the same name, a different Momentum research project in the DRC was financed by the Gates Foundation.[133] It was designed as a gender transformative project, aimed at improving family planning, maternal and newborn health, and nutrition outcomes among first-time mothers aged 15–24 and their male partners. Nursing students conducted home visits to these young women approximately three months prior to delivery and again an average of three times during the 12 months afterward. Nursing students conducted monthly group education sessions for new mothers in which they discussed best practices for mother and baby, as well as gender inequalities, male roles in childcare, and violence prevention. Sessions with male partners covered their engagement in fatherhood, caregiving, and the health of mother and baby. Street theater and educational sessions in the larger community promoted attitudes and behaviors supportive of new mothers.

A team led by Dr. Anastasia Gage (Tulane University), Dr. Rianne Gay (Tulane International), and Professor Pierre Akilimali (KSPH) evaluated the impact of the intervention using a quasi-experimental design (three interventions and three comparison health zones in Kinshasa). Quantitative survey data was complemented by focus groups and other qualitative methods to assess the extent to which people receiving the Momentum intervention considered it to be appropriate and culturally acceptable, and explore how the intervention could be modified and scaled up.

The evaluation demonstrated positive effects regarding family planning behaviors. Young mothers in the intervention area were significantly more likely to use

modern contraception at six and twelve months post-delivery than those in the comparison area. They also had higher levels of contraceptive knowledge and personal agency; they were more likely to have spoken to their partner and a health provider about family planning; and they were less likely to believe in myths and misconceptions about contraceptive methods. Married mothers were more likely to obtain and use modern contraception in the early postpartum period if their male partners had more gender-equitable attitudes.[134]

Based on the results not only for family planning but also for other maternal child health components of the intervention, the full Momentum curriculum has been revised to meet WHO standards and has been incorporated into 11 nursing schools in Kinshasa, as a first step to further scale-up within the network of nursing schools in the DRC.

DHIS2 provides national-level continuous monitoring of family planning uptake

Population-based surveys are the most reliable means of measuring contraceptive prevalence, but they do not provide a way to monitor progress on a monthly or quarterly basis for all districts of the country. To this end, health programs across the world collect data referred to as service statistics or program statistics that track activity through the facilities providing care.

Multiple sub-Saharan countries, including the DRC, have adopted the DHIS2 to monitor service statistics for all sectors of the government health system across the country.[135] Created by a group at the University of Oslo, the first pilot conducted in DRC tested this system in the provinces of Kasaï and Nord Ubangi in 2013 with financial and technical assistance from the ASSP Project.[136] Since late 2016, the National Health Information System Division (*Système national d'information sanitaire* or SNIS) has extended the DHIS2 to all 519 health zones of the country, although with differing levels of *complétude* (completeness) of the reported data. Curiously, Kinshasa, having far more resources, has often lagged behind the other provinces.[137]

Family planning is but one of 12 components included in the DHIS2. As the system became increasingly operational in the DRC, family planning benefited from the technical assistance of a Gates-funded project Track 20, managed by Avenir Health and directed by Dr. Emily Sonneveldt. Track 20 held workshops with PNSR and SNIS staff in Kinshasa and the provinces to improve understanding of the different indicators used to track family planning performance, and it supported supervisory visits to the provinces to reinforce the capacity of those reporting data into the system. Dr. Zenon Mujani, representing the PNSR, became the local expert for DHIS2 as it related to family planning. Later, Avenir Health tapped him to provide technical assistance on family planning service statistics in other francophone countries, another example of DRC's growing footprint in the region.

As part of a larger overhaul of the system in 2016, SNIS invited family planning experts from the PNSR and implementing partners to update the data entry forms

for family planning in the DHIS2.[138] The SNIS division manager at the time, Dr. Salomon Siyangoli, listened as workshop participants debated the relative importance of different indicators. When he rose to speak, he did not mince words: "I want indicators that conform to international standards." No locally-created, DRC-specific indicators for him. He recognized the value of having numbers that would be useful not only in the DRC but to the international audience.

The exercise to update the family planning section of the DHIS2 again shone light on the value of the CTMP. Through a series of meetings, a subgroup of the CTMP arrived at a consensus on a set of indicators for family planning, thus avoiding a situation where each organization would independently approach the D5 to pitch its preferred indicators. The SNIS director complimented the CTMP for bringing him a set of indicators that had been endorsed by the family planning community. "Would that all health sectors did the same," he commented.

By 2022, the DHIS2 routinely provided data from the 519 operational health zones on family planning.[139] Provincial PNSR coordinators and SNIS staff developed the capacity to track progress using the DHIS2: the levels of CYP generated, the percentage of health facilities that offered family planning, and the existence of stockouts of specific methods by location, among others. Despite much discussion, it was impossible to rid the system of "new users," an indicator that seems intuitively clear but is open to three different interpretations at the field level; indeed the sacred cow of the DHIS2 indicators.

Given the many weaknesses of the health system in the DRC, the DHIS2 justifiably remains a source of pride for the DRC government.

The fast-moving train encounters obstacles

Starting in 2018, the fast-moving train that was family planning in the DRC ran into impediments along the track. Was it a change in leadership at the PNSR, the tensions intrinsic to the system of financing family planning in the DRC, or a combination of the two?

The DRC is almost entirely donor-dependent for family planning (and all health) programming. The UN agencies – UNFPA, the World Bank, UNICEF – fund government agencies directly. By contrast, the bilateral family planning donors (e.g., USAID, FCDO) and private foundations (e.g., Gates, Packard) tend not to fund the DRC government directly, either because of specific regulations prohibiting it or risk aversion given the record of weak financial accountability. Instead, the bilateral agencies and private foundations channel their funding through international NGOs and, to a lesser extent, local NGOs. The result is a patchwork of organizations and projects, each with slightly different mandates and agendas.

These organizations often partner with and fund the PNSR or PNSA for specific activities, such as training, supervision, communication campaigns, or research, but the iNGOs hold the purse strings for these grants or contracts.

As the lead agencies, the PNSR and PNSA speak for the government on issues of family planning and sexual and reproductive health, respectively. They are responsible for developing norms and guidelines for programming, coordinating

key activities such as the national family planning conference, and representing the government at international meetings. They may have a role in approving a given donor-funded project, but once awarded, they have no control over the project budget.

The iNGOs that win the contracts and grants usually understand the importance of coordinating with the PNSR or PNSA, yet they are also beholden to the donor to achieve a specific set of objectives. Their work generally aligns with the Strategic Plan for Family Planning, but they often operate in parallel with government agencies. Although exceptions exist, the iNGOs have several advantages over government agencies. Most iNGOs in-country form part of a larger international organization with a deep commitment to development work in general and family planning in particular. iNGOs often attract "crusaders," individuals who identify with the mission of their organization. To increase the likelihood of winning future bids, iNGOs place a premium on responsiveness and performance. And they tend to pay higher salaries than government agencies.

Because of the donor-dependency, the family planning movement advances most effectively when the government agencies and iNGOs work well together. That is, both parties remain mission-driven for the common objectives of improving access, generating demand, and increasing the use of modern contraception. The two parties take advantage of whatever funds are available to work jointly toward these objectives. The progress made in family planning in the DRC in the 2010s built on this model, and was solidified by the highly functional CTMP stakeholders' group.

When government agencies and iNGOs find themselves at loggerheads, the model breaks down. If the government agency feels that iNGOs are usurping its position of leadership, then productive collaboration becomes more difficult. The breakdown of communication may occur over the perceived standing of key individuals within the family planning community or over the financial resources available to the iNGOs. Because multiple organizations contribute to family planning programming, progress continues but the collective momentum of the stakeholders falters. The fast-moving train derails.

In July 2018, the minister of health announced a change in leadership for PNSR. Director Mbadu Muanda – who had held that position for only nine months – would be replaced by Dr. Lis Lombeya.

Dr Lis assumed her position and began learning the nuts and bolts of family planning programming, as well as familiarizing herself with the players in the family planning community. Possibly because of different power dynamics and funding mechanisms in HIV, she appeared to believe that the PNSR would "run" family planning for the country. She soon learned that the international NGOs controlled a disproportionate amount of funding in comparison with the national program. Whereas the considerable success realized by the family planning community between 2012 and 2018 came from a collegial and mutually supportive working relationship between the PNSR, PNSA, and the iNGOs, she took the PNSR in a different direction.

It did not help that at a time when Dr. Lis was trying to establish her leadership, most of the existing stakeholders had been working together for several years as a well-oiled machine. At a meeting in June 2018, FP CAPE presented the results of a

sociometric study they had conducted for the purposes of better understanding the partnership network among recipient organizations of Gates' funding.[140] In response to the question, "Who are you currently connected to?" the coordinator of the CTMP, Arsene Binanga, received by far the most mentions (twice as many as the next person). Similarly, he was most frequently named in response to the question: " Who would you like to be connected to in relation to achieving your project objectives?" Whether or not Dr. Lis ever saw these results, she was faced with the reality of informal leadership networks within the family planning community. In a society where personal connections are often all-important, perceived power carries weight.

Small conflicts began between the PNSR director and the CTMP coordinator, Arsene Binanga, which over the course of a year escalated into an increasingly acrimonious relationship. Why did the CTMP play an oversized role in advancing the family planning agenda in the country? And who controlled the *caisse* (bank account) that supported its activities? Despite insistence from many CTMP members that there was no *caisse* (member organizations split the costs for the activities undertaken), the question surfaced repeatedly.

The situation spiraled downward in mid-2020, with the secretary general for health suspending Dr. Lis for three months for unrelated reasons. Upon her return, PNSR staff staged a televised protest in front of the building, calling for her removal. The situation hit rock bottom when on September 4, 2020, a full-page article appeared in a local newspaper *Le Monde des Affaires*; the headline accused Binanga and the secretary general of a "monstruous embezzlement" of $600,000M (which contradicted the $60M claim within the article). The journalist who had been put up to writing the story quickly found himself ensnarled in a fierce legal battle.[141]

To detoxify the atmosphere and allow the CTMP to regain its normal functioning, Binanga resigned as coordinator in December 2018. In February 2019, Dr. Jacquie Bapura, a Pathfinder staff member working on the USAID-funded PROSANI+ project, assumed the CTMP coordinator role but served for less than a year. The prospect of lawsuits spooked USAID, which requested that Dr. Bapura resign her position on the CTMP. The discord within the family planning community was sufficient to hinder any meaningful work by the CTMP. For two years, the national CTMP did not have a designated leader, although the organization existed in name.

Tensions within the family planning community ran high in 2019 and 2020. Members from multiple organizations beseeched the minister of health to replace Dr. Lombeya. Given tricky political allegiances, the minister procrastinated in making any decision. Finally, in October 2020, the minister appointed a new PNSR director, Dr. Anne Marie Tumba.

Like her predecessor, Dr. Anne Maria Tumba wished to return the PNSR to a position of strength within the family planning community. This goal was laudable, yet the organization was stymied by multiple problems typical of government agencies within the DRC. The PNSR did not have the financial or human resources to manage a program of national scope. Nor was there any donor with deep pockets or an appetite to support such an endeavor. The building that housed the PNSR, renovated in the early 1980s, had fallen into disrepair; it lacked air-conditioned offices and high-speed internet, two essentials for productive work

in a tropical climate. The agency was saddled with numerous staff who had been previously placed on the payroll as part of a patronage system. It suffered from the low morale that pervaded government offices since the 1970s. Whereas the PNSR had a number of qualified staff who contributed significantly to programmatic advances, it suffered from leadership turnover.

By late 2022, multiple parties were working to rebuild the CTMP into the cohesive mechanism it had been in the previous decade. UNFPA took over the coordination, first in the person of Pierrot Mbela, then Ali Wanogo. The PNSR remained in its mandated role as the secretariat for the group. But the CTMP has yet to regain its role as the engine to the fast-moving train.

Updating the family planning landscape since 2020

This book was purposely organized as five decades of family planning. Serendipitously, key events occurred two years into each decade: President Mobutu's speech (in 1972), the start of the national family planning services project PSND (in 1982), the withdrawal of all major international donors (by 1992), and the mini conference that jump-started family planning (in 2012). Yet the chapters follow the convention of starting each decade with the year ending in zero: 1960, 1970, 1980. With this logic, the reader might expect a separate chapter on the decade starting in 2020.

Figure 8.13 Jane Bertrand, Arsene Binanga, and Julie Hernandez in Maluku, 2022

Since January 2020, the major changes that have occurred relate to the donor landscape, as outlined below. Most large projects awarded between 2020–22 represented an extension of previous funding, as described earlier in this chapter.

The Gates Foundation drops the DRC from its list of priority countries for family planning

For over a year, the Gates Foundation worked on a "refresh" of its family planning strategy. Then in April 2021, Ann Starrs, the director of family planning at Gates, presented the new family planning strategy via webinar to the foundation's grantees. Her presentation confirmed what had been corridor talk for many months: the foundation planned to drop the DRC as a focus country for family planning.

According to Gates' senior managers, this decision reflected the foundation's interest in concentrating its funding where it had a country office (the DRC does not) and multiple health projects to bring synergy across the health sector. Gates was moving out of "retail contraceptive delivery" (support of service delivery projects), possibly as it distanced itself from the 2012 London Summit objective of reaching 120 million women and girls with access to contraception. Rather, it would focus on the development and introduction of new contraceptive methods, implementation research, and global and regional mechanisms that supported scale-up.

Given the catalytic role of Gates' funding in advancing family planning for close to a decade across multiple areas of family planning – advocacy, service delivery, behavior change communication, survey research, pilot testing of innovative approaches, and capacity building – this news was met with dismay and disbelief. The generous funding from the Gates Foundation and multiple other donors allowed the DRC to develop its army of local family planning specialists. To many, it was unfathomable that at the moment when this group of specialists was poised to unleash its newfound knowledge and skills to expand programming, Gates would reduce its investment.

Staff at the Gates Foundation worked hard to soften the blow. Perri Sutton organized a DRC Family Planning Donor Group, which met online each month to share information, improve coordination, and strategize about new sources of funding for the DRC. The Gates Foundation slowed its exit by issuing close-out funding through December 2023 to several existing grantees. Also, the DRC would continue to participate in and thus benefit from global initiatives partially funded by Gates (e.g., the Track 20 project, FP2030, Reproductive Health Supplies Coalition, UNFPA Supplies, Access Collaborative, Global Financing Facility, and others).

Among the family planning community, hope remains that the Gates Foundation will reconsider its decision vis-à-vis the DRC, where the needs for family planning, sexual reproductive health, and gender equality remain immense and the family planning community stands ready to advance this agenda.

The UK reduces its funding for development work in the DRC

FCDO, the UK international development agency, was historically the second largest bilateral donor in family planning in the DRC, after the United States. Yet

in 2021, it was forced to reduce its budget for international development by 21.1%, reflecting the catastrophic financial effects of the Covid-19 pandemic and costs to support Ukrainian refugees in the UK.[142] Brexit could not have helped.

This reduction in funding had a direct impact in at least three ways. First, it reduced its support to UNFPA Supplies Partnership for the procurement of contraceptives, which had a negative trickle-down effect on the DRC. Second, when it rebid its large integrated health project (the successor to ASSP and ASSR), it reduced the target area to a single province: Kasaï. Third, as a co-funder on the WISH project, it postponed payments to the grantees (MSI and DKT, among others) by three months, causing these implementing agencies to slow their work in the field.

Reflections on the 2010s

For years, family planning had existed in the shadows of the larger and better-funded health programs: HIV/AIDS, malaria, and immunization. Yet by the mid-2000s, it had come into the spotlight. Billboards announcing the Third National Conference for Family Planning towered over the *Boulevard du 30 juin*. Images of President Tshisekedi appeared on the publicity for the Fourth National Conference. Family planning still had far less funding than these other health programs, but

Figure 8.14 One of many ways of promoting family planning

it had gained considerable local and international recognition for its work in advancing the field.

The stars had aligned mid-decade to create a dynamic movement that augured well for family planning. In 2013, the government had pledged its commitment to FP2020 and endorsed the National Multisectoral Family Planning Strategic Plan: 2014–20, opening the floodgates for donor funding to this sector. The PNSR played a valuable role in engaging with donors and implementing partners. PNSA remained a vibrant organization working in the controversial but crucial space of sexual and reproductive health for adolescents and young people. The CTMP developed into a mechanism that brought cohesion to family planning stakeholders: donors, government agencies, and international and national NGOs. Traditional donors – USAID, UNFPA, and DFID/FCDO – increased their funding in this domain. New donors – the Gates and Packard Foundations, World Bank, CAFI/FONAREDD (with support from the Norway government), and others further increased donor funding and supported capacity building of local staff. Consequently, the international NGO community grew to include some 20 organizations involved in family planning, while the local NGOs working in family planning or sexual and reproductive health numbered close to a dozen. DHS, PMA, and MICS surveys provided evidence of the steadily increasing contraceptive prevalence in Kinshasa and some other provinces. Thanks to the DHIS2, for the first time ever the country had national-level service health statistics on contraceptive uptake.

This set of accomplishments in less than a decade put the DRC on the road to achieving real progress in family planning. It was as though no one had told this group of family planning stakeholders that such progress was impossible in a country facing as many political, economic, and social challenges as the DRC. The family planning movement was indeed the fast-moving train, with plenty of distance still to go.

It would have been convenient to end the story in 2018, with this list of achievements to the credit of all involved in advancing family planning. Yet the fast-moving train encountered problems in 2018 that altered the trajectory of family planning in the DRC. The disproportionate amount of external funding that went to iNGOs was not new, and initially it provided the fuel to advance family planning across the multiple areas of programming. In the years that the PNSR and PNSA remained mission-driven, tremendous strides occurred, creating a solid foundation on which to build for the future.

Yet in 2018, with a change in leadership at the PNSR and pique over the influential role that the CTMP had come to play within the family planning community, the harmony that had reigned for the better part of the decade gave way to personal conflicts and legal skirmishes that had a chilling effect on donors (however supportive they tried to be). After several years without a clear leader, the CTMP has struggled to return to being the dynamic mechanism it previously was.

Some might question whether an organization such as the CTMP should even exist, given that it represents a parallel structure to local government. The 2015 ministerial decree conferring official status to the CTMP explicitly gave the

coordination role to an iNGO, with tacit recognition that an iNGO would be better equipped to sustain it as an engine for advancing the field. Equally troublesome to others is the system whereby bilateral donors and private foundations fund iNGOs (who in turn work with government agencies) rather than funding the government itself. In an era with the ongoing debate over decolonialization, power shifting, and local ownership, the patchwork funding for family planning in the DRC is itself a topic for debate.

For those in the Kinshasa-based family planning community who experienced the taste of success for the better part of the 2010s, there remains a deep-seated desire to get the fast-moving train back on the tracks and moving forward in the years to come.

Notes

1 *Plus ça change, plus ça reste la même chose*: The more things change, the more they stay the same.
2 Stiftung, Bertelsmann. "BTI 2022 Country Report – Congo, DR." Gütersloh: Bertelsmann Stiftung, 2022, p 7–8
3 *Democratic Republic of Congo: Background and US Relations*. Congressional Research Service, 2022, p 4
4 Congressional Research Service, 2022, p 10
5 "The World's Worst Places to Be a Woman." Amnesty International USA, June 17, 2011. https://www.amnestyusa.org/updates/the-worlds-worst-places-to-be-a-woman/
6 Congressional Research Service, 2022, p 11–12; Baraza, Salim. "DRC: A History of Pillage, Destination Unknown." The Africa Report.com, October 30, 2020. https://www.theafricareport.com/47442/drc-a-history-of-pillage-destination-unknown/
7 Aikins, Matthieu. "How Is Your Phone Powered? Problematically." The *New York Times*, January 23, 2023. https://www.nytimes.com/2023/01/23/books/review/cobalt-red-siddharth-kara.html
8 Lipton, Eric, Dionne Searcey, and Michael Forsythe. "Race to the Future: What to Know about the Frantic Quest for Cobalt." The *New York Times*, November 20, 2021. https://www.nytimes.com/2021/11/20/world/china-congo-cobalt-explained.html
9 Congressional Research Service, 2022, p 13
10 Stiftung, 2022, p 5, 25
11 Van Reybrouck, David. *Congo: The Epic History of a People*. London: Fourth Estate, 2014. p 491
12 "Democratic Republic of Congo." UN Habitat, 2023. https://unhabitat.org/sites/default/files/2023/07/drc_country_brief_en.pdf, p 2
13 "Congo, Dem. Rep." World Bank Open Data, 2023. https://data.worldbank.org/country/congo-dem-rep
14 Ventura, Luca. "Poorest Countries in the World 2023 [Updated September]." Global Finance Magazine, September 17, 2023. https://www.gfmag.com/global-data/economic-data/the-poorest-countries-in-the-world?page=10; "The World Bank in the DRC: Overview." World Bank, September 25, 2023. https://www.worldbank.org/en/country/drc/overview#:~:text=Between%202000%20and%202017%2C%20primary,read%20and%20understand%20simple%20text
15 Stiftung, 2022, p 15
16 "Democratic Republic of the Congo – Food Security Portal." IFPRI, 2018, https://www.foodsecurityportal.org/
17 World Bank, 2023
18 Stiftung, 2022, p 23

19 "République Démocratique Du Congo 2013–2014 Du Congo." Demographic Health Survey, September 2014. https://dhsprogram.com/pubs/pdf/fr300/fr300.pdf, p 72
20 World Bank, 2023
21 News Wires. "Poverty, but Also Rumba and Resilience: Five Things to Know about DR Congo." France 24, January 31, 2023. https://www.france24.com/en/africa/20230131-poverty-but-also-rumba-and-resilience-pope-starts-long-awaited-dr-congo-trip
22 World Bank, 2023
23 Mukaba, Thibaut, Arsene Binanga, Sarah Fohl, and Jane T Bertrand. "Family Planning Policy Environment in the Democratic Republic of the Congo: Levers of Positive Change and Prospects for Sustainability." *Global Health: Science and Practice* 3, no. 2 (2015): 163–73. https://doi.org/10.9745/ghsp-d-14-00244, p 165–166
24 "About the Global Fund." The Global Fund to Fight AIDS, Tuberculosis and Malaria, n.d. https://www.theglobalfund.org/en/about-the-global-fund/
25 "About Us – PEPFAR – United States Department of State." US Department of State, May 9, 2023. https://www.state.gov/about-us-pepfar/#:~:text=The%20U.S.%20President's%20Emergency%20Plan,through%20the%20American%20people's%20generosity
26 "The London Summit on Family Planning." FP 2030, 2011. https://fp2030.org/sites/default/files/About_the_London_Summit_on_FP_-_Summary_Document.pdf
27 FP2030, 2011
28 Kwete, Dieudonné, Arsene Binanga, Thibaut Mukaba, Théophile Nemuandjare, Muanda Fidele Mbadu, Marie Thérèse Kyungu, Perri Sutton, and Jane T. Bertrand. "Family planning in the Democratic Republic of the Congo: encouraging momentum, formidable challenges." *Global Health: Science and Practice* 6, no. 1 (2018): 40–54, p 45
29 Binanga, Arsene, Grace Matawa, Jennifer Racher, Protais Musindo, and Jane T. Bertrand. "Advocacy as a Tool for Advancing Family Planning in the Democratic Republic of the Congo: A Case Study." *Global Health, Science and Practice* 11, no. 6 (December 22, 2023): e2300021. https://doi.org/10.9745/GHSP-D-23-00021, p 6-7
30 "DRC – Programme de Planification Familiale EN RDC." Advanced Family Planning, January 2015. http://planificationfamiliale-rdc.net/media/Advance%20family%20planning%20drc%20brief.pdf, p 3
31 Binanga, et al., 2023, p 6–7
32 Cabinet du Premier ministre, ed. "Décret N°15/003 Du 06 Mars 2015 portant création, organisation et fonctionnement du Comité technique multisectoriel permanent de la Planification familiale, en sigle CTMP/PF." Journal officiel de la République démocratique du Congo, no. 7 (April 1, 2015): 15–18. https://www.droitcongolais.info/files/812.03.15-Decret-du-6-mars-2015_Comite-de-la-planification-familiale.pdf
33 "Sustainable Pathways to Reproductive Choice: How the Wish Programme Supported National Efforts to Improve SRHR in West and Central Africa." Marie Stopes International, n.d. https://www.msichoices.org/news-and-insights/resources/sustainable-pathways-to-reproductive-choice-wish-report/, p 5
34 Binanga, *et al.*, 2023, p 7–8
35 SMART Advocacy: Achieving policy and funding change– User's Guide." SMART Advocacy, 2021, https://static1.squarespace.com/static/611ffd5cf6dc40442e4f8ffa/t/6166265c461ed52f1b8c35a1/1634084452697/Final+English.pdf
36 Advanced Family Planning, 2015, p 3; Video of presentation available at https://www.youtube.com/watch?v=v3kmJDGxwfY
37 Ministère de la Santé Publique (MSP). "Planification Familiale: Plan Stratégique National à Vision Multisectorielle (2014–2020)." Kinshasa: MSP, January 2014. https://advancefamilyplanning.org/sites/default/files/resources/Final%20Plan%20Strategique%20de%20PF%2020%20Fev%20Ok.pdf, p 1
38 MSP, 2014, p 8
39 MSP, 2014, p 1–3

40 MSP, 2014, p 8–9
41 Binanga, *et al.*, 2023, p 10–11
42 Villers, Stéphanie. La question de la dénatalité et la loi de 1923 In: *L'avortement et la justice, une répression illusoire? Discours normatifs et pratiques judiciaires en Belgique (1918–1940)* [online]. Louvain-la-Neuve: Presses universitaires de Louvain, 2009 (generated 07 juin 2023). Available on the internet: http://books.openedition.org/pucl/778, p 35–72
43 Binanga, *et al.*, 2023, p 4
44 Binanga, *et al.*, 2023, p 11–12
45 Population Reference Bureau. "Policy Change for Women's Rights: A Case Study of the Domestication of the Maputo Protocol in the Democratic Republic of the Congo." Population Reference Bureau, October 2021. https://www.prb.org/wp-content/uploads/2021/10/safe-engage-case-study-maputo.pdf, p 3–6
46 African Union. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003. https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf
47 "Sustainable Pathways to Reproductive Choice: How the Wish Programme Supported National Efforts to Improve SRHR in West and Central Africa." Marie Stopes International, n.d. https://www.msichoices.org/news-and-insights/resources/sustainable-pathways-to-reproductive-choice-wish-report/, p 16
48 Mukaba, *et al.*, 2015, p 163–164
49 "UNFPA Democratic Republic of the Congo." United Nations Population Fund, 2022. https://www.unfpa.org/data/transparency-portal/unfpa-democratic-republic-congo
50 "Saving and Transforming Lives UNFPA: Democratic Republic of Congo Annual Report 2018." United Nations Population Fund: DRC, 2018. https://drc.unfpa.org/sites/default/files/pub-pdf/sowp2021-fr_report-v3261_5.pdf, p 8
51 "Final Country Programme Document for the Democratic Republic of the Congo 2013–2017." United Nations Population Fund, October 2012. https://www.unfpa.org/sites/default/files/swop23/SWOP2023-ENGLISH-230329-web.pdf
52 "Evaluation de l'impact Du Projet ASSP (Accès Aux Soins de Santé Primaires) en République Démocratique du Congo – Résumé." Tulane University School of Public Health and Tropical Medicine (SPHTM), August 2019. https://crhpp.wp.tulane.edu/wp-content/uploads/sites/447/2020/03/Synopsis_ASSP-impact-evaluation_FR.pdf, p 13
53 Tulane University SPHTM, 2019, p 13–15, 210
54 Couple-years of protection (CYP) is the estimated protection provided by contraceptive methods during a one-year period based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. It is the most widely used indicator of output in international family planning programs.

"Estimating Unintended Pregnancies Averted from Couple-Years of Protection (CYP)." Guttmacher Institute, September 30, 2011. https://www.guttmacher.org/estimating-unintended-pregnancies-averted-couple-years-protection-cyp
55 Tulane University SPHTM, 2019, p 471
56 "Health Systems Support in the DRC Appui AU Syteme De Santee n RDC| ASSR." IMA World Health, DRC, February 6, 2023. https://imadrc.org/project/assr/, p 5
57 Taylor, Russell. "UK Aid Spending: Statistics and Recent Developments." House of Lords Library, December 8, 2022. https://lordslibrary.parliament.uk/uk-aid-spending-statistics-and-recent-developments/
58 "Sustainable Pathways to Reproductive Choice: How the Wish Programme Supported National Efforts to Improve SRHR in West and Central Africa." Marie Stopes International, n.d. https://www.msichoices.org/news-and-insights/resources/sustainable-pathways-to-reproductive-choice-wish-report/, p. 5

59 Canada, Global Affairs. "Search Projects: DRC and Family Planning." Canada.ca, March 1, 2019. https://w05.international.gc.ca/projectbrowser-banqueprojets/filter-filtre
60 FP2020. *New Country Commitments to FP2020: Benin, Democratic Republic of the Congo (DRC), Guinea, Mauritania, and Myanmar*. FP2020, 2013, p 2
61 "BMGF Family Planning Investments in the DRC." FP CAPE, 2023. https://www.fpcape.org/projets-de-planification-familiale-en-rdc/
62 Hernandez, Julie H, Pierre Akilimali, Patrick Kayembe, Nelly Dikamba, and Jane Bertrand. "The Value of Spatial Analysis for Tracking Supply for Family Planning: The Case of Kinshasa, DRC." *Health Policy and Planning* 31, no. 8 (2016): 1058–68. https://doi.org/10.1093/heapol/czw036
63 Scofield, Carolyn. "Tulane Receives $7.2 Million to Continue Family Planning Work in Democratic Republic of Congo." *Global Health Magazine*, January 12, 2017. https://tulanesphtm.wordpress.com/2016/06/28/tulane-receives-7-2-million-to-continue-family-planning-work-in-democratic-republic-of-congo/
64 "NOS Programmes." DKT RDCongo, 2023. https://dkt-rdc.org/index.php/nos-programmes/
65 Chae, Sophia, Patrick K. Kayembe, Jesse Philbin, Crispin Mabika, and Akinrinola Bankole. "The Incidence of Induced Abortion in Kinshasa, Democratic Republic of Congo, 2016." *PLOS ONE* 12, no. 10 (2017). https://doi.org/10.1371/journal.pone.0184389
66 "Democratic Republic of Congo." Ipas, June 8, 2023
67 "MSI United States." Marie Stopes International, 2020. https://www.msiunitedstates.org/wp-content/uploads/2021/07/MSI-2020-Annual-Report-1.pdf, p 5
68 Bertrand, Jane T, Mbadu Muanda, Saleh Babazadeh, and Ann-Marie Yongho. "Analyzing Supply and Demand for Family Planning in ASSP–Supported Health Zones in the DRC: A Case Study." New Orleans, LA: Center for Reproductive Health Policy and Programs – Tulane SPHTM, July 11, 2016. https://crhpp.wp.tulane.edu/wp-content/uploads/sites/447/2020/03/Report_family-planning.pdf, p 33
69 El Kadiri El Yamani, Fatima. "Disclosable Version of the ISR – Health System Strengthening for Better Maternal and Child Health Results Project (PDSS) – P147555 – Sequence No: 18 (English)." Washington, DC: World Bank, 2023 http://documents.worldbank.org/curated/en/099090501312342771/P1475550fbdf890ac0ad660d3bd3dc62a81, p 4
70 World Bank. Performance-based Financing in the Health Sector of the Democratic Republic of Congo: Impact Evaluation Report. Health, Nutrition, and Population Discussion Papers. World Bank Group, Oct 2022. https://doi.org/10.1596/38132, p 8.
71 World Bank Group. "World Bank Approves $502 Million to Reduce the Prevalence of Stunting in the DRC." World Bank, June 4, 2019. https://www.worldbank.org/en/news/press-release/2019/05/28/world-bank-approves-502-million-to-reduce-the-prevalence-of-stunting-in-the-drc
72 World Bank Group, 2019
73 Desmon, Stephanie. "CCP to Study Nutrition and Family Planning in DRC – Johns Hopkins Center for Communication Programs." Johns Hopkins Center for Communication Programs – Inspiring Healthy Behavior Worldwide, January 12, 2022. https://ccp.jhu.edu/2021/11/08/nutrition-family-planning-drc-research/#:~:text=The%20Johns%20Hopkins%20Center%20for,health%20issues%20in%20the%20country
74 "What We Do." What we do | Central African Forest Initiative (CAFI), 2023. https://www.cafi.org/what-we-do
75 "Letter of Intent For the Establishment of a Partnership Between The Government of the Democratic Republic of the Congo (DRC) And The Central African Forest Initiative (CAFI) On the Implementation of the National REDD+1 Framework Strategy and Investment Plan of the DRC." CAFI, April 2016. https://redd.unfccc.int/uploads/3262_6_loi_v7_final_18_april_2016_-eng_-_with_logos.pdf, p 7, 17

76 "Promis-PF." Center for Reproductive Health Policy and Programs, n.d. https://crhpp.wp.tulane.edu/projects/promis-pf/
77 Openaid. "Explore Aid." Openaid, 2023. https://openaid.se/en/activities?filterA=%5B2022%2CCD%2C%2C%2C130%2C%2Cfalse%2Call%5D&filterB=%5B%5D&filterC=%5B%5D&filterD=%5B%5D
78 "Reproductive Health Access Information and Services in Emergencies." Columbia University Mailman School of Public Health, April 26, 2023. https://www.publichealth.columbia.edu/research/programs/reproductive-health-access-information-services-emergencies
79 "The Netherlands and the Great Lakes Region." Publication | Government.nl, August 14, 2019. https://www.government.nl/topics/development-cooperation/documents/publications/2019/08/13/the-netherlands-and-the-great-lakes-region
80 Plan stratégique nationale à vision multisectorielle de la planification familiale 2021–2025 avec regard sur 2030, République démocratique du Congo, Ministère de la Santé publique, de l'hygiène et de la prévention, Secrétariat général, Programme national de santé de la reproduction (PNSR), 2021.
81 Plan stratégique nationale de la santé et du bien-être des adolescents et des jeunes 2016–2020. République démocratique du Congo, Ministère de la Santé publique, Programme national de la santé des adolescents (PNSA). March 2016, p 23–24
82 "Advancing Social Marketing for Health in the Democratic Republic of Congo Task Order # GHH-I-05-07-00062-00." Submitted by Population Services International for USAID, July 2013. https://pdf.usaid.gov/pdf_docs/PA00JH5M.pdf, p 3, 8, 18
83 Warren, Penny. "Phil Harvey Obituary." The *Guardian*, January 4, 2022. https://www.theguardian.com/society/2022/jan/04/phil-harvey-obituary
84 "Democratic Republic of Congo." DKT International, February 14, 2023. https://www.dktinternational.org/country-programs/democratic-republic-of-congo/
85 "Investigation in Democratic Republic of Congo." Investigation in Democratic Republic of Congo – Office of the Inspector General – The Global Fund to Fight AIDS, Tuberculosis and Malaria, March 12, 2019. https://www.theglobalfund.org/en/oig/updates/2019-03-12-investigation-in-democratic-republic-of-congo/, p 7–8
86 Office of the Inspector General, 2019, p 4
87 Kisangani, Emizet F. *Historical dictionary of the Democratic Republic of the Congo*. Fourth ed. London: Rowman & Littlefield Inc., 2016, p xlvi
88 "Informed Push Distribution DRC." i+solutions, February 10, 2021. https://www.iplussolutions.org/projects/informed-push-distribution-drc-project/.
89 "Ebola Outbreak 2018–2020 – North Kivu-Ituri." World Health Organization, June 2020. https://www.who.int/emergencies/situations/Ebola-2019-drc-.
90 I+solutions, 2011
91 Spieler J. Sayana® Press: can it be a "game changer" for reducing unmet need for family planning? *Contraception*. 2014 May;89(5):335-8. doi: 10.1016/j.contraception.2014.02.010. Epub 2014 Feb 26. PMID: 24703826
92 Binanga, Arsene, and Jane T. Bertrand. "Pilot Research as Advocacy: The Case of Sayana Press in Kinshasa, Democratic Republic of the Congo." *Global Health: Science and Practice* 4, no. 4 (2016): 542–551. Accessed June 30, 2023. https://doi.org/10.9745/GHSP-D-16-00236, p 543–545; Bertrand, Jane T., Paul Bukutuvwidi Makani, Julie Hernandez, Pierre Akilimali, Bitshi Mukengeshayi, Saleh Babazadeh, and Arsene Binanga. "Acceptability of the Community-Level Provision of Sayana® Press by Medical and Nursing Students in Kinshasa, Democratic Republic of the Congo." *Contraception* 96, no. 3 (2017): 211–15. https://doi.org/10.1016/j.contraception.2017.05.014, p 212
93 Ntabona, Alexis, Arsene Binanga, Mr Désiré Bapitani, Beatrice Bobo, Bitshi Mukengeshayi, Pierre Akilimali, Gloria Kalong, Zenon Mujani, Julie Hernandez, and Jane T Bertrand. "The Scale-up and Integration of Contraceptive Service Delivery into Nursing School Training in the Democratic Republic of the Congo." *Health Policy*

and Planning 36, no. 6 (2021): 848–60. https://doi.org/10.1093/heapol/czab014, p 849

94 "Promis-PF." Center for Reproductive Health Policy and Programs, 2018. https://crhpp.wp.tulane.edu/projects/promis-pf/

95 Tsui, Amy O., Win Brown, and Qingfeng Li. "Contraceptive Practice in sub-Saharan Africa." *Population and Development Review* 43, no. S1 (2017): 166–91. https://doi.org/10.1111/padr.12051

96 Bankole, Akinrinola, Lisa Remez, Onikepe Owolabi, Jesse Philbin, and Patrice Williams. "From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress." Guttmacher Institute, December 31, 2020. https://doi.org/10.1363/2020.32446, p 7–8

97 Chae, *et al.*, 2017, p 11

98 Timothée Lunganga, *et al.* "État des lieux de la contraception et de l'avortement en République démocratique du Congo." Ministry of Public Health, 2017, unpublished

99 Glover, Annie L., Patrick Kayembe, Didine Kaba, and Pélagie Babakazo. "Assessing Readiness to Provide Comprehensive Abortion Care in the Democratic Republic of the Congo After Passage of the Maputo Protocol." *International Perspectives on Sexual and Reproductive Health* 46, no. Supplement 1 (2020): 3–12. https://doi.org/10.1363/46e0420, p 7

100 Population Reference Bureau (PRB). "Policy Change for Women's Rights: A Case Study of the Domestication of the Maputo Protocol in the Democratic Republic of the Congo."PRB, 2021, p 3

101 PRB, 2021, p 4

102 Glover, *et al.*, 2020, p 7

103 Normes et directives des soins complets d'avortement centrés sur la femme en RDC, République démocratique du Congo, Ministère de la Santé publique, Secrétariat général, 2020.

104 "Prévenir et prendre en charge les grossesses non désirées en RDC." Fondation Médecins du Monde, October 21, 2020. https://fondation-medecinsdumonde.org/prevenir-et-prendre-en-charge-les-grossesses-non-desirees-en-rdc/

105 "Legal Access to Abortion Expands in Democratic Republic of Congo." Ipas, May 16, 2022. https://www.ipas.org/news/legal-access-to-abortion-expands-in-democratic-republic-of-congo/

106 "Democratic Republic of Congo." Médecins Sans Frontières, August 31, 2021. https://www.msf.ie/democratic-republic-congo

107 "MSI RDC." Accueil | MSI RDC, n.d. https://www.msi-rdc.org/

108 "Safe Abortion." DKT International, June 15, 2023. https://www.dktinternational.org/services/safe-abortion/

109 Glover AL, Mulunda JC, Akilimali P, Kayembe D, Bertrand JT. "Expanding access to safe abortion in DRC: charting the path from decriminalisation to accessible care." *Sex Reprod Health Matters.* 2023 Dec;31(1):2273893. doi: 10.1080/26410397.2023.2273893. Epub 2023 Nov 13. PMID: 37955526; PMCID: PMC10653615.

110 Binanga, *et al.*, 2022, p 14–9

111 "Planification Familiale : Plan stratégique national à vision multisectorielle (2014–2020)." Planification Familiale – familyplanning-drc.net, January 2014. http://familyplanning-drc.net/docs/Final%20Plan%20Strategique%20version%20officielle.pdf, pp. 1–3.

112 "The 3rd National Conference to Reposition Family Planning in the DRC Lays Groundwork for Permanent Multi-Sectorial Technical Committees at the Provincial Level." Gates Institute, 2015

113 Hettige, Harshi. "DRC Government Releases Recommendations from 3rd National Conference on Repositioning Family Planning." Family Planning | JHU – Advance Family Planning, January 29, 2015. https://www.advancefamilyplanning.org/drc-government-releases-recommendations-3rd-national-conference-repositioning-family-planning "Detailed Session Information." Programme de planification familiale en RDC, n.d.

114 Ngoy, Angel Makadi. "RDC: La 4ème conférence nationale pour le repositionnement de la planification familiale sera consacrée aux jeunes et adolescents." 7sur7.cd, October 10, 2019. https://7sur7.cd/2019/10/10/rdc-la-4e-conference-nationale-pour-le-repositionnement-de-la-planification-familiale

115 "The Demographic and Health Surveys Program: Global Health." US Agency for International Development, March 7, 2023. https://www.usaid.gov/global-health/demographic-and-health-surveys-program#:~:text=The%20DHS%20Program%20provides%20technical,America%2FCaribbean%20and%20Eastern%20Europe

116 "Enquête nationale sur la situation des enfants et des femmes— MICS2/2001". UNICEF, July 2002. https://mics.unicef.org/surveys; UNICEF. "Enquête par grappes à indicateurs multiples— MICS-2010 Rapport final". UNICEF, May 2011. https://mics-surveys-prod.s3.amazonaws.com/MICS4/West%20and%20Central%20Africa/Congo%2C%20Democratic%20Republic%20of%20the/2010/Final/Congo%20DR%202010%20MICS_French.pdf; UNICEF. "République Démocratique du Congo MICS-Palu 2018" Résumés statistiques." UNICEF, December 2019. https://mics-surveys-prod.s3.amazonaws.com/MICS6/West%20and%20Central%20Africa/Congo%2C%20Democratic%20Republic%20of%20the/2017-2018/Snapshots/Congo%2C%20Democratic%20Republic%20of%20the%2C%202017-18%20MICS%20Snapshots_French.pdf

117 "Main Results of the MICS-Palu Survey 2017–2018." UNICEF, July 1, 2019. https://www.unicef.org/drcongo/en/reports/summary-mics-palu-2017-2018, p 3

118 "Medical Eligibility Criteria for Contraceptive Use." World Health Organization, February 3, 2015. https://www.who.int/publications/i/item/9789241549158, p 15

119 New, JR and L Alkema. *Family Planning Estimation Tool (FPET)*, 2015. http://fpet.track20.org/

120 New and Alkema, 2015

121 "Introduction | Progress Report." FP 2020, n.d. http://progress.familyplanning2020.org/introduction#:~:text=The%20leaders%20who%20gathered%20at,lowest%2Dincome%20countries%20by%202020.

122 "About PMA Data." PMA Data, n.d. https://www.pmadata.org/about

123 Team, MPC UX/UI. "About IPUMS PMA." IPUMS PMA, n.d. https://pma.ipums.org/pma/about.shtml

124 "PMA2020 publie les résultats de Kinshasa, RDC." École de santé publique de Kinshasa, December 27, 2015. https://espkinshasa.net/pma2020-publies-les-resultats-de-kinshasardc/; Performance Monitoring for Accountability (PMA2020). PMA, 2017,"PMA2013/KINSHASA-R1" https://www.pmadata.org/sites/default/files/data_product_results/PMA2020-DRC-Kinshasa-R1-FP-Brief-EN.pdf

125 "PMA Datalab: DR Congo." Explore the Data | PMA DataLab, 2023. https://datalab.pmadata.org/data/charts?regions%5B258%5D=258&regions%5B259%5D=259&indicators%5B5%5D=5

126 "Technical Areas: Family Planning." Family Planning | PMA Data, 2023. https://www.pmadata.org/technical-areas/family-planning#data-products-section-heading

127 Mbadu Muanda and Parfait Gahungu, 2012. *Cartographie de la PTME compréhensive en RDC.* Unpublished report

128 Akilimali, Pierre Z and Luc Kilabi. "Évaluation des indicateurs pour le suivi du programme de sécurisation des produits de santé de la reproduction en République démocratique du Congo." 2022 (unpublished report), p 15–18

129 École de santé publique de Kinshasa ESPK/Kinshasa, République démogratique du Congo and ICF. "République démocratique du Congo : Évaluation des présentations des services de soins de santé EPSS 2017–2018." Kinshasa, République démocratique du Congo: ESPK and ICF, 2019. Available at http://dhsprogram.com/pubs/pdf/SPA30/SPA30.pdf, p v

130 ESPK/ICF, 2019, p 26

131 "Growing Up GREAT! End of Project Report." Institute for Reproductive Health, Georgetown University for the US Agency for International Development (USAID),

Washington DC. May 1, 2021. https://www.comminit.com/global/content/growing-great-end-project-report, p ii–v

132 Justus, Rebecca. "Bien Grandir/ Bien Grandir Plus." Align Platform, January 10, 2022. https://www.alignplatform.org/resources/bien-grandir-bien-grandir-plus

133 Gage, Anastasia J., Francine E. Wood, Darling Kittoe, Preethi Murthy, and Rianne Gay. "Association of Male Partners' Gender-Equitable Attitudes and Behaviors with Young Mothers' Postpartum Family Planning and Maternal Health Outcomes in Kinshasa, DRC." *International Journal of Environmental Research and Public Health* 19, no. 19 (2022): 12182. https://doi.org/10.3390/ijerph191912182

134 Gage, Anastasia J., Pierre Z. Akilimali, Francine E. Wood, Rianne Gay, C. Olivia Padis, and Jane T. Bertrand. "Evaluation of the Effect of the Momentum Project on Family Planning Outcomes among First-Time Mothers Aged 15–24 Years in Kinshasa, DRC." *Contraception* 125 (September 1, 2023): 110088. https://doi.org/10.1016/j.contraception.2023.110088.

135 "District Health Information System 2 (DHIS2)." Open Health News, June 8, 2018. https://www.openhealthnews.com/resources/district-health-information-system-2-dhis2

136 "DHIS2." IMA World Health, DRC, November 10, 2020. https://imadrc.org/dhis2/

137 Krafft, Max. "Supporting Effective Health Data Use in the Democratic Republic of the Congo with Dhis2." DHIS2, August 2, 2022. https://dhis2.org/drc-data-use/

138 République démocratique du Congo, Ministère de la Santé publique. "Plan national de développement sanitaire 2017–2020." Population Reference Bureau, March 2016. https://prb.org/wp-content/uploads/2020/06/Mauritanie-Plan-National-de-Developpement-Sanitaire-2017-2020.pdf, p 48–49

139 Krafft, Max, 2022

140 "Insights Deck– the Democratic Republic of the Congo (DRC)." Prepared by UNC Carolina Population Center for FP Cape, June 2018. https://www.fpcape.org/wp-content/uploads/2018/11/FPCAPEdeck-2018June29-DRC_FINAL_Blurred_SN.pdf

141 Mboyo, Yves Van Der. "La directrice du PNSR, Dr Lis Lombeya en lutte contre la corruption, le détournement des appuis à la PF et l'instrumentalisation des agents du PNSR par un réseau mafieux au ministère de la Santé." Infocongo, September 3, 2020. https://infocongo.net/2020/09/03/pnsr-un-vaste-reseau-mafieux-de-detournement-des-appuis-et-dinstrumentalisation-du-personnel-dementele-par-la-directrice-lis-lombeya/

142 Taylor, 2022; "UK aid: Spending Reductions since 2020 and Outlook from 2023" House of Commons Library, December 13, 2022. https://commonslibrary.parliament.uk/research-briefings/cbp-9224/

Part III

Looking Backward, Pressing Forward

9 The Past, Present, and Future

How the Congo's difficult past has shaped contemporary family planning

This book began not with President Mobutu's 1972 discourse on *Naissances Désirables*, but rather with King Leopold II's horrific plundering in his personal territory, the Congo Free State. One can draw a direct line from colonial systems and practices to modern-day obstacles to family planning. Some of these factors are by no means unique to the Congo, but they converge to produce a mosaic of barriers that is particular to the DRC.

We begin with five factors that have negatively impacted contraceptive use at the individual level, followed by five others that have impeded family planning programming at the institutional level.

Failure to educate women

King Leopold II spent next to nothing on education for either boys or girls. In the Belgian Congo, the colonial powers entrusted primary school education to the Catholic missionaries, who in turn channeled almost all resources to the education of boys. On the eve of independence, none of the 16 graduates with university degrees from Belgium was female. None of the 100 students enrolled in the two newly established Congolese universities was female. And of the 800 students who graduated from high school in 1959, only one was a girl.[1]

Girls' education favors contraceptive use in multiple ways. The more education a girl has, the more knowledgeable she is in navigating her path through life. She is more likely to develop professional aspirations. With higher education, she is more likely to learn about contraception, find a source of it, and use it effectively. Contraceptive use increases her chances of avoiding a pregnancy that would end her educational career. An educated girl is more likely to feel the autonomy needed to make this type of decision and have the financial means to take action.

Barriers to employment for women

It made news when, in 1957, a Congolese woman was given a salaried position in the colonial administration (as an auxiliary clerk). The magazine breaking this

DOI: 10.4324/9781032718897-12

news explained that it was possible, thanks to the ability of the young woman "to remain in her place."[2] Only after independence did Congolese women in urban areas obtain salaried positions, and invariably at a low level of responsibility and pay. President Mobutu paid lip service to improving the status of women in his doctrine on *authenticité*, but little change actually occurred under his watch. "*Hommes nouveaux/femmes nouvelles: émancipation*" (New men/new women: emancipation) never moved beyond a catchy slogan.[3] By the end of the 1980s, women's presence in the formal wage-labor force had increased significantly, especially in the private sector, but rarely did women occupy senior positions.[4]

As of 2023, only 13% of members of parliament are female.[5] One in five of the cabinet ministers in DRC are women.[6] Of the over 20 Kinshasa-based international NGOs with major family planning projects in the DRC, only one has a female country director. This contrasts markedly with the field as a whole, where increasingly, leadership positions in international family planning and reproductive health are held by women.

Women who have work opportunities or aspire to them are more likely to want and need contraception. Delaying pregnancy will allow them to stay in school and obtain the education or training needed to enter the workforce. Having the means of controlling their own fertility will allow them to plan births consistent with their employment situation and to spend more years in the workforce. The conflict between childcare duties and work may be less problematic in the African context where other female members of the extended family are available to take care of children. Nonetheless, working mothers may opt for fewer children as a means of giving each one more of their time.

Women's status within society and the family

The inferiority of women was well-ingrained in Congolese society long before Leopold II laid claim to the territory, and it was reinforced during the colonial era. Although male dominance prevails in societies worldwide and especially in sub-Saharan Africa, the DRC has particular issues with gender equality. The decades of inferior education for girls and the barriers to employment in the colonial era have had a profound effect on women's status in Congolese society that persists to the present day. The DRC ranks 151 of 179 countries on the Gender Inequality Index.[7]

Although the constitution prohibits discrimination against women, the power of custom prevails throughout society. Not until 1967 did women receive the right to vote.[8] The Family Code of 1987 still required a woman to obey her husband, obtain his permission to work, or engage in any legal transactions;[9] it further cemented the role of women as secondary citizens within their own households.[10] It also allowed the husband to claim ownership of his wife's property. If the husband died without a will, the widow was unable to inherit her husband's property; rather the law stated that the husband's children had claim to it.[11] These provisions were updated in the Family Code in 2016, but societal norms continue to serve as major barriers toward gender equality.[12]

Much of society equates women's status with childbearing. Given the high fertility norms of the country, having more children can bring greater social status within her community. The existing barriers to personal fulfillment through meaningful engagement in the labor force further reinforce the tendency to seek community approbation through childbearing, especially in rural areas.

Gender inequality extends far beyond discrimination. Sexual harassment is prevalent, particularly in the workplace and at universities. Sexual violence, especially in the eastern regions of the country, is pervasive; rape is used as a weapon of war, particularly in the Kivu provinces.[13] In response, interventions for gender-based violence are integral to most reproductive health programming in the east. Yet SBGV is by no means limited to the east. Sexual violence, transactional sex, and other SGBV issues are pervasive throughout the country, although often less highlighted.

Gender inequality has a direct impact on contraceptive use in several ways. In households where the male is the sole decisionmaker, he will have the ultimate say on the woman's reproductive choices and potential contraceptive use. In controlling the family's finances, he may withhold from his wife the funds needed to seek services. Research from SSA has repeatedly demonstrated that where couples communicate with each other on the topic of childbearing, they are more likely to use modern contraception.[14] Fear of gender-based violence prevents many women from even broaching the subject of contraception with their spouses.

The grinding poverty that robs women of agency

In countries worldwide, extreme poverty is part of a constellation of factors (including a lack of education) that decreases women's use of modern contraception.[15] There can be no question that the decades of misuse of government funds and the plundering of the country's natural resources without benefit to the population contributed to the DRC being among the five poorest countries in the world today. A staggering 62% of the population survives on less than $2.15 a day.[16]

Unless contraceptives are readily available at a negligible price or free of charge, they remain out of reach for many poor families. Opportunity costs – finding childcare and paying for transportation – are additional barriers. In a perpetual scramble for survival, planning for the future may be a luxury few poor women can afford.

Much is made of the "resilience" of the Congolese people. Outsiders often wonder how the population can maintain a sense of hope in the face of oppressive poverty. Dr. Alexis Ntabona provided an answer that speaks volumes for the value that Congolese place on having a large family. "Many people say that '*Dieu nous aidera*.' (God will intervene to help us). Yet behind that belief is the expectation (and reality) that in a crisis, the helping hand will be from members of one's family." According to this logic, having a large family increases the chances that at least one person will grow into a position of being able to help other family members in times of trouble.

Fear of sterility

It would be a stretch to claim that the epidemic of sterility that afflicted pockets of the Congo in the late 1930s through the 1940s still shapes contraceptive decision-making today. Yet among women – even in the modern city of Kinshasa – deep-seated fear of infertility greatly influences their decision to use contraception and their choice of method. Studies from the DRC have repeatedly shown that "fear of side effects" is a major barrier to contraceptive use.[17] Only in recent years have researchers realized that "fear of side effects" often equates to fear of jeopardizing one's future fertility in a country where an all-important premium is placed on motherhood.

Among those who do use some means to prevent pregnancy, traditional methods – rhythm and withdrawal – remain far more prevalent in the DRC than in other low- and middle-income countries, including other SSA countries. One reason may be the availability and affordability of these methods, compared to contraceptives that require a trip to the clinic, pharmacy, or community health worker. Yet another plausible explanation is their lack of side effects. Until 2021, all representative studies of family planning use in the DRC (DHS, MICS, PMA) showed condoms to be the most widely used modern contraceptive method. One explanation is their ready availability, often at little or no cost, thanks to HIV campaigns. Another is avoidance of hormonal methods, which many women fear could negatively affect future childbearing.

******

If the legacy of the past has influenced contraceptive use at the individual level, it has also impacted family planning programming at the institutional level, in at least five different ways.

The strong influence of the Catholic Church

Dating back to the Congo Free State, King Leopold II gave favored status to the Belgian Catholic missionaries in terms of subsidies for "civilizing" the Congo. After annexation in 1908, the Catholic Church remained closely aligned with the colonial government and private enterprise (the "colonial trinity") during the entire Belgian Congo era. Only in 1948 did the colonial government extend educational subsidies to Protestant missionaries as well.

In the six decades since independence, the Catholic Church has continued to play an outsized role in health, education, and governance in the DRC. For over a decade after independence, the government gave the Church subsidies for healthcare and education in locations countrywide. After the international donors withdrew from the country following the 1991 pillage, the Catholic Church stepped in to run a humanitarian service that made medications available to the population, Catholics or not. A more recent example is the mediating role that the Catholic Church played between the opposition and the government in the 2018 presidential election.[18]

Historically, the Catholic Church has promoted the Bible verse from Genesis: "Be fruitful and multiply. Fill the earth." Pope Pius XI declared in 1930 that marriage is intended to result in childbearing, and Pope Paul VI explicitly condemned the use of contraception in 1968.[19] In the earliest days of *Naissances Désirables*, the Catholic Church made known its objections to artificial contraception and abortion, though it did not try to obstruct the development of family planning programs. Many of the Catholic-funded health facilities in the DRC today refuse to offer modern methods, though some will provide clients with methods secretively or refer them to other facilities for this service. Since the 1980s, the national program (PSND and later PNSR) has worked in a complementary fashion with the Catholic organization *Conduite de la Fécondité* to promote "natural" methods of pregnancy prevention and birth spacing.

Yet the influence of the Catholic Church was strongly felt in the debate over abortion. The DRC parliament ratified the Maputo Protocol in 2008, which allowed for abortion in cases of rape, incest, or to save the life of the mother. However, the law did not take effect until published in the *National Gazette*. For ten years, the Catholic Church brought its influence on lawmakers to delay the publication of the Maputo Protocol in the *Gazette* which, despite opposition from the Church and through strong advocacy work by its supporters, was published in 2018.

It is less clear the influence of the Church's position on women's decision to use modern contraception. In the latest population-based survey in Kinshasa, the percentage of married women using a modern method was similar among Catholic respondents (24.2%) and Protestants (25.8%).[20] The large percentage of women who continue to rely on traditional methods (rhythm or withdrawal) may do so for religious reasons or because they fear the side effects of hormonal methods.

As yet unclear is the influence of "born-again" evangelical churches (*églises de réveil*) that have vastly expanded in popularity over the past two decades in the country. Many of these churches hold great sway over the population, especially young people, and many are diametrically opposed to family planning. The position of pastors on family planning is not a defining principle of the religion; rather, it reflects their individual views. The influence of these churches on contraceptive use in the DRC deserves more study.

Government accountability: the legacy of Article 15

The DRC is not alone in the lack of transparency and accountability in the financial management of government programs. Many other low- and middle-income countries suffer from corruption, embezzlement, and cronyism. Yet since independence in 1960, the country has not experienced an administration rooted in the principles of good government and accountability.

The phrase "Article 15" will bring a knowing smirk to the face of most educated Congolese. Since the days of the Congo crisis in the early 1960s, Article 15 is humorous shorthand to describe or even justify petty thievery or corruption. It refers to a fictional provision of the 14-article constitution of the secessionist state

of South Kasaï, purported to read: "*débrouillez-vous!*" (meaning, figure it out yourself or do what you need to do). Over time, it even made its way into popular culture through Congolese rumba songs: *Article 15, oyebi yango* (1963), and *Article 15 Beta Libanga* (1985).[21]

Mobutu exemplified Article 15. His use of the national treasury for personal gain was legendary. As the Zairian population scratched for survival, Mobutu diverted funds to pay for his townhouse in Paris, a 32-room estate in Switzerland, and a 16th-century castle in Spain.[22] For his daughter's wedding in his jungle mansion in Gbadolite, pink champagne was flown in from Paris.[23] When the government coffers ran dry, he would print more money, driving the country to a staggering level of hyperinflation. Mobutu allegedly stole up to $4 billion while in office.[24]

When President Laurent-Désiré Kabila deposed Mobutu in 1997, the population dared to believe that the situation would improve. Yet Kabila – quickly embroiled in armed conflict with neighboring countries and dealing with rebel factions in the east – did little to develop "good governance." He, too, exploited the country's resources for the benefit of his entourage. As of 1998, the World Bank ranked the DRC as the third lowest of 214 countries on its control of corruption index.[25]

After the 2001 assassination of Kabila *père*, his son Joseph Kabila was appointed president. He was then elected to the office in 2006 and reelected in 2011. Kabila *fils* established a Commission of Economic Crimes, and he worked with the World Bank to curtail corruption and improve the economy. Yet the pattern of high-ranking officials personally benefiting from the government has persisted.[26] A 2021 judicial investigation alleged that he had embezzled $138M. Félix Tshisekedi emerged victorious from the 2018 presidential election,[27] and within 18 months, his chief of staff was found guilty of embezzling almost $50M.[28] His minister of health was sentenced to five years in prison for embezzling the country's Ebola response funds.[29] As of 2022, the DRC ranked 166 of 180 countries on the Corruption Perception Index.[30]

The legacy of financial mismanagement in the public sector directly impacts contemporary family planning programming. None of the bilateral family planning donors (e.g., USAID or FCDO) or private foundations (e.g., Gates or Packard) directly fund the DRC government, either because of a specific regulation prohibiting it or the poor record of the DRC government in financial accountability. Rather, as described in the chapter on the 2010s, they channel much of this funding through international NGOs (iNGOs), which has resulted in a patchwork of funding, creating its own set of tensions between government agencies and international implementing partners.

The dearth of trained managers

The leaders of a nation set the tone for governance and accountability, but good government relies on managers at multiple levels to define and ensure sound governance practices.

Paradoxically, the Belgian Congo was run as a tightly organized bureaucracy that prided itself on the rule of law. It operated as a well-oiled machine with colonial officials – imported from Belgium – overseeing different levels of the bureaucratic hierarchy. It placed a high value on efficiency and productivity, and the incentive system strongly discouraged corruption.[31] Yet colonial authorities – in an attempt to maintain an iron grip on power – barred Congolese from the top positions of leadership in government or the private sector. The two dozen Congolese lucky enough to be trained in Belgium could only specialize in subjects that would not threaten the existing power structure. As a result, on *30 juin* 1960, the country was void of a top-level managerial class ready to govern this vast, complicated country.

Strong managers should promote the principles of good governance: participation, rule of law, transparency, responsiveness, consensus orientation, equity and inclusiveness, effectiveness and efficiency, and accountability.[32] These principles have been largely absent in the public sector since independence. Rarely would a public servant have received "on-the-job training" in these principles, as the different regimes gyrated between political crises, armed conflicts, and economic freefall. If the relative quiet of the 1980s allowed for some progress in developing a cadre of managers, the pillages and wars of the 1990s left the population – even many professionals – scrambling for survival. Never was Mobutu's principle of *debrouillez-vous* more relevant to staying alive.

As the country inched its way back to normalcy by the mid-2000s, a cadre of managers did emerge – in the commercial private sector, the non-profit NGO sector, and (to a lesser extent) the public sector. Yet the rules of the game had a very Congolese flavor, and professional survival depended on walking a thin line between "internationally recognized" principles of management and locally accepted norms for governing. International NGOs tend toward the former, and government agencies toward the latter. Was it a coincidence that the majority of staff in a given agency came from the same province or ethnic group as the director? Was it problematic that recent hires were family members of the director? Especially in the public sector, officials knew that their term in office might be short, and thus they needed to take advantage of their position quickly, while the opportunity was still there.

One must also recognize the role of iNGOs in robbing the public sector of its most promising managerial talent. Given the higher salaries that iNGOs can offer, government staff who demonstrate talent and skill are often lured from government posts for such positions. One can hardly criticize the individuals for this choice, but it has profound repercussions on the public sector.

Vestiges of tribalism persist. Across sectors – not just health – ministers will appoint program directors who are "one of their own," someone from their province or ethnic group. They will send family members or friends to that director, insisting that they be added to the payroll – whether the agency needs additional personnel or the individuals are qualified to do the work. They may expect their program directors to hand over money from the accounts of large donors to them, then submit falsified receipts to the donor to justify the funds expended. Rarely does one protest, if one wants to hold onto the director position. It is part of the game.

Today in the public sector, there are honest, dedicated civil servants who work diligently to improve the wellbeing of the population. Family planning has been privileged to have a number of such individuals among its stakeholders, who have fought relentlessly to advance family planning, even when it was unpopular among their superiors or peers.

Over the past 20 years, the international and local NGOs have produced a superb cadre of program managers in the field of family planning. Several expert managers have also come through the ranks of government agencies and universities. These individuals are mission-driven, knowledgeable in their areas of expertise, skilled at managing their staff, and committed to advancing family planning. The emergence of this set of dedicated leaders is a major source of optimism for the future of family planning in the DRC. But the "bench is thin." The number of Congolese with this managerial acuity is still far fewer than needed.

The paucity of funds in government coffers

King Leopold II exploited the Congo Free State of rubber, ivory, and minerals for his own financial aggrandizement. The Belgian Congo was organized to benefit the financial interests of private companies that in turn directed this wealth back to the metropole. More recently, the mineral wealth of the country has found itself in bank accounts in the West and China. Since independence, the wealth of the country has been siphoned off by political elites. As reported by Global Witness, a toxic combination of corruption and mismanagement has leached one-fifth of all mining revenues away from the state budget.[33] The Congo's fragmented tax system remains open to abuse by political elites.

As of 2020, the DRC spent $21.25 per capita on healthcare, less than one-third the average of the rest of SSA, despite its vast mineral resources.[34] A small fraction of this meager amount goes to reproductive health, although the government did release $2.1M toward contraceptive procurement in 2021. The failure of the government to adequately tax the major sources of revenue for the country and invest these funds in the social sector results in a situation where the wealth of the nation fails to lift the citizens of the DRC out of poverty. Without a robust treasury with strong systems of financial management, family planning is but one of many underfinanced sectors in the DRC.

Donor dependency

A direct result of the government's lack of investment in the social sector is the near-complete dependency on donors to fund health, education, and other areas of development. Van Reybrouck argues that the government underfunds these areas, knowing that international donors will jump in to fill the gap in the name of development and humanitarian assistance.[35] The data in Figure 9.1 supports this conjecture. Compared to an illustrative group of SSA countries, the DRC ranks among the lowest in government funding of family planning, at $0.12 per capita as of 2021.

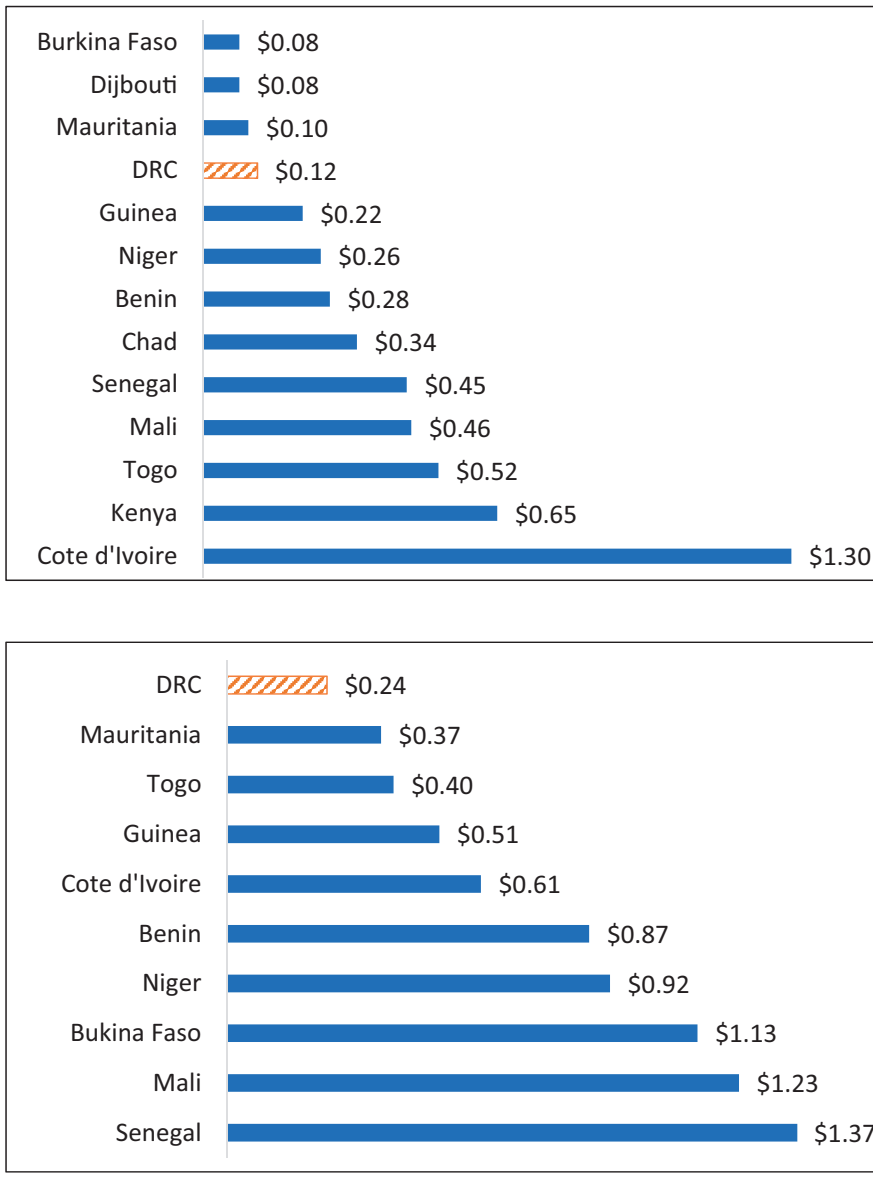


Figure 9.1 Estimated annual national government FP funding per capital, 2021; and Estimated FP funding per capita ($) from private and bilateral donors in DRC (2020) and in Ouagadougou Partnership countries (2019)

Yet even with millions of dollars invested by international donors, the DRC receives far less family planning funding per capita than most countries in SSA. Comparable data measured in standard fashion are difficult to obtain across all

low- and middle-income countries (LMICs), but they are available for the nine francophone countries participating in the Ouagadougou Partnership, a regional network in West Africa to promote family planning. In comparison to this group, the DRC ranks rock bottom with only $0.24 per capita of funding for family planning, five times less than Senegal (see Figure 9.1). The large population of the DRC, estimated near 100 million in 2022, creates an enormous challenge for the DRC government and donors alike trying to reach this population over a vast land mass the size of Western Europe. In assessing progress in family planning, one cannot overlook this far lower level of investment in the DRC than in comparable countries in the region.

The lack of investment in family planning results in one of the greatest obstacles to continued progress: chronic shortages of contraceptive methods. No amount of quality counseling and demand creation activities can boost modern contraceptive use if government facilities, private clinics, pharmacies, and community-based distributors do not have adequate supplies of contraception, especially of the methods most desired by this population (currently the implant).

******

If vestiges of the past have hindered progress in family planning, we can also point to two factors that have favored it.

The ingrained understanding of the importance of birth spacing

Long before the international donors arrived with modern contraceptive methods, even in traditional societies far removed from urban areas, women and men understood the importance of allowing one baby to breastfeed and grow before having another following on too quickly.[36] After delivery, mothers were sent back to their villages for extended periods, to avoid sexual contact with the husband. Alternatively, the mother or mother-in-law would move in with them to ensure *lits séparés* (separate beds). This awareness did not translate into the quick adoption of new-fangled drugs and devices when modern contraception arrived in the 1970s.[37] However, the basic principle of birth spacing to improve the survival chances of the baby was well-ingrained in the mindset of the population.

The expansive presence of Protestant missionaries across the country

By the time of independence, Protestant missionaries were working in 80% of districts in the country.[38] Research on birth rates in the 1940s showed significantly lower fertility in communities located within 100 kilometers of a Protestant mission than in a Catholic one.[39] Three decades later, soon after Mobutu endorsed the concept of *Naissances Désirables* in 1972, Protestant missionaries began incorporating contraception into their existing maternal child health programs. The *Eglise du Christ au Zaire* (ECZ) – the umbrella organization for some 60 Protestant denominations in the 1970s – quickly took up the charge of systematically introducing contraception through its church-supported hospitals.

Reverend Ralph and Florence Galloways were truly pioneers in seeking out funding from Pathfinder and exploring strategies to introduce this new service in rural areas.[40] When the USAID-funded rural health program SANRU, administered by the ECZ, began to support primary healthcare in health zones spanning the country in 1982, family planning was an integral (if not prioritized) part of the services offered.

Why should donors continue to invest in family planning in the DRC?

In 1972, when President Mobutu Sese Seko authorized *Naissances Désirables*, the total fertility rate for Zaïre was 6.4 children per woman. Fifty years later, in 2022, it was still 6.1.[41] By international standards, the needle has barely moved. True, *Naissances Désirables* never signified limitation of births, but some decrease in the fertility rate would be the expected by-product of widespread contraceptive use.

Since the 1994 Cairo Conference, the field has shifted away from the demographic rationale for family planning to a rights-based approach with the ideal of gender equality and greater female autonomy. Client-oriented family planning services should serve to improve the wellbeing of women and girls as an end to itself. By increasing the status of women in society and providing them with greater access to resources, a natural drop in fertility is expected to follow.

The extensive list of factors hindering family planning begs the question: why should donors continue to invest in family planning in the DRC? More specifically:

- Why should donors fund health initiatives in a country with such vast mineral wealth?
- Why are Western donors so intent on promoting family planning in a country where most couples want large families?
- Why has progress been so slow?
- Why should we expect better results in the future than in the past?
- What explains donor commitment to investing in family planning?

Why should donors fund health initiatives in a country with such vast mineral wealth?

The DRC is the poster child for the curse of natural resources: the paradox whereby countries with an abundance of natural resources (such as fossil fuels and certain minerals) have far less economic growth, less democracy, and worse development outcomes than countries with fewer natural resources.[42] The resources per se do not condemn the country, but rather the way in which the government utilizes them.

Despite the billions of dollars generated annually from mineral and other exports, only 9.9% of the GDP goes to government spending, slightly over half the 2021 average of 17.0% worldwide. As such, the DRC ranks among the lowest (109) of 125 countries worldwide on this measure and sixth lowest in SSA.[43]

The situation is even bleaker for health. The DRC government spends less than one-tenth the average of the rest of sub-Saharan countries on health. As of 2020, the country allocated only 4.0% of its GDP and 10.8% of its budget to health financing.[44] In short, inadequate government support is by no means limited to family planning.

Wresting the financial resources of the country for the benefit of the population is far beyond the power of international donors. Whereas institutions such as the World Bank and International Monetary Fund may attempt to influence the structure of health financing in the DRC, they are unlikely to succeed in the short-term. The DRC government has made a symbolically important purchase of contraceptives ($2.1M in 2021), but for the foreseeable future, the DRC will remain highly donor-dependent in the health sector, including family planning.

Why are Western nations so intent on promoting family planning in a country where most couples want large families?

Western nations have supported the introduction of family planning in LMICs since the 1950s for diverse reasons: health and quality of life benefits (reduced risk of maternal mortality and improved health for children), improved life options, and greater autonomy for women. At the macro level, family planning contributes to socio-economic development, easing the burden on schools and public services, and reducing pressures on the environment. At the micro level, it improves the family economy.[45] Of the many international development programs implemented to date, family planning has been among the most successful and cost-effective.[46]

The pattern of introducing family planning in LMICs has repeated itself many times over. When programs were first introduced – as they were in selected Asian countries in the 1960s and Latin American countries in the 1970s – they initially met with opposition, precisely because they challenged societal norms and religious ideologies. Falling infant mortality meant that couples were less likely to have "supplemental children" as insurance against losing one or more to premature death. As programs expanded, generally in urban areas first, women came to understand that there were alternatives to endless childbearing that also improved the wellbeing of their other children. Whereas governments in some Latin American countries felt that USAID too aggressively promoted family planning in the 1970s, by the 1980s almost all countries had growing family planning programs.[47] In short, societal norms about the number of children are not fixed and may change in response to access to means of preventing pregnancy.

The watchword for international family planning is voluntarism. In countries with low contraceptive prevalence, demand creation works to provide potential clients with the information needed to understand that family planning exists, why it may be beneficial to them, and where to find it. In countries where contraceptive use has become a norm, demand creation – especially through social marketing – provides motivational messages that encourage use with themes tailored to specific audiences.

The history of family planning is marred by rare, severe ethical violations in the past: luring men in India to have vasectomies in the 1970s in exchange for a transistor radio[48] or forcing women in China in the 1980s to abort rather than have a second child.[49] However, the rights-based approach to family planning that emerged from the 1994 ICPD in Cairo and was further championed at the London Summit in 2012 decisively endorses informed choice and voluntarism. Users should be women who want contraception, and donor-funded programs should provide access to those women or couples based on their desire for the product or service.

Why has progress been so slow in the DRC?

Multiple factors explain the slow progress to date in family planning, as measured by national-level fertility rates or modern contraceptive prevalence. The list begins with the political history of the country that explains why it ranks among the lowest in the world on health, education, and other indicators of socio-economic development:

> decades of colonial rule where the local population lacked opportunities for education and advancement; independence helter-skelter for which the country and its leaders had no time to prepare; deep ethnic divides that led to political instability;
>
> President Mobutu's oppressive reign for 37 years; his use of the country's riches to support a lavish lifestyle for himself and his entourage; the large patronage system that benefited a favored few at the expense of the health and education of the masses; a population repressed from protesting by a military that answered only to Mobutu; the pillages of 1991 and 1993 that ravaged the major cities and caused the international donors to halt development assistance; the staggering levels of inflation that sent the country into economic freefall;
>
> the Kabila take-over of power in 1997, followed in 1998 by the Second Congo War that ensnared eight neighboring countries in armed conflict; the rebel control of the eastern provinces of the country, making them ungovernable from 1998–2006, with residual tension to this day; the assassination of a president in 2001, followed by the efforts of two presidents to modernize the country without addressing the underlying corruption in government and issues of social justice;
>
> widespread illiteracy and malnutrition among a population that struggled simply to survive; the infrastructure of many government buildings, railroads, hospitals, health centers and schools in shambles; a government underfunded to address the myriad needs in all sectors; a class of civil servants who are underpaid – and who sometimes go unpaid – month after month; the country's vast mineral wealth serving the interests of a political elite; and a continuous dependency on Western powers that stymied country initiative and ownership.

This set of factors has hindered the development of the country across all sectors. To this long list, one can add the obstacles related to the high fertility norms: laws

that codified the superiority of men over women in household decision-making; the social status attached to having children; a girl becoming a woman when she has her first child, and conversely not being considered an adult until she has given birth; pressure from the husband's family that the wife produce many children in return for their having paid her dowry; and the likelihood of the man's seeking out another woman – with his family's approval – if his wife refuses to have additional children.

One must also figure in the obstacles specific to contraception: the widespread fear that contraceptive use will jeopardize future fertility; where methods are available, the social stigma of attending family planning services; the judgmental attitudes of service providers, especially for adolescent clients; the cost of obtaining a contraceptive method and the fees related to service (the *fiche* or registration card), even if the methods are free; or the lack of access to contraception in many rural areas of the country.

What explains donor commitment to investing in family planning?

For more than six decades, international donors have supported family planning for three key reasons that remain as valid today as ever. Although the relative importance of the three differs by country, all apply in the DRC.

To improve the health of women and children: women who avoid having babies "too early, too late, too many, or too closely spaced" lead far healthier lives. They are less likely to die in childbirth or to suffer obstetrical complications or botched abortion. Children spaced by at least 36 months have higher chances of reaching their fifth birthday and less risk of stunting, a major problem in the DRC.

To ensure the reproductive rights of women to control their own fertility. Consistent with the emphasis on gender equality championed at the 1994 International Conference on Population and Development held in Cairo, many donors now support family planning as a means of improving the life chances of women worldwide. Women who can control their own fertility are more likely to stay in school, find a job in the formal sector, and pursue opportunities beyond childbearing.[50] This rationale also extends to adolescents who face special barriers in accessing contraception. Consistent with the mantra of client-centered services, donors also emphasize quality of care in family planning and sexual and reproductive health programming.

To influence population distribution and growth in ways favorable to economic development and the environment in the country. Although the demographic rationale for family planning had fallen out of favor by the ICPD in 1994, many countries still view decelerating population growth as a means of facilitating economic development. By reducing the large economic burden of healthcare and schools associated with a young population, governments can channel resources into productive investments.[51] Many African governments aspire to become "emerging nations," which gives them a new interest in the demographic dividend. The indirect benefits of family planning in terms of improved educational opportunities, access to alternative livelihoods, and more sustainable rural development contribute in the long term to climate change adaptation and mitigation.[52]

Why should we expect better results in the future than in the past?

Against the formidable challenges that face family planning in the DRC,[53] reasons abound to believe that progress is realistic.

Recently passed laws protect the rights of women to access contraception and safe abortion. The Public Health Law of 2018 reads that: "All persons of reproductive age – after benefiting from counseling – have the right to voluntarily use a reversible or irreversible contraceptive method" (article 81). Its passage repealed the antiquated Law of 1920 that prohibited contraception. The wording of the law skirted the sensitive question of giving adolescents access to contraception by citing "all persons of reproductive age."[54] The publication of the Maputo Protocol in the National Gazette in July 2018 legalized abortion in the DRC, in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother.

Reliable surveys show measurable improvement in contraceptive use and method mix. A series of PMA surveys were conducted in two provinces in the DRC: from 2013–2022 in Kinshasa and from 2015–2022 in the adjacent province of Kongo Central. Modern contraceptive prevalence among married women jumped from 18.9% to 29.2% in Kinshasa and from 21.0% to 28.6% in Kongo Central. Among unmarried sexually active women, the increase was even more dramatic: from 31.6% to 49.4% in Kinshasa and from 28.3% to 41.8% in Kongo Central. In both provinces, the method mix (distribution of users by contraceptive method) has moved away from a reliance on condoms to greater use of the far more reliable implant. Among all women of reproductive age in Kinshasa, emergency contraception ties with the implant for the greatest proportion of users.

The position of the DRC on the S-curve favors a take-off in contraceptive use. The history of family planning in LMICs conforms to a S-curve. When contraceptive use is extremely low, it is hard for a country to develop the momentum needed to trigger the uptake of contraception. Yet once a country reaches a prevalence of 15%, it is far more likely to experience an acceleration in contraceptive uptake, especially in the presence of strong family planning programming (see Figure 9.2). Given the current estimate of MCPR at 17.1% for the country as a whole in 2023, the DRC is poised to begin a more rapid increase in contraceptive use, if supply and demand creation initiatives support it.

The current demand for contraception outstrips the supply of methods available for distribution in the DRC. UNFPA, the major provider of contraceptives to organizations working in family planning (outside of USAID), cannot meet the demand for contraceptive procurement from its client organizations. Critics claim that "Congolese women aren't interested in contraception." Yet this constant struggle to obtain sufficient quantities of contraception argues to the contrary and bodes well for increasing use if commodities can be made available. The ever-increasing population of young women entering their reproductive years combined with a growing demand for contraception has left donors and implementing partners alike scrambling to cover this gap. With increased investment in contraceptive procurement, contraceptive prevalence will continue to rise.

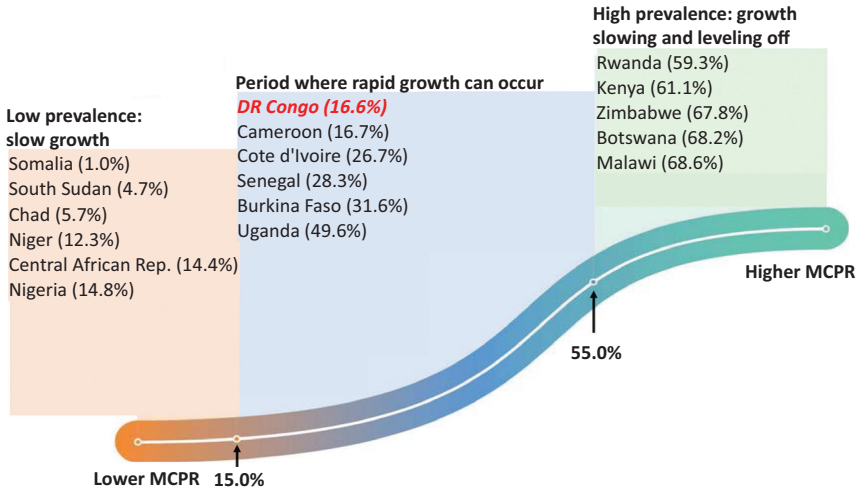


Figure 9.2 The DRC is favorably placed on the S-curve for accelerated adoption of contraceptive use

The machinery is in place to accelerate implementation. Thanks to the strong support for family planning in the DRC since 2012, the two government agencies responsible for family planning (PSNR) and sexual/reproductive health for adolescents and youth (PNSA) have developed a greater level of management proficiency and technical expertise. The number of international and local NGOs working in FP or SRH in the DRC doubled in a matter of years. The family planning community in the DRC now consists of organizations and individuals with expertise in the multiple domains required for successfully manage and implement FP programming: advocacy/policy, training, supervision, demand creation, contraceptive logistics and supply chain management, health information systems, applied research, and monitoring and evaluation. Future programming will build on the experience of this cadre of family planning experts and the lessons learned to date.

The continued trends toward urbanization favor a decrease in desired family size. At the time of independence, only 22% of the population lived in urban areas.[55] As of 2022, the percentage had more than doubled to 47%.[56] Global trends indicate that urbanization tends to decrease the desired and actual number of children. Whereas children are a valued asset in agrarian society, they represent an economic liability in the city, where parents need to pay for food, rent, and school fees. Also, it is easier and more cost-effective for family planning organizations to reach people with services in urban than in rural areas.

The explosion of cellphone technology and the increased reach of the internet favor contraceptive adoption. Although low by international standards, the DRC – like other countries in SSA – has experienced a revolution in communication technology. As of 2023, close to half (47.9%) of the population have

cellphone connections; 22.9% have access to the internet, and 4.9% use social media.[57] Improved connectivity greatly strengthens the systems needed to implement programs: training, supervision, data collection, and contraceptive logistics and supply chain management. M-Health apps provide health personnel with digital counseling guides, allow adolescents to access "embarrassing information" anonymously, and provide clients with appointment reminders. More importantly, these tools of technology expose the population to new ideas such as opportunities for women beyond motherhood, and new behaviors, such as contraceptive use.

How best to accelerate progress in family planning in the DRC

This history of 50 years of family planning in the DRC helps us not only to understand the road traveled to date but also to chart the potentially most effective path forward. In the case of the DRC, this blueprint is not based on elusive "what ifs" but rather on the lived experiences in the DRC in recent history. For nine brief months in 2017–18, the stars aligned such that the family planning machinery worked at peak efficiency. Although different countries have achieved success in family planning through very different approaches, six elements contributed to the momentum of the family planning movement in the DRC.

1 **Solid donor funding to results-oriented organizations.** In a country dependent on external donor funding, multiple donors coalesced to prioritize family planning: USAID, UNFPA, the World Bank, DFID/FCDO, Canada Global Affairs, Sweden, Netherlands, the Gates Foundation, the Packard Foundation, and CAFI/FONAREDD with support from Norway. Each had different interests and priorities (e.g., youth, quality of care, testing of innovative research strategies, and climate change mitigation and adaptation), but the collective effect of this solid base of funding accelerated the pace of family planning programming in the DRC. The number of iNGOs and local organizations more than doubled to utilize this funding, and donors chose organizations with a demonstrated track record for achieving results.
2 **A cohesive, mission-driven stakeholder group (CTMP).** *The Comité Technique Multisectoral Permanent* provided a mechanism for coordination in a situation where the National Program for Reproductive Health (PNSR) did not have the technical nor financial resources – nor the mandate – to operate a program at the national scale. The CTMP was open to all organizations working in the family planning space and allowed this group of stakeholders to speak with one voice. The establishment of provincial CTMPs in 20 of the 26 provinces provided a means of connecting those working in remote regions of the country. And for the first time ever, members of the family planning community took great pride in being part of a group recognized for its accomplishments, something previously reserved for better-funded programs such as HIV or immunization.
3 **Appointment of directors of the PNSR and PNSA based on a demonstrated track record in family planning.** Political appointees exist in

countries worldwide. Yet the potential for effective programming is greatly enhanced when the top positions in the relevant government agencies – in this case, the PNSR and the PNSA – go to persons experienced in managing family planning projects. Since turnover in these positions may occur every two or three years, it is important for each new director to understand family planning programming from day one, to hit the ground running. When Mr. Mbadu Muanda was appointed to direct PNSR in 2017, the stars aligned for nine short months; all six elements to success were in place in the DRC. However, a new Director can partially make up for a lack of experience with a strong mission-oriented approach, giving priority to advancing the field over other interests.

4 **Collegial, productive working relationships among these government agencies and international NGOs.** In a system where the government pays its employees less than iNGOs do and where it receives far less direct donor funding (for historical reasons of financial accountability, outlined above), there may be inevitable tensions around issues of money, authority, and perceived standing. Yet the period from 2012–18 demonstrated the results that are possible from a sense of shared mission, further enhanced by membership in the CTMP and reinforced by the supportive actions of the PNSR directors. When colleagues would end meetings with the phrase "*on est ensemble*" (we are together), it reflected a genuine sense of shared purpose and mission.

5 **Talented, motivated Congolese staff who have become top-notch managers, often through on-the-job training.** When Dr. Sylvain Yuma, secretary general for the ministry of health, stood to address an audience of 100 staff from different organizations convened in 2021 to work on the second strategic plan for family planning, he began his remarks with the observation: "I stand before a room of experts in family planning." This statement spoke volumes for the work accomplished in the decade of the 2010s in building a cadre of Congolese who had developed a wide-ranging skillset in the management of family planning programming. In 2010, the key players in family planning in the DRC could sit around a single conference table. A decade later, the "army of experts" filled a conference hall.

6 **Strong advocacy group to sustain government commitment to family planning.** Because family planning often takes a backseat to other areas of public health, it is essential to maintain a core group of advocates who can continuously push for legislative and political victories for family planning. Advocacy "wins" in the past decade include the passage of the Public Health Law of 2018 (repealing the obsolete Law of 1920 and ushering in legal abortion) and the release of government funds for contraceptive procurement ($2.1M in 2021). The systematic approach to advocacy, promoted by the Advance Family Planning and Options projects, contributed to securing these wins in a challenging climate.

There is no single control center for aligning the elements in this roadmap for success. The donors will make their individual decisions on levels of funding, or

whether to even continue funding family planning in the DRC. The minister of health will decide what criteria to use in selecting the leadership at the PNSR and PNSA. The CTMP plays an invaluable role as the glue that holds together the many diverse organizations within this growing community, yet its success depends heavily on those at the helm of this coordinating body. Without sufficient contraceptive commodities, even these six elements cannot ensure strong results.

One may not be able to replicate this winning formula. Yet there is value in recognizing the elements that contributed to accelerating the pace of family planning in the recent past and working toward achieving this mix in the future.

Notes

1 Yates, Barbara A. "Colonialism, Education, and Work: Sex Differentiation in Colonial Zaïre." In *Women And Work In Africa*. Boulder, CO: Routledge, 1982, p 127
2 Lauro, Amandine. "Women in the Democratic Republic of Congo." In Oxford: *Oxford Research Encyclopedia of African History*, 2020. https://doi.org/10.1093/acrefore/9780190277734.013.544, p 13
3 Lauro, 2020, p 16
4 Lauro, 2020, p 16
5 World Bank. "Proportion of seats held by women in national parliaments (%) – Congo, Dem. Rep." World Bank Group, 2023. https://data.worldbank.org/indicator/SG.GEN.PARL.ZS?locations=CD
6 Inter-Parliamentary Union and United Nations Entity for Gender Equality and the Empowerment of Women (UN Women). 2023. "Women in Politics: 2023." UN Women, 2023. https://www.unwomen.org/en/digital-library/publications/2023/03/women-in-politics-map-2023
7 United Nations Development Programme (UNDP). "Breaking Down Gender Biases: Shifting social norms towards gender equality". New York: UNDP, 2023, p 33
8 Lauro, 2020, p 16
9 Zaïre. "Act No. 87–010 Setting Forth the Family Code, 1 August 1987." *Annual Review of Population Law* 15 (1988): 69, p 439–60
10 United Kingdom Home Office. "Country Policy and Information Note Democratic Republic of Congo (DRC): Gender Based Violence, Version 2.0." 2018, p 7
11 US Department of State (USDOS). "2021 Country Report on Human Rights Practices: Democratic Republic of the Congo". USDOS, 2022, p 47
12 Agapitova, Natalia, Julia Braunmiller and Marie Dry. "Reforms to enhance gender equality in the Democratic Republic of Congo: From advocacy to implementation." World Bank Blog, 2022.
13 United Kingdom Home Office, 2018, p 8
14 Toure, Lalla Badji. "Male involvement in family planning: a review of selected program initiatives in Africa." SARA, 1996, p 2–4
15 Ahmed, Saifuddin, Andreea A. Creanga, Duff G. Gillespie, and Amy O. Tsui. "Economic Status, Education and Empowerment: Implications for Maternal Health Service Utilization in Developing Countries." *PLOS ONE* 5, no. 6 (June 23, 2010): e11190. https://doi.org/10.1371/journal.pone.0011190, p 3; Prata, Ndola. "Making Family Planning Accessible in Resource-Poor Settings." *Philosophical Transactions of the Royal Society B: Biological Sciences* 364, no. 1532 (October 27, 2009): 3093–99. https://doi.org/10.1098/rstb.2009.0172, p 3093
16 World Bank. "The World Bank in DRC: Overview". The World Bank, 2023. https://www.worldbank.org/en/country/drc/overview

17 Muanda, Mbadu, Parfait Gahungu Ndongo, Leah D. Taub, and Jane T. Bertrand. "Barriers to Modern Contraceptive Use in Kinshasa, DRC." *PLOS ONE* 11, no. 12 (December 1, 2016): e0167560. https://doi.org/10.1371/journal.pone.0167560, p 4
18 Châtelot, Christophe. "Democracy in the DRC Owes a Lot to the Church." *Le Monde.Fr*, January 31, 2023. https://www.lemonde.fr/en/international/article/2023/01/31/democracy-in-the-drc-owes-a-lot-to-the-church_6013850_4.html
19 Luneghe, Merveille Kavira. "Faith and Family Planning At Odds for Catholic Families in DRC." *Global Press Journal*, May 20, 2019. https://globalpressjournal.com/africa/democratic-republic-of-congo/faith-family-planning-odds-catholic-families-drc-reprohealth/
20 University of Kinshasa School of Public Health, the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health, and Jhpiego. "Performance Monitoring for Action (PMA) Democratic Republic of Congo (Kinshasa & Kongo Central) Phase 3: Household and Female Survey". DRC and Baltimore, MD, 2022. https://doi.org/10.34976/dgpr-sz30
21 Stewart, Gary. *Rumba on the River: A History of the Popular Music of the Two Congos.* London and New York: Verso, 2003, p 25
22 Châtelot, 2023
23 Van Reybrouck, David van. *Congo: The Epic History of a People*. London: Fourth Estate, 2014, p 409
24 Bueno de Mesquita, Bruce, Alastair Smith, Randolph Siverson, and James Morrow. *The Logic of Political Survival*. The MIT Press, 2003. https://doi.org/10.7551/mitpress/4292.001.0001, p 167
25 World Bank. "Worldwide Governance Indicators". The World Bank Group, 2023. https://www.govindicators.org/interactive-data-access
26 Nguh, Augustina. "Corruption and Infrastructure Megaprojects in the DR Congo: A Recipe for Failure?" International Rivers, December 2013. https://archive.internationalrivers.org/sites/default/files/attached-files/corruption_in_the_drc_.pdf, p 3
27 *BBC News*. "Historic Day as Tshisekedi Is Sworn in as DR Congo President," January 24, 2019, sec. Africa. https://www.bbc.com/news/world-africa-46987439
28 BBC News Online. "Vital Kamerhe: DRC President's Chief of Staff Found Guilty of Corruption," June 20, 2020, sec. Africa. https://www.bbc.com/news/world-africa-53121994
29 Bujakera, Stanis. "Former DR Congo Health Minister Convicted of Embezzling Ebola Funds." *Reuters*, March 23, 2020, sec. Healthcare. https://www.reuters.com/article/health-ebola-congo-corruption-idUSL8N2BG8GO
30 Transparency International. "Corruption Perception Index 2022 Report." 2023, p 10
31 Kisangani, Emizet François. *The Belgian Congo as a Developmental State: Revisiting Colonialism*. New York: Routledge, 2022, p 98
32 United Nations. "What is good governance?" *UN Economic and Social Commission for Asia and the Pacific*. United Nations, 2014, http://www.unescap.org/resources/what-good-governance, p 1
33 Global Witness. "Regime Cash Machine: How the Democratic Republic of Congo's Booming Mining Exports Are Failing to Benefit Its People, July 2017 – Democratic Republic of the Congo | ReliefWeb." August 30, 2017. https://reliefweb.int/report/democratic-republic-congo/regime-cash-machine-how-democratic-republic-congo-s-booming – mining, p 6
34 World Health Organization. "Global Health Expenditure Database." World Health Organization, 2023. https://apps.who.int/nha/database
35 Van Reybrouck, 2014, p 509–10
36 Hunt, Nancy Rose. 1988. "Le bébé en brousse: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo." *The International Journal of African Historical Studies* 21 (3): 401–32. https://doi.org/10.2307/219448, p 406
37 Waife, Ronald S. "Traditional Methods of Birth Control in Zaïre." 4. Chestnut Hill, MA: Pathpapers. The Pathfinder Fund, 1978, p 2

38 Guirkinger, Catherine, and Paola Villar. "Pro-Birth Policies, Missions and Fertility: Historical Evidence from Congo." Development Finance and Public Policies, 2022, p 16
39 Guirkinger and Villar, 2022, p 23
40 Waife, 1978, p 2
41 United Nations, Department of Economic and Social Affairs, Population Division. "World Population Prospects: The 2022 Revision, Data Portal." UNDESA, 2022. https://population.un.org/dataportal/home
42 Smith, Benjamin, and David Waldner. *Rethinking the Resource Curse*. Cambridge: Cambridge University Press, 2021
43 World Bank. "General government final consumption expenditure (% of GDP)." World Bank Group, 2023. https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=CD
44 World Bank. "Current health expenditure (% of GDP) - Congo, Dem. Rep." World Bank Group, 2023. https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=CD; UNICEF. "Country Office Annual Report 2020: Democratic Republic of the Congo." UNICEF, 2020, p 1
45 DaVanzo, Julie, and David M. Adamson. "Family Planning in Developing Countries: An Unfinished Success Story." Namur: RAND Corporation, August 17, 1998. https://www.rand.org/pubs/issue_papers/IP176.html, p 4
46 Stenberg, Karin, Henrik Axelson, Peter Sheehan, Ian Anderson, A. Metin Gülmezoglu, Marleen Temmerman, Elizabeth Mason, *et al.* "Advancing Social and Economic Development by Investing in Women's and Children's Health: A New Global Investment Framework." *Lancet* (London, England) 383, no. 9925 (April 12, 2014): 1333–54. https://doi.org/10.1016/S0140-6736(13)62231-X, p 10, 14
47 Bertrand, Jane T., Victoria M. Ward, and Santiso Galvez Santiso G. "Family planning in Latin America and the Caribbean: the achievements of 50 years." Chapel Hill, NC: MEASURE Evaluation, Carolina Population Center, 2015, p 44
48 Harkavy, Oscar, and Krishna Roy. "Emergence of the Indian National Family Planning Program." In *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*, edited by Warren C. Robinson and John A. Ross, 301–23. Washington, D.C.: World Bank Publications, 2007, p 309
49 Ebenstein, Avraham. "The 'Missing Girls' of China and the Unintended Consequences of the One Child Policy." *Journal of Human Resources* 45, no. 1 (January 1, 2010): 87–115. https://doi.org/10.3368/jhr.45.1.87, p 89
50 Starrs, Ann M., Alex C. Ezeh, Gary Barker, Alaka Basu, Jane T. Bertrand, Robert Blum, Awa M. Coll-Seck, *et al.* "Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission." *The Lancet* 391, no. 10140 (June 30, 2018): 2642–92. https://doi.org/10.1016/S0140-6736(18)30293-9, p 2649
51 Bloom, David, David Canning, and Jaypee Sevilla. *The Demographic Dividend: A New Perspective on the Economic Consequences of Population Change*. Santa Monica, CA: Rand Corporation, 2003, p 20–21
52 Starrs *et al.*, 2018, p 2649; Meyer, William B., and B. L. Turner. "Human Population Growth and Global Land-Use/Cover Change." *Annual Review of Ecology and Systematics* 23, no. 1 (1992): 39–61. https://doi.org/10.1146/annurev.es.23.110192.000351, p 52–55
53 Kwete, Dieudonné, Arsene Binanga, Thibaut Mukaba, Théophile Nemuandjare, Muanda Fidele Mbadu, Marie-Thérèse Kyungu, Perri Sutton, and Jane T Bertrand. "Family Planning in the Democratic Republic of the Congo: Encouraging Momentum, Formidable Challenges." *Global Health: Science and Practice* 6, no. 1 (March 21, 2018): 40–54. https://doi.org/10.9745/GHSP-D-17-00346
54 Binanga A, Matawa G, Musindo P, Racher J, Bertrand JT. Advocacy as a Tool for Advancing Family Planning in the Democratic Republic of the Congo. Unpublished manuscript, 2023

55 World Bank. "Urban population (% of total population)." World Bank Group, 2023. https://data.worldbank.org/indicator/SG.GEN.PARL.ZS?locations=CD
56 Kemp, Simon. "Digital 2023: The Democratic Republic of the Congo." DataReportal – Global Digital Insights, February 13, 2023. https://datareportal.com/reports/digital-2023-democratic-republic-of-the-congo
57 Kemp, 2023

Index