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Bryant C. Freeman, Ph.D.
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Family Planning Initiatives and Kalfounò Peasants: What's Going Wrong?

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FAMILY PLANNING INITIATIVES AND KALFOUNÒ PEASANTS: WHAT'S GOING WRONG?

This is the thirteenth in a series of texts concerning Haiti to be made available through the University of Kansas Institute of Haitian Studies. Its author, Jennie Marcelle Smith, is soon to defend her Ph.D. dissertation, entitled "Answering the Lambi: Social Critique and Collective Action in Rural Haiti," at the University of North Carolina at Chapel Hill, and this Fall will join the faculty of Berry College as Assistant Professor of Anthropology. Few can equal her first-hand knowledge of Haiti, its people, their ways and their language. A Phi Beta Kappa graduate of Furman University, she lived for three years in a small hut working in one of the most remote areas of North-East Haiti, in a fashion no different from that of her peasant neighbors. In late 1991 and early 1992, after the violent overthrow of Haiti's first truly democratically-elected government, thanks to her fluent Haitian Creole she was one of only two non-Haitian Americans chosen to help interview refugees at the U.S. Naval Base at Guantánamo Bay, Cuba. In 1993 she was named a human rights observer for the UN/OAS Mission in Haiti (MICIVIH) for the Jérémie area. Early in 1995 she returned to Haiti with an Inter-American Foundation Dissertation Research Fellowship and soon thereafter received a 1995-96 Fulbright Scholarship to Haiti, again living in a peasant hut, in the Grand'Anse. She has lectured widely in the United States on things Haitian. The feature which distinguishes Jennie Smith from so many other Haitianists is her deep-seated ability to perceive reality not just through the mind of an educated Westerner, but as well through that of the Haitian peasants among whom she has so long dwelled.

A heartless, but true, statement by a noted US geographer declares: "All of Haiti's potentials appear submarginal, save the child-bearing capacity of its women." Haiti's poverty is often

explained as caused by too little arable land for too many people, with the problem becoming ever more acute thanks to the intervention of modern hygiene and medicine, however limited in much or most of the Haitian context. Haiti is described as an agricultural nation that cannot even feed itself. Thus having too many people is often seen as at the core of its problems of deforestation, soil erosion, poverty and attempted emigration. Yet its 1997 population density of 618 persons per square mile is surpassed by that of Japan (861), Belgium (866), the Netherlands (976), and South Korea (1,197) - and is vastly lower than that of Singapore (13,847) and Hong Kong (15,422) which has a per capita GDP among the highest in the world. Thus population density is not necessarily a factor inhibiting economic growth and prosperity. But Haiti is in dire need of a sense of nationhood where both the elite minority and the peasant majority work together (Rolph Trouillot) to develop the human capital necessary to take full advantage of the country's three main economic assets: a hard-working labor force, proximity to the world's largest consumer market, and climate. However, before prosperity ("the world's most effective birth-control device") can be attained, the birth rate - although because of high infant mortality unspectacular compared with that of many Two-Thirds World countries - remains a major problem. And here Jennie Smith presents a first-hand account of the factors involved, and offers a wise solution.

Bryant C. Freeman

("Tonton Liben")

FAMILY PLANNING INITIATIVES AND KALFOUNÒ PEASANTS: WHAT'S GOING WRONG?*

Jennie Marcelle Smith

Introduction

Walking up the steep path toward Lizèt's home, I heard the voices of Niniz, Bouganou, and Wozmini, three of her seven children, laughing, arguing and singing as they played in the yard around their house. Tigrenn, the newest baby, and sixth girl, had just been born a couple of weeks before. So, approaching their yard, I was surprised to see Lizèt under the lean-to behind the house, squatted down at the fire. As a *ti nouris* (a woman who has recently given birth), she should have been lying in bed with her new baby in a dark corner of the house.

As I called out greetings and talked with the children, Lizèt emerged from her kitchen with tears streaming down her face. "Oh, Sè Jeni," she exclaimed, "I just can't stand this anymore . . . I'm *ti nouris* and should be in bed; I feel so weak . . . But Janklod [her husband] is sick again, and can't take care of me or the children. He can't even fix the holes in the thatch. They're getting bigger and bigger, and it's raining every night . . . The kids are all hungry. The harvests aren't in yet, and I'm not fit to go work in the field . . . Ti Dyelin is sick with the fever and a cough . . . They're all crying all day long, and I can't even muster up enough milk to satisfy Annèt . . . Edwann and Niniz [the two oldest children, around 13 and 11] are helping some, but they can't do it all . . . I just can't bear it any longer! And what if Janklod dies! What will I do with all these children?!"

Lizèt and Janklod told me many times that they would be happy if God would not give them any more children. Their fields were barely large enough to feed two people, and simply could not meet the needs of seven. They could not afford to build a new home to replace their tiny

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*This paper was written in December 1991. Minor revisions were done in February 1998. Many thanks to Tonton Liben for his suggestions and encouragement. The names of all the individuals discussed here have been changed, as has the name of the zone and village I call "Kalfounò." Only the names of major cities and of nationally or internationally known organizations have been left unaltered.

run-down one. Amidst all these circumstances, Janklod's short-lived but frequent illnesses became catastrophes. This latest one had left Lizèt more overwhelmed than ever. Yet their family would surely increase. Though Lizèt was, as she and her neighbors said, "getting old and worn before her time" with unceasing childbearing, she was probably in her early thirties—more than young enough to have several more children.

Lizèt and Janklod found themselves in the situation of many rural Haitians. Their families are growing even as their capacity to care for them declines. Malnutrition among children who must share increasingly scarce resources is rampant. Even caring well for a small number of children has become an impossible task for many parents, as their plots of land shrink and become less productive, while prices in the marketplace climb. Despite recent political changes, neither national nor local economic indicators offer promise of more plentiful days to come.

Why then, the North-Western observer asks, do they not practice "family planning"? In fact, there are several opportunities and resources for birth control within their reach. Why do they not utilize them? In this paper, I would like to explore that very question: Why is it that family planning is so rarely practiced in rural Haiti, particularly in this northeastern area of Kalfounò? My analysis is largely speculative, and draws primarily from experiences and conversations I had during three years of living and working in Kalfounò (1988-1991). During that time, I directed a preventative health education program designed for small community-based organizations called *gwoupman peyizan*, or "peasant groups." I will also draw from and evaluate some of the literature on this topic. This is hardly the first time I have confronted the question. Indeed, I have posed it many times and in many ways, to myself, to "development experts," to Haitian co-workers, and to neighbors. Each time I have walked away less sure of the possibility of finding an exhaustive response. Still, I am convinced that there are valuable insights to be gained from asking again.

Family Planning Initiatives in Haiti

I begin here with a brief presentation of relevant national statistics, then a summary of family planning initiatives carried out in Haiti. I will then briefly describe the Kalfounò rural

section and opportunities for birth control that existed during my time there. Finally, I will suggest some reasons why family planning has been so rarely practiced there by looking at some of the conflicting assumptions, beliefs, concerns, resources, and relationships involved in this issue.

Statistics on Haiti consistently place it well below all other countries in the western hemisphere in terms of economic well-being. Although statistics on Haiti are difficult both to acquire and substantiate—and thus should be taken with more than a small grain of salt—glancing at a few may help us gain an understanding of the fabric into which the people of Kalfounò are woven and are weaving. Most, around 75%, of Haiti's citizens are peasant farmers. The majority of these folks cultivate land considered "non-arable" by standard agricultural models, and have an annual income of less than $100 (US), living well below the World Bank's absolute poverty line. There are seven to eight million people crowded onto the nation's 27,749 square kilometers, filling every square mile with some 618 people. Recent estimates of the crude birth rate range from 34/1000 to 42/1000. The population grows at an estimated rate of 1.4 to 2.26% each year, and is expected to double within 33 years. The crude death rate is around 19 per 1000. Infant mortality is said to range between 94 and 110 per thousand live births. Life expectancy figures range from 43 to 54 years. Illiteracy may be at least as high as 85%. There is barely one physician for every 10,000 people, though substantially fewer than that in most rural areas, since most are concentrated in Port-au-Prince, provincial capitals and other large towns.[1] In addition to increasing population pressure, economic decline, and continual impoverishment of the land with rampant deforestation and over-cultivation, political instability—accompanied by frequent suspensions of foreign aid and bouts of insecurity—continues to threaten the already desperate standard of living for most of Haiti's citizens.[2]

Public health education, and in particular the promotion of family planning, in this country is not a simple task. Nationwide primary health programs launched by the national Ministry of Public Health and Population (MSPP) during the past few decades have repeatedly featured family planning as a major priority. MSPP began such a "health campaign" in 1978[3] and then again in 1983.[4] As explained to me by the Minister of Public Health in 1988, the priorities of that initiative

were: 1) diarrhea prevention, 2) tuberculosis prevention, 3) vaccinations, 4) AIDS, and 5) the health of women and children under 5 years of age. The last point involves family planning education and provides for consultations and the administration of contraceptives free of charge to all Haitians consulting in public clinics and hospitals. One of the goals of this and subsequent initiatives has been to reduce the birth rate to 20 per 1,000 by the year 2000.

The MSPP's family planning programs have generally been co-sponsored (and often co-directed) by organizations such as the United States Agency for International Development (USAID), the Pan American Health Organization (PAHO), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the Rotary Club International. They have involved spending many thousands of dollars setting up administrative structures throughout the countryside, developing educational devices, dispensing contraceptives, and providing birth control options.[5] But their objectives, however impressive on paper, have met many barriers, not the least of which have been frequent changes in directors, administrators and local staff. The MSPP Minister with whom I spoke in 1988 had just taken office after a recent coup d'état, but was replaced only a few months later in a subsequent coup. MSPP has seen several ministers come and go since, sometimes leaving with several staff members, sometimes with most of them (not to mention unused supplies and unspent funds). Besides political and economic insecurity, other particularly formidable barriers faced by these programs include corruption within the various administrative levels of MSPP, and the very poor (to nonexistent) state transportation and telecommunication systems in Haiti. As I will demonstrate in the following pages, also contributing to the lack of success stories (Haiti's population continues to grow at an ever-more-rapid pace) are gaps in culture, status and vested interests between employees of MSPP and beneficiaries of the local clinics.[6] I now turn to Kalfounò in order to illustrate "what's going wrong" at the local level.

Family Planning in Kalfounò

Kalfounò is a rural section (or "zone") in the northeastern mountains of Haiti, with a population of around 10,000-12,000 and an area of 132 km2. It is a very isolated zone, its central village (also called Kalfounò) being accessible only by the most rugged of four-wheel vehicles (and then only during dry seasons). Residents are peasants who farm the land and practice "small commerce" (buying and selling in markets around the area). The Haitian proverb, *dèyè mòn gen mòn* ("beyond the mountains are more mountains"), is used often there to illustrate both the rugged geography of the landscape and the never-ending challenges of day-to-day life. Although the zone still has a few patches of secondary-growth pine forest, it is largely deforested, and the topsoil continues to erode rapidly—making harvests progressively smaller every year, and pushing more and more families into the situation of Lizèt and Janklod.

There were two "dispensaries," or health clinics, in the Kalfounò zone during my time there. One was funded by a Catholic development organization and supervised by the parish's European priest. The other was run by MSPP. There were many traditional health care providers in the area—*oungan* and *bòkò* (Vodou priests), *manbo* (Vodou priestesses), *doktè fèy* ("leaf doctors"), *fanm saj* (midwives) and others. While these practitioners have assisted individual women in preventing pregnancy or inducing miscarriages, to my knowledge, they have not promoted family planning as such. Nor have they been integrated in a systematic way into programs sponsored by MSPP and private agencies (see endnote #1).

In 1989, the development organization with which I was working, the Mennonite Central Committee (MCC), integrated into our Kalfounò health education program a lesson on *Planin Familyal* ("Family Planning"), and taught it to dozens of peasant groups throughout the zone. MCC also offered occasional seminars and written materials on the topic. Other sources of education and information about family planning accessible to residents of the zone included sound bytes broadcast on national and regional radio commercials (many neighborhoods in the zone had a radio or two that was shared between several households), and small booklets published by NGOs in other areas which occasionally made their way up to the region.

Since neither traditional health care professionals, MCC, nor the Catholic dispensary offered planning consultations, or prescribed or administered birth control methods—the community's primary center for family planning resources was the MSPP dispensary. This clinic was usually stocked with at least one kind of birth control pill, condoms, and perhaps some foam—all of which were supposed to be administered at no cost to anyone in the community who requested them. The health agent there had undergone training in family planning, and offered preliminary consultations for the pill, along with follow-up advice and evaluations. There were other clinics, some of which had more resources, in a few towns within walking distance of Kalfounò (that is, between a three- and eight-hour walk away). The nearest hospital (an eight-hour trek from Kalfounò by foot) was well supported by MSPP and USAID funds, and offered a variety of birth control options. At least most of the time, they provided (for the most part, free of charge) pills, condoms, IUD's, foams, diaphragms, Depo-Provera, Norplant, tubal ligations and vasectomies. MCC offered free transportation to and/or from the hospital for women and men interested in receiving any of the methods listed above.

There were, then, family planning options available to the people of the Kalfounò zone. So why did Lizèt, Janklod and their fellow community members rarely utilize them? The most recent health auxiliary at the MSPP clinic reported that he rarely administered pills. Most of the condoms he gave out, he suspected, were sold in the market as balloons for children. In a community survey conducted by MCC in 1984-85, out of 110 couples questioned about whether they had ever "followed family planning," only seven said yes (the surveyors suspected that most of those participants were likely referring to practicing temporary abstinence).

The Kalfounò community is not odd in Haiti for its lack of participation in family planning programs. A study completed by PAHO reports that Haiti has the lowest rate of contraceptive use in all of Latin America and the Caribbean (7% compared, for example, to 51% in Jamaica and 35% in Honduras), and is the only one of those countries in which the annual percentage of use is decreasing (by 1.4%).[7] Thus, in probing the question of why people in Kalfounò rarely *swiv*

planin ("follow planning"), it is important both to look carefully at particular factors present in that community itself, but also place it within the context of the larger Haitian community.

"Children are Our Riches"

A proverb commonly heard around Kalfounò says that *timoun se richès pòv malere* ("Children are the riches of poor folks"). Children are valuable to Haitian peasants in many ways. One of the reasons children are "always welcomed" into a family is that they provide a very essential labor component. The tasks to be done are many and never-ending, and without several children it seems virtually impossible for a family to function well. When speaking of a couple without children, or with only one or two, neighbors often lament their predicament. The adults must gather the firewood, graze the animals, sweep the yard and house, fetch the water, wash the clothes, tend to the gardens and the harvests . . . all on their own. Many resort to "borrowing" a child or two from relatives to live with them and do some of those chores. "When you don't have children," the saying goes, "you are a dog."[8] During the three years I spent in the Kalfounò area, I received numerous offers from parents to "lend" a child or more to me and my housemate (also a single, female American). It made little sense to anyone there that we chose not to take them up on it. Our yard and house were rarely free of children when we were around, however, and they were happy to offer us both companionship and small tasks. Children are valuable neighbors as well.

Besides performing many other important tasks, a Haitian girl as young as five years may be the primary caregiver for the youngest sibling(s). Boys of the same age commonly tend to small livestock (generally goats or pigs) on their own. Even younger children are often responsible for carrying out tasks such as caring for chickens, harvesting root crops, and fetching water and firewood. As the children get older, their labor increases exponentially in value, and may become a very important economic resource. Older children and teenagers may greatly increase the yields of their families' fields. A girl who has learned well the art of marketing will often take over for her mother in that task (women do the vast majority of commerce in rural Haiti), or branch out into

buying and selling other kinds of goods. And, of course, in one's old age, it is one's children upon whom one depends. The pragmatic benefits of children, then, are rarely taken for granted by parents. Family strength and security were of paramount importance for my Kalfounò neighbors.[9]

But having several children is valued for many other reasons besides economic and labor-saving ones. What seems to me one of the most obvious ways that children are important to rural Haitians is strikingly absent from the studies I have found on the subject: they make life more joyful and fulfilling. People in Kalfounò often noted that, "A yard without children is a yard without joy." Babies and toddlers are particularly cherished for their creative abilities to amaze and entertain. Neighborhoods are filled daily with the singing of songs and squeals of games and quarrels. A home or neighborhood that lacks these sounds and activities is said to be a "sad" one.

Another way in which children are important is in establishing the status of the women and men who are their parents. The reputation of women seems to be especially contingent on fertility. *Tout fanm se fanm men tout fanm pa menm* ("All women are women, but all women aren't the same") is a proverb laden with many meanings and implications. As George Simpson points out, in rural Haiti a woman believed to be sterile may be referred to as a "mule," or similarly degrading terms.[10] While I am not sure such labels are as prevalent as Simpson implies, it is clear that childless women often get less respect than women who have produced offspring. They are likely to be suspected as being cursed, or involved in some sort of sorcery themselves. Gerald Murray speculates in his analysis of *pèdisyon* (a disease in which a woman incapable of having children is said to have conceived a child, but that the child's development in her body has been arrested for an indefinite period of time) that it is in part a social response to the negative stigma of female subfecundity and infertility.[11]

Although infertility problems are generally assumed to be located in women's bodies, men who cannot seem to produce descendants may also find their reputations scarred, and may be taunted about "lacking force." Men with many children, on the other hand, are often admired for being the head, or "chief," of a large family—particularly if they provide well for their offspring and mate(s). A very important aspect of the reputation of the most prominent *bòkò* (Vodou priest)

in Kalfounò was his legacy of having multitudes of children scattered throughout the zone—so many that one of his youngest sons once told me, "Many days everyone I meet in the path on my way out to the fields is either my half-brother, or a sister, or cousin, or uncle, or stepmother!"

Having children is not only important to the status of individual women and men, but also plays a significant role in legitimizing unions. There are many different types of acceptable unions in Haiti, though prescriptions do vary somewhat with different religious affiliations (Protestant stipulations being more strict than those professed by Catholics and Vodounists). Besides legally marrying, it is also generally acceptable: 1) for a woman and a man to live together in a common-law marriage (*plasaj*); 2) for a man may take one wife (common-law or legal) and have several other women (*manmzèl*) on the side (again, provided that he cares for them and the children they birth for him); and 3) for an individual to enter and leave different *plasaj* arrangements consecutively. While men have much more flexibility and freedom (women, for instance, are generally expected to have only one lover at a time), it is common for both men and women to have more than one—and often several—partners during their lifetimes.[12] Perhaps the most important prerequisite for gaining public legitimization for any sort of each of these unions is the birth of one or more children. In fact, one of the advantages of *plasaj*, I was told, is that if the couple is not able to have children, the union can easily be annulled in favor of a more promising one. In the words of one man, recorded by Simpson, "It is better not to buy a cat in the bag; if the woman is no good, you can send her back to her father."[13] On the other hand, if a *manmzèl* or wife bears children, the father is held responsible for providing extra support for that woman. Generally, he will be expected to build her a house and help substantially in providing food, clothing and education for the children. Women are well aware that the more children they have for men, the more men are bound by obligation to "care for" them in these ways.

Most of my friends and co-workers in Kalfounò had lost at least one, and often several, children (usually infants). PAHO estimates that "between 100 and 120 in every 1,000 live-born children in Haiti die before reaching their first birthday, and approximately 200 per 1,000 die before age 5.[14] Everyone in the Kalfounò area was keenly aware of the ever-present threat of

having children die, and not just the smallest ones. A pastor told me once upon the sudden death of his daughter-in-law (who had been in her mid-twenties and seemingly healthy), "It is maddening how vulnerable we all are. In your white country, you have all sorts of doctors and hospitals to take care of you. Here, a simple fever can kill one of our children—*pap!*—in no time." The ever-present fear of losing children to death made it all the more sensible for Kalfounò residents to have several.[15]

"We will not play God"

So there are many incentives for people in Kalfounò to have several children. Perhaps the most powerful reason Lizèt and Janklod continued to have babies, however, was one rooted in a common belief: that it is God, not humans, who have control over childbirth. There are some things that people may determine about their own lives—such as their choice of spouses, and what they plant in their fields. They may invite the *lwa* (Vodou divinities) to assist them in these decisions, and to help them in other ways—with healing sicknesses, averting curses, gaining wealth and so forth. But there are other realms which only God (*Bondye*) controls. As Gerald Murray notes, "Lwa can harm crops; but only God can make them grow. The lwa cannot bring rain; they can only push the already existing rain clouds toward or away from the fields of their devotees."[16] And although the *lwa* may act (for good or ill) on a child already conceived—even if it is still in the womb—only God can create children. Thus, "planning a family" is for most folks a contradiction in terms, a conceptual impossibility. Or, if not, it is a possibility that threatens to trespass into God's territory. This is a step not to be taken lightly. Elifèt, one of my closest neighbors, once commented when his wife had said she would like to consider undergoing a tubal ligation. But, he said, "That's God's business; we best keep out of God's business, or you don't know what might happen." Lizèt had told me when I first met her family that having so many children made it awfully hard on her and Janklod, but added that "the Good Lord has given us all of these, and we tell him thanks, and if he decides to give us more, we'll accept them and thank

him again and again." "We don't know why," Janklod explained, "he gives us so many when we can't seem to take care of them well . . . , but we'll just have to keep thanking him."

Foreign Perspectives on Local Concerns: a Call for Re-evaluation

Many researchers who have written about family planning in Haiti have noted this difference in Haitian and North-Western perspectives toward the determination of family size. Stycos records a particularly telling statement from one of the women he interviewed: "If God gives me two I would be happy. If He gave me 100 children I would be happy too, because that is not for me to decide."[17] But statements such as this, when quoted in isolation, can mislead readers into perceiving Haitian peasants as simple-minded, unreflective, or fatalistic. Never in any of the literature I could find on this subject is the Haitian viewpoint described simply as a <u>different</u> viewpoint, but always as one <u>lacking</u> a "concept of family limitation."[18] My neighbors, on the other hand, might accuse these scholars of being quite lacking in sensibility. I would suggest, in fact, that one of the primary reasons family planning programs have been so unsuccessful in Haiti—particularly in more isolated zones like Kalfounò—is because they are simply proposing the preposterous! Rather than respecting and trying to understand this deep-level resistance and the reasons behind it, program planners instead tend to see it as yet another sign of the "underdevelopment" of "traditional" ideas and practices. They have therefore systematically failed to address the most profound concerns of their clients. The prospect of such concerns being allowed to transform in real ways the programs they administer (that is, beyond designing "education" programs aimed at debunking their clients' perspectives) is beyond consideration.

Researchers have also repeatedly glossed over the issue. For instance, even though Allman, a "resident advisor" for DHF (Department of Family Hygiene) in Port-au-Prince, offers a detailed study of the acceptance of family planning programs in Haiti, he leaves this factor (one that would surely blur the clarity and optimism of his statistics and tables) completely out of his analysis.[19] Until both researchers and program planners begin to respect Haitian peasants' reasons for resisting family planning, there will be neither adequate research nor successful programs.

Speculations on Potential Interest in Family Planning

On the other hand, as Allman points out, there was virtually nothing done to promote awareness of or interest in family planning in Haiti before the creation of DHF in 1973.[20] It is probably true, then, that most rural Haitians have not thought about the issue for a very long time. Thus, its lack of success does not necessarily imply that they are resolutely opposed to it. The adoption of new habits and ideas always takes time. Numerous people in Kalfounò, in fact, upon studying and considering it as a live option, expressed interest in doing something to limit the number of children they would have. Women tended to be especially enthusiastic. They were worn out, they said, with relentless childbirth. Plus, if they were not forever breast-feeding and caring for infants and toddlers, they could be free to do more marketing. And with fewer children, they might more easily manage to keep them fed and in school.

Many studies have shown that when willing to express a preference, Haitian women—like communities of "Third-World" women all over the world—tend to say they would prefer a smaller number of children than what is common where they live (though not as few as most planning advocates would like). Allman reports that his respondents would have preferred around three to four;[21] Stycos reports a medium of 2.4 in the responses he elicited;[22] and Ballweg et al, say that most of the women they interviewed would have liked three or less.[23] I find these reports to be very consistent with the preferences of many of the Kalfounò women with whom I spoke. Of course, it is probable that these researchers were seen by those interviewed as advocates of family planning; and I was very likely understood to be "pro-planning" by most Kalfounò residents. I must therefore consider these findings with some skepticism. Still, there did seem to be some genuine interest on the part of a significant number of people in Kalfounò in the issue of family planning.

So why were so few of them (almost none, in fact) taking birth control pills, or using condoms or foam, or having tubal ligations?[24] Why did even the people who seemed the most enthusiastically interested in the idea of *planin* rarely go beyond accepting the idea itself to actually

"following planning"? I mentioned earlier that the main headquarters for family planning resources in Kalfounò was the MSPP clinic there. I would first like to discuss this question, then, by asking what goes on there at the interface between the Kalfounò community and that local branch of "the national program." I would like to propose in this discussion that another central factor in why family planning initiatives are failing in Haiti (and another one that is left largely unaddressed in the literature) is this very relationship between Haitian peasants and the North-Western medical institutions and practices through which "planning" is administered.

The Kalfounò Clinic and its Clientele

Kalfounò's MSPP dispensary was established in 1985, partially in response to pressure put on the director of MSPP's Northern District Office by volunteers of MCC. It was to be staffed by one *oksilyè sante* ("health auxiliary") and an assistant. While I was there, the assistant was a woman who had been living in the area for several years and had her own medical practice "on the side," through which she treated various maladies not treatable (at least affordably) in the clinic. Most of her work involved giving people injections at the "mobile clinics" she created as she traveled from one open-air market of the region to another. During my time in Kalfounò, the clinic was staffed only by one *oksilyè* at a time. Two had worked there by the time I left the area in 1991. Both of them were young men from the northern port city of Cape Haitian, and both had finished their two years of training just before coming to Kalfounò.

Neither of these young men found it easy to adapt to their first assignment in this place, as one of them put it, "beyond the last of the mountains." Being wealthy (in Kalfounò terms) "city boys," they were jolted by the material and social deprivations they experienced upon moving to this remote village of peasant farmers. Actually, neither of them ever really "moved" there, as they each spent the better part of many months back in Cape Haitian. At the time I was leaving Kalfounò, the then-current *oksilyè* was trying desperately, like the one before him, to attain a transfer.

The discomfort of these young men with their new community was met with equally uneasy feelings on the part of many of their clients. Few Kalfounò residents had acquired many literacy skills at the grossly under-funded, under-staffed, and structurally dilapidated schools they attended, where the majority of teaching involved directing rote recitations of outdated French-language texts. Only a handful of children, at any rate, were able to attend school long enough to graduate from the sixth grade (the highest level offered in the zone). The parents of those who did could rarely afford to send them away for more advanced lessons. Most Kalfounò citizens hardly ever picked up a pen or pencil in going about their daily lives, or heard the French language spoken. They thrived instead in the oral mastery of their northern Haitian Creole. These folks thus understood their bodies and all their parts and functions in "folk" terminology and through traditional models and explanations. Whereas local health care providers operated on the authority of those same models (not to mention, on an intimate knowledge of the patient, her personal history and her family); the *oksilyè* looked primarily to his French-language scientific textbooks for guidance, and understood his clients' bodies and illnesses according to the terms and explanations therein.

Although rural Haitians commonly assert, using a well-known proverb, that "*pale franse pa di lespri pou sa*" ("speaking French does not mean you're intelligent"), the *oksilyè*'s eloquent verbiage was almost inevitably heard as intimidating as it was foreign. While this rendered him a certain amount of status and authority, it also meant that his clients generally sat before him head-bowed and silent, and though grasping only a fraction of what he was saying, did not dare to forward a question. Such behavior did nothing to help rid the *oksilyè* of the ideas he had learned in the city about the mental underdevelopment of the peasantry. The layers of miscommunication and misunderstanding that emerged in this setting were thick indeed.

It is not surprising, then, that although there is a certain level of belief in the wonders of such North-Western medicine on the part of Haitian peasants, there seems to be very little trust in its practitioners. I have seen many people return from visits to clinics such as this one with pills in hand, but with no idea as to what the diagnosis was, what medicine they had, or how to take it.

Many who did know would openly contest the wisdom of the instructions they had received, and decide not to use the medication as it was prescribed anyway.

But suppose you were a particularly confident person and had gotten beyond these initial barriers to trusting or talking in detail with the *oksilyè*. Many walls still remained. Even if the *oksilyè* were especially patient and interested in helping you make your own decision, acquiring an adequate understanding of your options would still be an overwhelming task. There are now some educational materials on family planning written in Creole and illustrated with pictures. If the *oksilyè* happened to have some, these might be useful. Consider, however, a few examples from such a booklet published and distributed by the hospital mentioned above.[25] The first picture is supposed to illustrate how to follow the sympto-thermo (or "calendar") method. Not only is the page too crowded with complicated drawings to be deciphered by most people with minimal literacy skills, but several of the items it presents as necessary equipment for following this method (such as the thermometer and calendar) are things to which few people in rural Haiti would have access. Something meant to be a learning technique thus becomes yet another source of confusion and intimidation. Marilyne Gustafson has written an article, "Research Among Haitian Village Women: Implications for the Nurse's Role in Health Education," in which she suggests that much of the educational literature aimed toward illiterate people rarely conveys the messages intended.[26] I want to temper my critique here, though, by acknowledging the fact that educational materials being written in Haitian Creole at all suggests that family planning advocates have begun to try to bridge the gap between the medical professionals and Haitian villagers.

Affecting levels of acceptance among Kalfounò residents of family planning initiatives were several other factors besides communication. One was the clinic building itself. Structurally extravagant by local standards, it had a cement floor, a tin roof and white-washed, concrete-block walls. A far cry from the smaller, darker, more soft-edged construction of most peasant homes, it inevitably felt to its clients at least as foreign and intimidating as the French medical terminology of its staff.

There were several other factors influencing the lack of acceptance of planning initiatives among Kalfounò folks that were related directly to their relationship and experiences with the MSPP clinic. One was economic. The Kalfounò clinic had a reputation for charging much more for its "big medicine" treatments than did local "leaf doctors" and other traditional health care professionals—who were also more amenable to bartering and delaying payments. Thus, although the planning consultations and contraceptives were supposed to be offered free of charge, the people in the Kalfounò community nonetheless tended to view going to the clinic as a luxury (or a last resort), and expected a hefty charge for any services offered there. In fact, the *oksilyè* did usually charge something for his consultations. Some people claimed he charged for pills and condoms as well. To scrape up even one *goud* (approximately 13 cents) for a consultation was no easy task for many, and for some could mean quite a sacrifice (like giving their children less to eat for a day or two). Another discouraging factor was the distance of the dispensary from most of the zone's residents, the majority of whom lived between a half-hour to three-hour walk from the village. To make a round trip, then, could take up most of a day—one that could be spent instead securing something for the night's meal or preparing for the next planting season. It is not difficult to understand how such barriers, in addition to the likelihood that one would get to the dispensary only to find it closed and empty, could easily stifle one's enthusiasm about the prospect of going for consultations.

Finally, there were the contraceptive methods themselves. Let us suppose again that you had gotten beyond all the barriers discussed above, were still interested in family planning, and had learned about different methods of contraception. How good were your options? Let us look very briefly at the most available methods.

Accessible(?) Methods of Contraception

1. The Pill

The pill was the method of birth control most commonly discussed in Kalfounò. As mentioned above, the MSPP clinic usually had at least one type in stock. It was also one of the

least "foreign" methods, since many people had taken pills already. It had its share of disincentives, however. First, there was a fear of the side effects it might have—namely, stomach aches, changes in menstruation, headaches and escalations in blood pressure (the chance of weight gain was generally considered an advantage). Such problems were not uncommon, since most of the pills administered in MSPP dispensaries contained very strong dosages of estrogen and progesterone. Another factor increasing the risk of negative side effects was the fact that the kind(s) of pills that might be in stock in the clinic at a given time was not at all dependable—obliging women to switch frequently from one sort to another. Moreover, even when their symptoms were not ones generally associated with contraceptive use, women in Kalfounò who fell ill while on the pill would very often point to the pill as the obvious source.

Also impeding the prolonged use of birth control pills was simply that taking a pill every day was not something to which the people in the area were accustomed. As I have suggested, there was very little understanding of what North-Western medicines were supposed to do in one's body. Women sometimes gave pills to sick family members, or took extra or fewer depending on the state of their own health. The *oksilyè* may have warned his clients against doing such things, but as should be clear from the above discussions, such messages were by no means consistently communicated or absorbed. Given all this, it is not surprising that very few Kalfounò women who started taking the pill during my time there stayed on it for more than a few weeks.

2. Condoms

Condoms were the other most accessible method of birth control for the people of Kalfounò. At the dispensary, they were given away free of charge (at least most of the time) and did not require an initial consultation. Many of those distributed from the dispensary were, true to the *oksilyè*'s suspicions, then sold for a penny (*senk kòb*) at Kalfounò's weekly market. I saw more than a few being used by children and youths as water balloons.

As is the case in many populations, one of the primary factors negatively affecting the use of condoms as a birth control measure in Haiti is the fact that women, not men or couples, are generally held responsible for "following planning." Condoms, moreover, hardly did much to

boost one's image of masculinity. One of the Kalfounò community health educators related to me how she had struggled to convince her husband to use condoms. Even though he had almost given in to the idea several times, she said, he always ended up refusing, saying in effect, "Real men don't wear condoms."

Many Kalfounò women also reacted negatively to condoms. In a study on "Condom Use in Haiti," James Allman et al conclude, in fact, that women are in general less receptive to condoms than are men.[27] I did not gather this from talking with people around Kalfounò. Their observations that women tend to associate condom use with illicit sexual relations, however, I did find to hold true in Kalfounò. In addition, many women worried that a condom might come off during intercourse and get lost inside their bodies. Others simply did not like the idea, and agreed with the men that it did not make for particularly masculine attire. Women as well as men also complained about physical discomfort and loss of sensation. It was no help that, like the birth control pills circulating there, the condoms circulating in Kalounò tended to be of poor quality.

While pills and condoms were the only birth control methods in fairly regular supply in Kalfounò, the aforementioned hospital was well stocked with several different methods. The ones that were of most interest to Kalfounò people were: Depo-Provera, Norplant, and sterilization operations. (IUDs had also been somewhat popular, but because of the risks incurred by administering them without sufficient follow-up, their use had dropped.)

3. Depo-Provera

Depo-Provera (Depo Mediacy Progesterone Acetate, or DMPA), known as "the three-month shot" in Kalfounò, is an injectable contraceptive that must be administered every three months. It has been used in Haiti since the mid-1970s,[28] and has several obvious advantages over the pill and condoms—namely that it is ideally much less trouble. Although Kalfounò women using Depo-Provera had to make the eight-hour trek to the hospital every three months to get their shots, this was often much easier than keeping supplied with the birth control pills and managing to take one every day.

DMPA is a very controversial method of contraception, though, and is hotly debated among family planning programs internationally. It is approved in many countries around the world, but has not been accepted by the USFDA for use in the United States. This is due to several factors, including some adverse side effects such as complications with high blood pressure, chronic headaches and depression, prolonged infertility, excessive weight gain, and irregularities in the menstrual cycle. It was this last point that was perhaps the most powerful deterrent to its use among Haitian women.

Depo-Provera may sometimes cause a woman to bleed more heavily during menstruation (or bleed between periods). It might also cause the cessation of menstrual bleeding—not only during the time that she is receiving injections, but also after she ceases to use it. Loss of menses due to DMPA can last for several months, and possibly even years. This a very unacceptable side effect for Haitian women, for they know that if the blood they are supposed to "get rid of" every month is not leaving the body, then it is building up inside. To have *twòp san*, or "too much blood," is associated with having high blood pressure, and is considered a very serious, and potentially life-threatening, condition. Ma Jak, one friend of mine who lived in the village of Kalfounò, began receiving Depo-Provera injections after weaning her sixth child. She was very upset by the loss of menstruation that ensued, and after two or three doses decided not to continue. She did not have her period again for over two years. During that time, the blood building up in her body caused her several problems. Word of such complications spreads quickly around Kalfounò, and DMPA has earned little trust there.

4. Norplant

Norplant (Levonorgestral implants), or "the five-year method," has been used in Haiti for several years. It shares some of the pill's and DMPA's possible side effects, but is still less of a hassle. People in Kalfounò were just beginning to learn about it when I was there. One of the most frequent comments I heard when discussing this method with people in the area was, "Five years is a long time." Many women wanted to "space" children but not completely stop giving birth, and were uncomfortable with such a long period of infertility. Although the implants could

theoretically be removed at any time, I am not at all sure that a peasant woman requesting such a service would be accommodated, except in the case of a medical emergency. To my knowledge no one in Kalfounò had tried Norplant by the time I left.

It may have ceased to be an option, in fact, just as acceptance of it had begun to take root in the region. Soon after the USFDA approved it for use in the United States—where it would be sold for several thousand dollars per "dose"—it disappeared from the hospital. The physicians with whom I discussed the matter doubted that it would be restocked. Once enough testing of the method on "Third-World" women had occurred, they suggested, there would be little incentive for funding organizations to continue subsidizing so expensive a procedure.

This raises an important issue: Do Haitian women and men perceive that the promotion of family planning in their communities is done (at least in part) for objectives having little to do with concerns for their own needs? Undoubtedly, the answer is yes. In fact, the family planning "promoters" who worked for the hospital were often called, with more than a little resentment, "the head hunters."

5. Sterilization Operations

The hospital also offered both tubal ligations and vasectomies. The consultations, the surgery itself, and the medications involved were all free. However, speculations abounded concerning the tragic consequences this operation might have, as did horror stories about past victims. Many Kalfounò residents believed, for example, that vasectomies cause men to urinate uncontrollably, to urinate during intercourse, to lose their masculinity, and/or to simply become unattractive to his woman. Again, no man in the zone had been willing to take such risks during my time there.

A few women, however, had undergone tubal ligations. As all of them recovered well, the reputation of the operation improved somewhat. Still, it continued to be viewed as very risky and threatening on several levels. When a Haitian woman gives birth to a child, she is "opened up," and very special care must be taken to ensure that she does not *pran fredi*, or "take in cold." If she does, she can do irreversible damage to her reproductive organs, or suffer from some other serious

illness. *Fredi* prevention involves special prescriptions for her diet, for bathing, for dress, and for daily activities. Her period of vulnerability lasts for several months, but she is most susceptible during the first four to six weeks after childbirth.

This is precisely the time period during which the hospital preferred to perform tubal ligations. In fact, if a woman did not undergo the operation then, they would not do ligation surgery until she had her first period, and it had to take place during that period. Many women were either pregnant again by that time, or were not able to make it down to the hospital while they were menstruating. Yet for a woman to undergo surgery within the first month after childbirth would mean to consent to "open herself up" in the most extreme sense to a multitude of *fredi* threats: besides the actual "hole" in her body, she must submit to exposure to a chilly metallic operating table, harsh florescent lights, lying "virtually naked" for long periods of time, and so on. For Kalfounò women, it would have also meant subjecting her and her baby to a lot of painstakingly difficult travel over rough terrain during a period in which they should have been spending most of their days lying together in a warm bed in a dark corner of their home, being cared for by relatives and neighbors.

Some Additional Considerations

Each of the methods mentioned above poses its own set of physical threats. All of them pose social threats as well, many of which have been addressed already. There is one more general threat related to contraceptive methods, particularly to the more long-term or sterilizing ones, which should not go unmentioned here. If a woman is ensured against pregnancy, will she then not be more likely to have extra-marital affairs, knowing that the consequences are much less risky and the chances of being caught much fewer? This possibility is no small concern, for "loose women," unlike men who have several partners at a time, are often viewed as threatening to the moral fabric of their communities. In fact, a woman who has undergone a tubal ligation might very well be labeled by those around her a *bouzen* ("prostitute"). One prominent tale of scandal and intrigue in Kalfounò was of a woman who had undergone the operation, and soon thereafter started having an

affair with one of the local army officers. It was said that she had begun to neglect her husband and even her own children, and was planning to "run off" with her new lover upon his transfer to another village.

Another more general disincentive to using North-Western methods of contraception is simply that they are *etranje* ("strange" or "foreign"). One of the local health educators who had been working with MCC for several years told me one day about a new contraceptive method she was thinking about trying. The description she gave me went like this: First, you shell a pound of peanuts and boil them, storing the shells away in a container. Then you sit down in the middle of the doorway of your house, legs and arms crossed, facing inside. You put several peanuts in each of your crossed hands, and eat them, alternating hands with every mouthful. This will "tie up" your reproductive capacity. When you want to have more children, you simply take the same peanut shells, boil them, and drink the water.

When I first heard this prescription, I was surprised that my co-worker would put enough confidence in this method to try it. After all, she had attended, and even taught, several lessons and seminars on reproductive anatomy and family planning. But upon considering it more carefully, I realized that this technique should not seem one bit more bizarre than taking a shot that automatically "ties you up" for three months, or having five tiny bars planted under the skin of your arm, bars which supposedly send mysterious chemicals to your reproductive organs in little surges over a five-year period of time. In the end, however, the issue is not relative degrees of bizarre-ness, but where one puts one's trust. And why should my friend not more readily trust the "peanut method" prescribed for her by local practitioners she had consulted since childhood, as opposed to the seemingly magic solutions offered by the likes of me (who had never given birth, after all—a fact somewhat suspicious in itself), or the French-speaking agent at the Kalfounò clinic? As Haitians say, *se pa tout moun ki degize nan madigra* ("it's only certain people who disguise themselves in the Mardi Gras parade"); you can see clearly who some people are, but for others it is difficult to be sure.

The "Natural" Method

If a Kalfounò couple had refused all the above-mentioned methods of contraception, but still wished to space their children, they might have tried to follow *planin natirèl* ("natural planning"), which usually indicated the sympto-thermal method. Unfortunately, little thorough education had been done on it in the area. Thus, most of those who tried it were soon pregnant, and consequentially even more discouraged with "planning." One woman, the wife of a pastor and one of the more educated people in the village, had been "following natural planning" for years. She had eleven children to show for it. I eventually discovered that she had been engaging in or refusing intercourse at exactly the opposite times required in order to avoid pregnancy.

In addition, "natural planning" depends even more than the other methods on the health status of the woman. If she is lactating, suffering from malnutrition and/or amenorrhea, is very young or beginning menopause, has any sort of venereal disease, or is under a lot of stress, her efforts will almost inevitably fail. These stipulations undoubtedly ruled out the majority of women of Kalfounò. Another impractical requirement is that of having a thermometer—a piece of equipment well beyond the means of most peasants.

Concluding Assessments and Speculations

In speculating about the reasons that the rates of "acceptance" of family planning in Kalfounò have been so low, I have discussed many possible factors. How applicable these factors are, and to what extent they might have interacted with one another in influencing decision-making, cannot be verified except perhaps by Kalfounò residents themselves. However, there are a couple of more general speculations I would like to offer in conclusion.

The first comes from reading literature related to the subject. Most scholarship asking questions about why family planning (and other public health) initiatives have not been accepted by the people of Haiti seems to reflect crucial (though often tacit) preconceptions. Not only do these scholars tend to assume that if people were more educated about the issue and more aware of their options, and if these options were more accessible to them, then they would choose to accept

family planning. They also tend to imply that this compliance would be good for them. (Looking back over the pages above, I find that I myself, however unwittingly, also seem to hold that underlying assumption.) If these two things are taken for granted, then the task before practitioners begins with searching for more effective ways to "sell" family planning to Haitians, along with ensuring the availability of contraceptive methods for their use. This could involve improving educational materials, better equipping hospitals and clinics, improving training for dispensary staff, and so forth so.

But there is another way of looking at the situation. One might also conclude that the systems and mechanisms through which family planning is taught, administered and practiced—and indeed family planning itself—are so incongruous with local beliefs, assumptions, concerns, and sensibilities that no Kalfounò peasant in her/his right mind would consent to practicing it seriously! This is to say, in effect, that the most serious and profound problems with family planning in Haiti rest not first and foremost in the obstinacy or ignorance of the Haitian peasantry, but rather in an obstinate, and in some ways very ignorant, system. In this case, the task laid before us would not be how to improve, reform and increase the acceptance of existing family planning programs, but instead how to *dechouke*, or "uproot," this system and replace it with one that takes into consideration a number of other priorities, concerns and types of knowledge.

One place to begin might be with the decision-making structures of the family planning industry. The situation now is one in which it is almost exclusively upper-class, formally educated, urban, and often "first-world"-based "experts" who are in charge of designing, supervising and administrating programs which "target" peasant women. To say that, in general, these two groups of people neither know the other's reality nor share similar vested interests is a great understatement indeed. Would it not be nearly impossible to plan a program that would be truly helpful to the people (women and men) of Kalfounò through this structure? While "participatory development" initiatives are becoming increasingly popular (not only in Haiti, but throughout the "Third World"), rarely are the people meant to be their ultimate beneficiaries invited to participate in decision-making processes that go on beyond superficial, or very localized, levels.

Rarely are they offered any real degree of voice in determining where and how funds should be spent, what types of training should be offered, or what sorts of technology should be (or not be) promoted.

Does suggesting that peasant women and men be allowed such involvement in the decision-making and power-holding realms of the development industry not sound more than a little far-fetched? That in itself, I would argue, is as good a sign as any of the seriousness and profundity of what is going wrong here. A final Haitian proverb tells us that *se kouto sèlman ki konnen sa k nan kè yanm* ("it's only the knife that knows what's at the heart of the yam"). Family planning initiatives in Haiti will be effective and appropriate—and justifiable—only when the people "at the heart" find themselves not just at the blade, but with a grip on the handle.

NOTES

[1]There are many more traditional health care providers than that, usually at least one or two in each village or neighborhood. But these people are usually regarded as backward, superstitious or even dangerous by North-Western health professionals. Thus, they have been largely uninvolved in family planning programs.

[2]These statistics and others on Haiti at the national level may be found in:

James Allman,"Fertility and Family Planning in Haiti," *Studies in Family Planning* 3.8/9 (1982).

Gretchen Berggren, Nirmala Murthy, and Stephin J. Williams, "Rural Haitian Women: An Analysis of Fertility Rates," *Social Biology* 21.4.

Anita J. Gagnon, "Health for All in Montrouis, Haiti," *International Nursing Review* 33.5 (1986)

Steven Williams, "Population Dynamics and Health in Haiti," *Social and Economic Studies* 30.2 (1981).

Pan American Health Organization (World Health Organization), *Health Conditions in the Americas*,Vol. II (Washington, DC: PAHO).

"Haiti," *Latin American Health Handbook* (White Plains, NY: Robert S. First), 1984.

The Economist Intelligence Unit and Business International, "Haiti," *Dominican Republic, Haiti, Puerto Rico Country Profile: Annual Survey of Political and Economic Background*, (London: EIU), 1991-92.

[3]Gagnon 1984: 135. Also see *Latin American Health Handbook*, pp. 570-571.

[4]*Health Conditions in the Americas*, p. 172.

[5]For examples of expenditures and program statistics, see Ibid, p. 174, and *Latin American Health Handbook*, pp. 571, 580.

[6]For a case study of one "successful" local health project sponsored by MSPP, see Gagnon 1984. For data at the national level, see *Health Conditions in the Americas*, pp. 170-174, and Allman 1982: 237-245.

[7]*Health Conditions in the Americas*, pp. 132-133. For an analysis of acceptance of a local family planning program in Haiti, see Berggen et al.: 376-377.

[8]For a good description of the chores of girls and boys around a rural Haitian home, see Jacqueline N. Smucker, *The Role of Rural Haitian Women in Development* (Port-au-Prince: United States Agency for International Development), 1981.

[9]The contribution of children to family strength and security is discussed in detail in J. Mayone Stycos, "Haitian Attitudes Toward Family Size," *Human Organization*, 23 (1964): 42-47, and Remy Bastien, "Haitian Rural Family Organization," *Social and Economic Studies* 10.4 (1961): 478-510.

[10]George E. Simpson, "Sexual and Familial Institutions in Northern Haiti," *American Anthropologist* 44 (1942): 662.

[11]Gerald Murray, "Women in Perdition: Ritual Fertility Control in Haiti," *Culture, Natality and Family Planning,* Marshall and Polgar, ed. (Chapel Hill: University of North Carolina Press, 1976), 59-78.

[12]For other more detailed discussions on unions in Haiti, see: Stycos 1964, Simpson 1942, Bastien 1961, Allman 1982, and James Allman, "Conjugal Unions in Rural and Urban Haiti," *Social and Economic Studies* 34.1 (1986): 27-54.

[13]Simpson 1942: 657.

[14]*Health Conditions in the Americas*, Vol. II, p. 170.

[15]For a detailed discussion of this issue, see John Ballweg, Ryland Webb and Gisele Biamby, "Mortality and the Acceptability of Family Planning in a Haitian Community," *Community Health* 5 (1974): 304-311.

[16]Murray 1976.

[17]Stycos 1964: 45.

[18]Williams 1981: 150.

[19]Allman 1982.

[20]Ibid., p. 240.

[21]Ibid.

[22]Stycos 1964: 45.

[23]Ballweg et al., 307.

[24]Because I did not carry out surveys on the matter, I cannot say with precision just how much each of these methods has been used. I do know that three Kalfounò women underwent tubal ligations at the Pinyon hospital during my three-year stay there.

[25]*Liv Pou Planin Familyal* (*Book for Family Planning*), Lopital Byenfèsans, Pinyon, Haiti.

[26]Marilyne B. Gustafson, "Research Among Haitian Village Women: Implications for the Nurse's Role in Health Education," *Public Health Nursing* 34 (1986): 250-256.

[27]James Allman, Ginette Desse, Antonio Rival, "Condom Use in Haiti," Working Paper #16, Center for Population and Family Health (New York: Columbia University), 1985.

[28]Jean Tafforeau, Anne-Mare Daney, Suzanne Allman, James Allman, "Attitudes Toward and Acceptance of DMPA in Rural Haiti," Working Paper #26, Center for Population and Family Health (New York: Columbia University), 1986.