the second largest extension worker population approximately 1700 (community Development Assistants and home economics/instructor and Adult literacy instructors). These have been trained to integrate CS message into their daily activities. Activities done so far include: Orientation of policy makers; Training of master trainers; Training of trainers; Training of community development assistants and home economics instructors; Orientation of CCAM, MCP Chairperson, Secretaries and Wives of MPs; Materials development, booklets, primers, flipchart and posters.

(b) **Family Life Education Project:** This project too has the same target group of extension workers to integrate FLE activities into their work. Activities being undertaken include: Integration of FLE into curriculum at Magomero is underway; Materials production - manuals for field workers; Orientation workshop for field workers; Pilot activities in six districts (Mangochi, Machinga, Salima, Ntchisi, Nkhata-Bay and Rumphi). The FLE manual includes topics like, child spacing, breast feeding, and healthy motherhood, etc.

(c) **Parent Education Project:** The idea is to ensure that parents are taught about family life activities, so as to ensure there is a dialogue between parents and their children on sex, sexuality and other family issues. The ultimate goal will be that parents will not be suspicious of what is happening in FLE which is targeted at the youth. Activities include: Audience research; Materials production (posters and flip charts on population, positive parenthood, sugar dad, communication, effects of teenage pregnancy, etc.); Orientation seminars for different target audiences; Implementation in a pilot district. It is planned to merge FLE and parent education projects soon.

5. Ministry of Agriculture (MOA)

The extension Aid Branch (EAB) of MOA provides media support to Agricultural extension network. Recently MOA has fielded a pilot project in one district to integrate population education in its agricultural extension.

In the past EAB has been supplementing MOH activities by assisting HEU to show the child spacing motivation films to the general public through the use of EAB's yellow vans which are equipped with cinema projection facilities. Some extension workers from different districts were oriented to child spacing activities and have been motivating the general public.

With the introduction of the new project it is expected that nearly 20% of field assistants in the country will be trained to integrate population education into agriculture extension education services.

This project, which started on pilot basis in Chiradzulu, is being funded by UNFPA but executed by FOA. The emphasis of the project has been on population IEC. The EAB identified and provided the development and delivery of messages in this project. Issues which will be addressed are, land holding sizes, land fragmentation, family planning aspects and social cultural values and traditions, demographic and geographic profile etc. as they relate to population.

A number of publication such as text books leaflets, brochures, calendars and posters were produced. The project proved very successful and it has been agreed in principal that the project should be replicated to other areas.

Another project to integrate Population Education into the Curriculum at the Natural Resources College is underway.

6. Chitukuko Cha Amai m'Malawi (CCAM)

CCAM is engaged in child spacing motivation and population activities and is instrumental in advocating and mobilising favourable environment for the implementation of population child spacing activities.

With funds from the International Planned Parenthood Federation (IPPF), CCAM is conducting community based IEC through party and church activities. Sometimes they have been involved in clinic based IEC. About 24 trainers of trainers (2 from each of the 12 pilot districts) have been trained in training and monitoring skills on child spacing motivation. These in turn have trained 240 volunteers who are motivating the general public on the benefits of child spacing.

7. Department of Youth and Malawi Young Pioneers (MYP)

The Department of Youth and MYP is responsible for out of school youth through provision of vocational training. There are MYP officers in each district and a sports instructor in every school.

The Department of Youth and MYP initiated a Family Life Education Programme integrated with income generating activities.

With funds from IPPF, the Department held consultative meeting on Family Life Education and youth needs. Many recommendations were made from these workshops, which lead to the development of two FLE manual for supervisors and instructors. Training of trainers was done to 20 youths (mainly girls from Mapanga MYP base) to start FLE with IGA in pilot districts in the South and in the Central Regions. It is envisaged that the Department in conjunction with other relevant organisation will produce other training materials.

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Community Based Distribution

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Background

Community Based Distribution (CBD) is a relatively new concept. It is a service that reaches beyond the clinic walls to provide contraceptives in the communities where people live. This is achieved by considering the following factors: *Geographical* (bringing the source of service and contraceptives closer to where people are); *Economic* (ensuring that contraceptives are affordable); *Administrative* (making it as convenient as possible to obtain and use contraceptives); *Cognitive* (providing information that is accurate, reliable and understandable so client can make informed choices about the method they wish to use).

The ultimate goal of the CBD programme is to improve the accessibility of contraceptive services and supplies in reaching and being utilised by individuals who need them.

To achieve the stated goal of CBD programme, the following issues need to be considered: Official support; Community support; Selection of distributors; Training; Supervision; Remuneration; Resupply systems; Pricing of contraceptives; Mix of services; Contraceptive method mix.

However as one is about to establish a CBD project a more serious consideration need be given to the following issues and possible alternatives: Goals and objectives of the program; Urban/rural coverage; Free/fee for service; Voluntary/paid agents; Child spacing (Family planning) only/integrated services; Clinic linked/free standing; Motivators/distributors; Inclusion/exclusion of pills; Government/non-government; Large/small project; Static/mobile service for support; Literate/illiterate workers; Logistics (Training, supervision); Monitoring and Evaluation.

In addition there are other more subtle issues that need to be thought about. For example whether the National family planning policy specifically include or exclude the Community

Based Program; the limitations on who can prescribe and dispense contraceptives, especially oral contraceptives; import restrictions and pharmacy laws; whether services should be provided to unmarried and younger clients and whether spouse consent and parent consent are required; Limitations on IEC messages and materials; Public Service Commission regulations for personnel.

Many countries in Africa are advocating and favouring use of CBD as a way of improving accessibility of contraceptives in various communities e.g. Kenya, Lesotho, Ghana, Zimbabwe, Swaziland, Nigeria. Zambia is in the process of starting its CBD project.

Community support

This is a critical factor in that the community concerned must get involved in the entire process from planning to evaluation of the project. A needs assessment to determine current use, demand of contraceptives, community perception and their interest precede all activities. Like any community development project, local leaders, health and family planning workers must be involved in early stages. They will provide valuable information on how best to design and implement the project and the community in the process should learn to own and support the programme.

Selection of CBD agents

A crucial factor is that the person chosen by the community to be a CBD agent has to be a well known and respected member of the community. Community leaders and other influential groups can help in selecting such persons. Though characteristics of a CBD agent vary from place to place and different environments, common factors in CBD selection include an older person (man or woman), preferably married, and a parent and a satisfied user. The agent must be confident, sensitive, and enthusiastic. The list is not exhaustive, and the community will add on to the criteria as necessary.

Training

This varies considerably by program and type of work expected for CBD, but is mostly intense and short. Two weeks initially, then one week covered as refresher course is the usual pattern. Topics covered include: Training and practice in basic physiology; Mechanism of action for the various contraceptive methods which they will distribute; Effective ways to approach and communicate with people in the community; Information of how CBD will work including physical assessment, resupply and record keeping; Correct use of a check list; Safety of methods; Advantages and disadvantages of contraceptives; Referral of clients with problems or for other methods; information on other methods such as vasectomy, Tubal-ligation, Norplant, Depo provera).

Supervision

Because the CBD have a limited training and are often isolated in rural areas, it is vital to monitor closely the work of a CBD through an effective supervision. This is a supportive and instructive supervision not a critical one. Ideally supervisors should visit CBD where they work. When this is not possible the supervisor should hold meetings monthly, or more frequent than this, at which their performance is discussed. This facilitates agents learning from each other so that monitoring can be effective. Supervision must be built informally into the program e.g. once every 2 weeks or on a monthly basis. The issue of who should be supervised by who is determined by: the background of the person being supervised; the complexity of the task; the personal style of supervisor and the agent; the atmosphere of the organisation; the culture in which the programme is operating.

The technical skills of CBD will be reinforced or rectified during supervision. Clarification in reporting procedures and functions as well as solving some of the problems and motivating the agents are some of the other tasks undertaken during supervision. Whichever way one chooses, the project design is affected by this as the quality and performance usually is linked with submission of reports. Long term effects of these factors must be considered as it affects the programme.

Free/fee

Most of CBD projects are externally funded, community funded, or a combination of both. It is generally implied that there must be a high level of community involvement and great potential for locally self sustained services. Free services in CBD are relatively easy to implement.

If services are paid for many factors need be considered such as pricing studies to develop fee structures appropriate for community. A system to incorporate and control cash flow generated through services or commodity sales; a more manageable financial system to facilitate budgeting, forecasting, cash flow management; book keeping and financial reporting. Transport availability for supervision might be a problem depending on how long the programme has been in operation. It is vital to schedule visits 3 months in advance.

Feedback Loop

Supervision should include regular feedback from programme officer to team-leader and agents so that CBD agents know how well they are doing and how to improve their performance. Checklists and forms which should be reviewed and compiling forms which the distributor has completed must be reviewed at the site so that any problems can be corrected. Supervision must be considered as a process which helps the organisation to achieve its objectives and goals.

Remuneration: Voluntary or Paid agents

Consideration should be made whether agents will volunteer their time or be paid for their services. If paid, is it a salary or a honorarium. If its a salary, is it a fixed amount or based on performance? Some committees pay their agents in non-cash incentives.

Resupply systems

This varies greatly depending on the specific geographical and logistic factors in an area. Availability and reliability of transportation and availability of proper storage area.

The existence of a reliable and operational resupply system is one of the most critical factors in a successful CBD program, especially in rural areas. The same goes for record keeping and supervision.

Mix of Services and Contraceptive Mix

In some countries CBD is offered as part of comprehensive health care or development assistance programmes. This usually increases acceptability and motivates people to use CS.

The mix of contraceptives is determined by government policy or guidelines used to provide CS. While there has been resistance to the provision of services by non-professionals, evidence is increasingly showing that with a properly trained CBD and properly supervised, there is little risk associated with the provision of non-clinical methods by non-professionals. In any CBD programs pills, condom, and foam are methods which can be purchased or obtained from a CBD agent. (S)he is also trained to refer potential clients for clinical methods such as injectables, IUCDs or surgical procedures and for check-ups.

Urban or Rural community based programs

The differences in the two is geographical and characteristics of population living in these areas, most programs target one or the other although some programmes target both. However, the concept of community is not nearly as strong in highly mobile urban populations. In urban areas the traditional geographical definition of community may or may not exist, timing of migration to the city, educational status, ethnicity and social economic status definition.

In terms of building information into such programmes such factors have to be considered i.e. Rural people are less formally educated than urban population and the latter have a more general access to clinic back up than rural population.

A combination of both motivators and distributors may be used in both rural or urban. A smaller geographical area can be covered to meet a larger target population in urban than rural areas. Because of lack of traditional community leadership structures in urban areas, it may be more feasible to recruit the populations who are not representative of the people being served.

Child Spacing only/integrated services

CBD programmes have a long history of integration with other development activities including health, sanitation, income generating activities, community development and education (adult literacy). Integration of activities tends to increase the overall acceptability to community but tends to distract community agents from their family planning services. When FP services are not integrated a considerable greater amount of community preparation needs to be done. Integrated services need a longer period of training and other factors too have to be considered including the impact on the phases of project design and implementation.

Clinic linked/Free standing

Historically CBD programmes have a relationship to clinical services. However, there are programmes in other countries where agents operate completely independent from medical support and whose clients are not required to see a medical professional to get FP services. On the other hand CBD agents might be working as outreach workers for clinics and provide relatively few services. CBD programme without clinic linkages must develop a strong referral system to manage clients with side effects and those wanting methods which are not allowed to be distributed by a CBD. The training approaches of such CBD agents will also be different to accommodate such difference.

Community Based Programmes Requiring checks for pill users

A major constraint could be policies limiting the distribution of contraceptive pills to medical personnel. The epidemiological evidence is clear that pills can be safely distributed by low level CBD agents. The agent uses a check list to identify appropriate client for initiation of one packet of a pill and refers client to clinic for a thorough physical check up. Thereafter, client reports back to her/his CBD for more supplies of pills or for other methods as suggested by clinic practitioner.

Governmental or Non Governmental

Whether or not CBD program will be located in public or private sector influences the structure of project. Government programmes generally cover a larger area and are integrated with other governmental development activities. Local support is easy to get for the non-governmental sector. NGO's usually are more flexible in starting activities on experimental basis before replication. CBD agents usually paid (Fee for service) and objectives and structure of CBD programme clearly, and strongly linked to implementing organisation and influences all aspects of project implementation.

Large versus small community based programs

Size of project can vary depending on geographic coverage or population served. Larger programmes require large pre-implementation planning to operate effectively, logistics, supervision and reporting system must be more sophisticated in order to manage the complex programme and needs greater flexibility in service delivery elements of a larger programme required because of diversity of population served.

Literate/illiterate agents

As much as possible CBD agents must be from the community they serve. While there are some exceptions to the rule it is generally accepted that selection must be made among the community members. If members of community are illiterate the chances of recruiting literate CBD agent are less. Training can be designed for illiterate agents. The reporting system has to be modified to allow for forms which can be filled in by an illiterate agent. The same for IEC, on which materials modification has to be done. Refresher courses have to be more often.

Feasibility and Justification of CBD programmes in Malawi

Since CS services were re-initiated in Malawi 1983 the demand of these services has increased tremendously from 2,795 acceptors, to 49,200 in 1984-1989, to 83,570 by 1990.

The family formation survey (FFS) of 1984 revealed that the prevalence rate of contraceptives for all methods was only 4.6% of the total Contraceptive prevalence rate (CPR). In the same FFS 1984 it was reported that women 15-49 years of age and who were married then only 7.5% were reported using a method of child spacing.

In 1988 CPR nation wide was found to be 3.3 (a published study) for traditional methods of child spacing. In 1991 child survival program under PHICS in unpublished study which was done in Dedza East (around Mua area), CPR for modern methods was found to be 4.6% (This might be contributed to by religious factors). Although no current study of 1990's has been included in this paper. It would appear that our CPR is still very low.

More Malawians live in rural areas (about 80%). At present CS services are hospital and clinic-based and mostly in urban settings with a few in the rural areas. One of the possibilities which can take CS services reach the rural areas where 80% of Malawians live is Community Based Distribution. Many countries in the Region have embarked on CBD programmes and this has proved to be an enabling, stretching-out, hand to provide CS services to rural communities. Health personnel involved in CS can help in supervising such services. It is time now for the medics to let go the fear that they have of "not being able to trust a non-health worker with contraceptives". The CBD agent can do quality work in CS if only (s)he is properly trained and supervised. The problems that come about due to pregnancy and pregnancy related factors far outweigh the problems that might be brought about by errors which a CBD agent might make in identifying clients suitable for a contraceptive method.

Our infant mortality and maternal mortality rates are still on the higher side. By closing the gap between delay of pregnancy and practice of child spacing which was shown in 1984 FFS (37% of non pregnant women wanted to delay their next pregnancy and 15% desired to prevent further pregnancies). Through use of CBD, we could reduce these uncalled for deaths that occur amongst women of child bearing age (15-49) and young children. Malawi has a fertile soil for CBD programmes if we have to improve the current situation in child spacing services. We need CBD programmes in the country. This is not hard to see.

Role of Physicians and other Health Personnel in CBD Programmes

It is important for a CBD programme to have official support from appropriate authorities, ministries and other organisations. In many situations, there is resistance from medical community to non-medical personnel prescribing. Approval of medical personnel is critical to overcoming such procedural obstacles and to establish linkages for support and referral. This is a vital component of a CBD program. Involving and getting support from local physicians and other health personnel can also help to legitimise the programme within the country.

The Role of National Family Welfare Council of Malawi in CBD Programmes

The National Family Welfare Council (NFWCM) has as its mandate the improvement and expansion of child spacing service delivery in collaboration with other agencies. The

NFWCM is a coordinating agency for all who are involved in provision of child spacing services. It is not at the moment an implementor but an advocate in advancing CS through promotion of positive changes in attitudes and policies in order to increase access to CS services, and to promote suitable government, Council and donor policies with a view to identify more resources for service delivery. The NFWCM, working in collaboration with the MOH, NGO's, private sector agencies and donor partners are developing a comprehensive CBD programme.

The programme proposes the identification, training and deployment of CBD agents in parts of the country and latter expanding the coverage with time and experience. The NFWCM also coordinated and participate in training of trainers of CBD at Malamulo, Thyolo in October 1992. The course was organised by SEATS specialists from Harare and NFWCM used this chance to invite and train participants from other collaborating ministries and organisations (MOH, Nkhoma Hospital, MOWCACS, Project Hope, Malamulo, NFWCM).

Recommendations made to Malawi following study tours and during a CBD managers course include:

- Need to sensitize governmental and non governmental organisations to CBD concept.
- CS services have to be taken to where consumers are. CBD can do this.
- Long distances to clinics deter clients from using child spacing services.
- Our contraceptive mix need to be expanded both in clinics and by CBD agents.
- Cost recovery in child spacing services needs to be introduced in the early stages of the CBD programmes.
- Quality project proposals for donor support should be encouraged.
- Individuals, families, and communities must be encouraged and motivated to have positive attitudes to child spacing and to use child spacing services as much as possible.

CBD Programmes in Zimbabwe and Kenya

In Zimbabwe CBD are the most common source of FP services for rural clients, with referral and back up provided by the rural health centres. The government is the largest provider (of family planning services) and these consist of MOH, municipal clinics, district and rural council clinics. It is estimated that about 1,200 of these facilities provide 44% percent of family planning services, and the Zimbabwe National Family Planning Council serves approximately 30% of current users through CBD and through a net work of 31 fixed and 5 mobile clinics.

The contraceptive prevalence rate has risen from 38.4% in 1984 to 43.1%, and total Fertility Rate is has dropped from 6.5% 1984 to 5.5% in 1989. Knowledge of modern contraceptive methods by women (15-49) has risen from 82.8% in 1984 to 96.3% 1988.

The Zimbabwe CBD programme appears to have already achieved a higher rate of coverage than employer-based services. The aim in expansion is to reduce total fertility rate (TFR) from 5.5% in 1988 to 4.5%. To do this the total number of users of modern methods will have to increase from approximately 486,000 to 781,000, an increase of 294,000 or 60%. Meanwhile Zimbabwe is working to reinforce the already existing CBD other than opening more.

In Kenya the 1992 population is estimated to be 24.5 million people and most (80%) live on 17% of the arable land. Kenya's eligible female population (15-49) for 1992 was estimated to be 5,690,696. In 1989 23.2% of all Kenyan women were using contraceptives (14.7% use modern methods and 8.5% use traditional methods). Periodic abstinence was highest and most commonly used method (7.5%), followed by pill (5.2%). 90% of respondents knew at least one method of family planning and more than 80% of women aged 15-49 years knew where to go for family planning services.

Both these programmes are successful in their own way and achieve this through different approaches. For example one programme uses CBD agents who are salaried and the other uses volunteer CBD agents.

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Community Based Distribution of Child Spacing Methods at Ekwendeni Hospital

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Ekwendeni Hospital is in the Northern Region of Malawi 20 kms west of Mzuzu. The Hospital started static Child Spacing Services in 1986, and in December 1987, information of child spacing (CS) services was carried out to all 9 outreach clinics. Some clients, who were able to attend these services, did so, but some who wished to come failed to do so because of long distances from their home to hospital, and some because they didn't want other people to know they were using the new methods. Sometimes clients had to wait a long time before they were attended to and some clients did not come because their husbands were against the modern methods of contraception.

Because of these problems, Ekwendeni Hospital staff decided to expand the CS services to the rural areas within the catchment area of the Hospital. It was hoped that this would help people understand the project better and let their wives come for the methods. This led to the development of the Ekwendeni Child Spacing Project, which is a collaborative effort between Ekwendeni Hospital and USAID (Funded family Planning Services expansion and technical support project or SEATS). The project started in September 1991 and will continue to June 1994.

The Project is under the supervision of Ekwendeni Hospital Staff and it's main components are:

- Extension of child spacing services into the rural community through a network of village health volunteers providing information, counselling and community-based distribution (CBD) of oral contraceptives, condoms and spermicides.
- Demonstration of a three-tiered child spacing services delivery model (community, clinic/outreach sites, and hospital) which can be replicated elsewhere in Malawi.
- Use of male motivators to educate men and promote acceptance of child spacing in the family and in the community.
- A perinatal/postpartum component which focuses on providing child spacing information and services integrated within the broad range of maternal and child health services.

The main goals of the project are as follows:

- To test a comprehensive model for extending child spacing services in rural communities.
- To train 100 community based distribution agents and 30 male motivators.
- To demonstrate the feasibility of community based distribution of oral contraceptives.
- To generate 4,800 couple years of protection.

Other activities of the project includes the development of: