

a CBD training curriculum; supervision and monitoring mechanisms to assure monthly supervision of CBD agents; a quality assurance action plan for facilitating informed choice, medical monitoring and infection control; and a management information system to monitor service delivery activity and to enable timely planning and decision making.

In 1991 we had the birth of the CBD Programme, in which the community is very much involved. The programme involves men as well as women. These are the male motivators. The impact of the programme is increased because the women and men volunteers are chosen by the community. The community has so far done very well with this programme as they are more free to talk to the CBD's agents than us at the Hospital; male motivators by talking to their male counterparts help them to accept that their wives should start using child spacing methods. Men may be a stumbling block to their wives using child spacing. Even if the wife has been motivated, she will usually first seek consent from her husband. The door-to-door nature of CBD services is appreciated as it allows for more privacy.

The CBD Project has increased the number of new users. There have been 442 new users in the first 6 months. This project looks as if CBD will be very helpful in controlling the rapid population increase and we feel that our goal of increased child spacing may be achieved through CBD. It must be emphasised that frequent supervision and refresher courses are needed to consolidate this CBD programme.

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survey will be conducted to measure to what extent IEF has been able to achieve its stated targets. A copy of the child survival survey report can be obtained from IEF/Blantyre.

Materials and Methods

A questionnaire was developed and tested prior to the survey. Census data was used to create a sampling frame of the district and a 5% probability proportional to size sample was taken to represent children in the district. In each of the 70 clusters 50 children < 72 months of age were randomly selected. Mothers of these children were interviewed. Our results are not representative of all women in Chikwawa District as women without a child < 72 months of age were not included. Women who gave birth to a child that subsequently died would not be included unless there was a live child < 72 months of age. Our results are therefore representative of mothers with children under 6 years of age.

Interviews were conducted by IEF and Ministry of Health health surveillance assistants (HSAs); some of these HSAs were women but most were men. In a few cases (estimated to be about 5%) the husband of the interviewee was present during the interview.

Results

There were 2,173 women interviewed, 15% of whom were literate.

Most women were between the ages of 20 to 29 and only 13% were over 40 years of age. Overall, 31% of women reported that they desired no additional children. This proportion increased as the age of the mother increased (Figure 1). We have no data on the parity of these mothers although it is likely that older mothers will have had more successful births than younger mothers.

Attitudes and Practices Regarding Child Spacing in Chikwawa District

Dr. P. Courtright, Mr. R. M'manga

Introduction

The recent adoption of new child spacing policies and contraceptive guidelines by the Government of Malawi affirms the belief that child spacing and family planning are important factors in the health and welfare of mothers and children in Malawi. Non-governmental organizations (NGOs) who have child survival projects in Malawi welcome the adoption of the new guidelines; they will be used to formulate plans for the introduction of child spacing activities in the areas where some NGOs have child survival projects. The International Eye Foundation (IEF), an NGO with a long history of work in eye care and child survival in Malawi, had not included child spacing as a project activity until recently; IEF's 1992-1995 USAID supported child survival project in Chikwawa District has included child spacing as a project activity starting in 1993. Village health volunteers (VHVs) are the backbone for the delivery of IEF's child survival activities and, over the next year, child spacing activities appropriate for female VHVs will be developed with the Ministry of Health.

As required by USAID, and essential to the establishment of project targets, IEF conducted a baseline survey in April 1992 in Chikwawa District. This survey covered a range of child survival topics, including child spacing. Results from this survey are being used to guide the development of IEF's goals and programme over the three year span of the project. In late 1994 an end-of-project

Desire for No Additional Children
 % of mothers who report that they desire no additional children

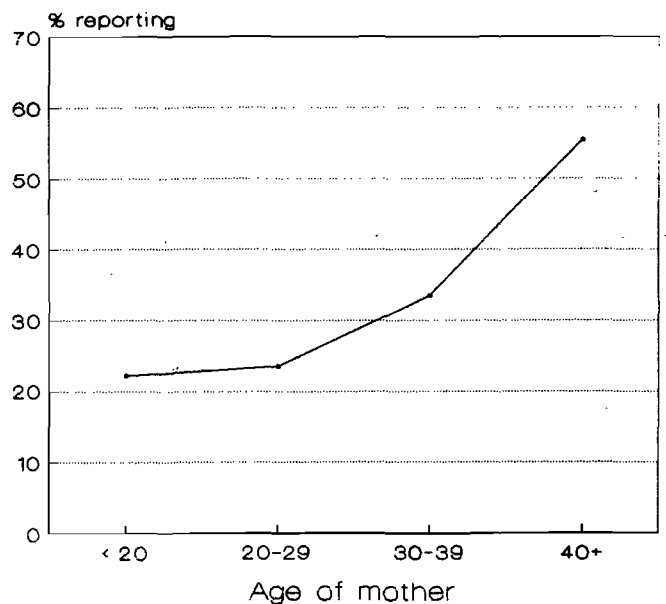


FIGURE 1

Overall, only 19% of the women who desired no additional children had ever sought clinic-based child spacing services. There is significant variation in the use of clinic based child

spacing services between traditional authorities (TA) (Figure 2). It is the authors' impression that the differences in the traditional authorities reflect the level of interest in child spacing activities by the health personnel. In particular, efforts made in TA Chapananga, a rural isolated TA, have been impressive.

Use of Child Spacing Services
% of women not desiring more children who have used child spacing services

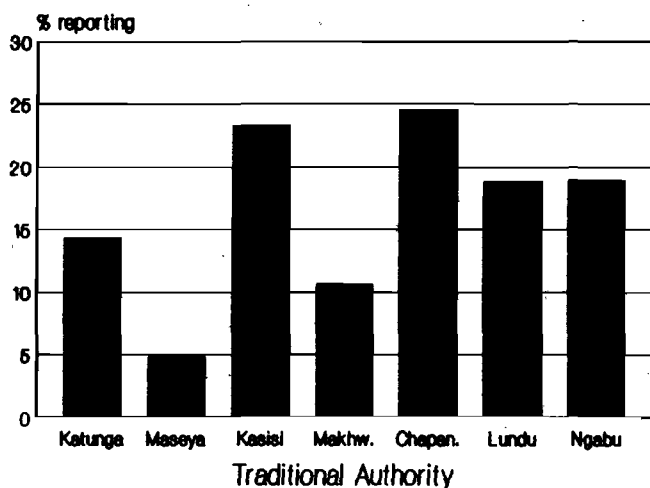


FIGURE 2

The use of clinic based child spacing services also increased with age (Figure 3). These women all state that they want no additional children. It is likely that, although younger women may not desire additional children, their husbands still do. In the previous child spacing policy the approval of the husband was required before women could receive these services. This probably explains why so few young women, reporting that they desire no additional children, have sought child spacing services.

As found in most developing countries literacy is a major contributor to the use of clinic-based child spacing services. In Chikwawa literate mothers were twice as likely to seek child spacing services as illiterate mothers (Table 1).

Table 1 Association between Literacy & Use of Child Spacing Services among Mothers who Desired no Additional Children

Literacy status	Used child spacing services	Did not use child spacing services
Literate	32 (31.1%)	71 (68.9%)
Illiterate	95 (16.9%)	465 (83.0%)

Odds ratio = 2.2 (95% CI 1.3, 3.64) p < 0.001

There was no correlation between births in the last year and the lack of desire for additional children; 46% of women who wanted no additional children had a birth in the last year while 42% of women who stated they wanted additional children had a birth in the last year. There is no statistical difference between these two proportions.

Women were not asked as to the type of child spacing method they favored although condom use was included (for

Use of Child Spacing Services by Age
% of women desiring no additional children who have used services

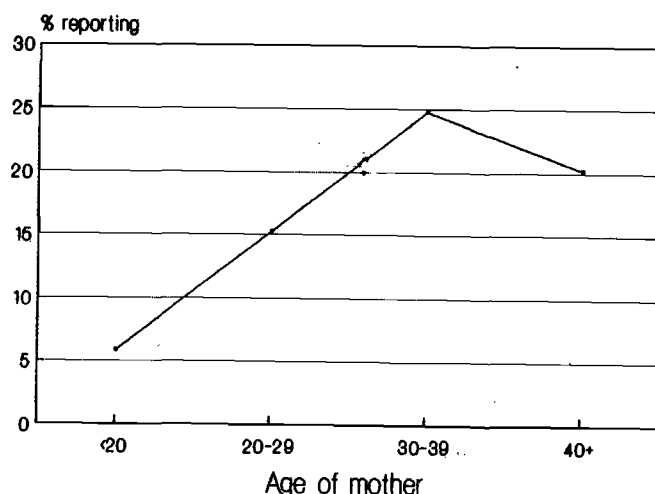


FIGURE 3

the development of AIDS control activities). Overall, only 7% of women reported that their husbands had used a condom in the past year. Condom use was infrequently reported in the rural TAs, especially TA Makhwira and TA Ngabu. Literate women were three times as likely to report condom use than illiterate women (Figure 4).

Condom Use by Age & Literacy
% of women reporting condom use in the last year

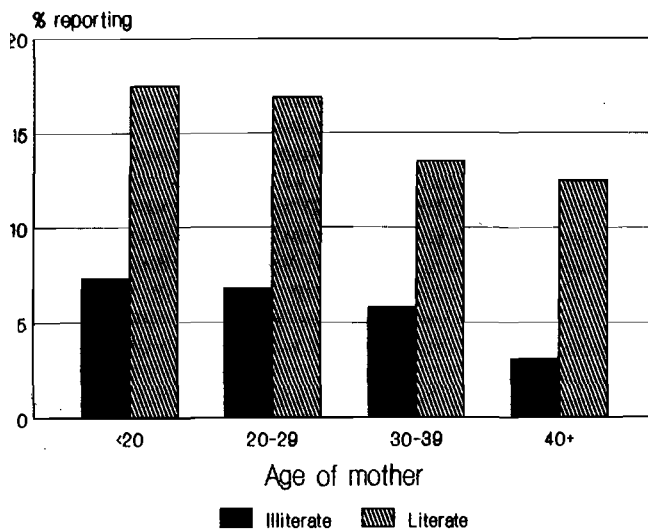


FIGURE 4

Discussion

Our results show that while many women report that they desire no additional children, few have used the clinic-based child spacing services. There are many factors responsible for the disparity between the desire for no additional children and the utilization of available services. We can only hypothesize the relative contribution of these factors in our population.

Literacy appears to be a major contributor and our data confirms findings elsewhere suggesting that as female literacy increases there are subsequent rises in the use of child spacing services.

It is encouraging that health workers in some settings have been particularly successful in their promotion of child spacing activities. It may be helpful to identify what characteristics of their work has contributed to their success. While distance to clinic is likely to be a factor in women's use of services the results from our study suggest that long distance is not a significant barrier to improving the proportion of women using services.

The lack of association between women's desire for no additional children and births in the past year is discouraging. This suggests that there are pressures (desire of the partner, lack of empowerment, and expectations of the extended family) that restrict the use of services by women who would otherwise use them.

Based on these findings the following recommendations have been developed:

1. Female literacy programmes should be expanded and special efforts should be made to ensure that all girls have access to educational opportunities.
2. Health personnel who have been particularly successful in promoting child spacing services should be commended for their work. This will help motivate all health staff to improve child spacing services.
3. Child spacing programmes directed only at women will fail. Programmes must be developed to educate men on the benefits of child spacing and family planning.

Acknowledgement

The IEF would like to thank the MOH/Chikwawa and MOH/Southern Region for their assistance in this survey.

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Attitudes to Child Spacing Amongst Rural Malawian Women

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Introduction

Child spacing is the principle that people should space their children by allowing a time interval of at least two years between live births. Repeated close-spaced pregnancies and heavy family loads put a great strain on a mother's nutritional and physical body resources. The quality of the women's children is also greatly reduced. Child spacing would therefore greatly improve the health of women by enabling them to have children when they are best prepared to have them¹.

The Malawi Government policy is to raise the level of the health of all Malawians via an efficient and relevant health service. To achieve this, the Malawi Government has set out to increase the access of people to modern health services. The emphasis is on the survival of children under 4 years². There is a link between the health and mortality of children and their birth spacing. Malawi has very high levels of child

mortality: 320/1000 live births³. Better child spacing is positively associated with reduced mortality⁴. The health of children is a crucial part of national health and it is apparent that with adequate spacing, children would be able to live a fuller life¹.

Child spacing services are widely available in rural areas at hospital and health centre level. What will determine the use and effectiveness of the clinics are the beneficiaries themselves and their attitudes towards child spacing and child spacing services. An attitude can be defined as an opinion that has an evaluative and emotional component⁵ and is very influential in a person's subsequent behaviour. The aim of this study is to examine the currently prevailing attitudes towards child spacing among village women in one District in Southern Malawi (Mangochi).

During preliminary investigation work for this paper⁶, a few informal discussions with women visiting some clinics made it clear that there was a lack of correlation between what people said they would/should do and what they actually did in practice. The vast majority of women spoken to at Monkey Bay and Nankumba Clinics knew what child spacing was, its advantages and even some of the methods. They had been constantly exposed to messages by radio and at various health meetings. Yet, despite this knowledge, they all admitted that they were not using child spacing methods themselves. Further more, there appeared to have been high drop out rates of child spacing methods at St. Martin's Hospital in Malindi on the shore of Lake Malawi. Between 1988 and October 1991, 101 women, who had begun receiving child spacing services at the hospital, had dropped out. Only 44 had remained active. By October 1991, the drop-out rate had reduced significantly, but still existed. The widespread failure rate of child spacing campaigns in rural society can be attributed in large part to insufficient awareness by programme administrators of the way of life and traditional attitudes - particularly attitudes to children - of the community involved. The preliminary investigation by Bandawe described above, served to fuel the need for a survey of attitudes towards child spacing amongst rural people.

Methods

Well established methodologies already exist for assessing needs, values, attitudes and other aspects of subjective experience. The pictorial projective technique was chosen as the form of assessment strategy. Liggett⁷ argues that this strategy can make a significant contribution to many of the developmental problems of the Developing World. The projective technique has been used in Sri Lanka, India, Malaysia and Indonesia and was used for the present study in Malawi. It is argued very strongly by Liggett⁷ that the technique uses wide ranging, open ended instruments to catch in a broad sweep the most salient attitudes, motivations and preoccupations of the particular community. It also provides the opportunity for insights into aspects not thought of by the researcher, thus avoiding investigators' preconceptions which might be exhibited in a questionnaire. The pictures can hold the attention of the respondent. Since there is no pressure to give the correct answer, a rich crop of ideas can emerge. Hence projective techniques facilitate "the free expression of ideas, speculations, doubts, and difficulties in terms which are familiar and significant to the respondent." Respondents do not feel threatened by intrusion into their private lives since the disclosures made are given in regard to the subject in the picture. It is the nature of these personal feelings which the study is trying to discover.

Results

The study was carried out in Mangochi District in various child spacing clinics. Mangochi was chosen because it is representative of most rural living patterns in Malawi, has low average age at marriage (16.5 years), high total fertility (7.1) and strong traditional beliefs.