Kulera". It was at this time that they first became aware of the need for child spacing and other related women's health needs amongst Mozambican refugee communities in Malawi. While the Malawi Government, through the Ministry of Health, and supporting international NGOs, including UNHCR, are doing highly commendable work in meeting the health needs of the refugees there are still other areas in health provision which need further input and support. One such area is improvement of women's health through provision of contraception. MSI came into Malawi to help meet this identified need.

Project Objectives

The overall goal of this project is:-

- To extend the health benefits of child spacing to the refugee communities of Malawi by providing the necessary information, education and services.

The working objectives are as follows:-

- To establish a coordinated working relationship with the community of refugees and other relief agencies.
- To build a child spacing based women's preventive health service programme to serve the un-met needs of the fertile in the refugee areas.
- To provide child spacing information, education and services for refugee and Malawian couples in the refugee impacted areas.
- To work with volunteers from the communities served to ensure the programme is culturally appropriate to their needs, fully integrated and sustainable.
- To provide the recruited displaced or other persons employed and volunteers participating in the programme with training and technical assistance in support of activities in line with the project's overall objective.

Implementation

The programme is being developed through a series of modules consisting of the following components:

- Two Family Health Centres
- A family Health outreach service to other clinics
- Family Health Outreach Workers (FHOW) in the communities served.

The MSI clinics provide elementary family health care including Maternal and Child Health (MCH) and the full menu of child spacing services to meet the preventive medical and family health needs of the women in each of the target communities at the greatest risk of pregnancy, STDs and AIDS. MSI has opened two clinics: one at Nyamithuthu in Nsanje district and one at Chimoto in Dedza district.

Service Acceptance

This programme is evaluated in terms of output based on caseload - that is clients seen by the programme. This paper will not discuss the programme's performance since our clinics have been operational for ten months only. However initial performance trends are very encouraging.

We are working hard to increase child spacing service uptake beyond the national figure of about 4% in our operational areas. We are steadily achieving this by satisfying our customer needs. This is achieved by tuning the process of education, motivation and supply of services. Both the repeat visits and the number of new clients have been going up steadily over the months. One crucial ingredient of our entire programme is that it is geared towards meeting the needs of the clients rather than anything else.

Conclusion

It is the policy of MSI worldwide to charge a small cost recovery fee for the services provided. In rare circumstances these fees have been waived particularly where the "client" while in need of the service but cannot afford to pay for it. In Malawi our services are available at no cost at all. The rationale is that the Mozambican refugee community who are the main target for our services have no meaningful income to enable them pay for child spacing services.

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Contraception and the Adolescent: Our Experience at the Blantyre Adventist Hospital

Dr. R. Mataya

The initiation of sexual intercourse during adolescence seems now to be the rule rather than the exception. The scene is painfully repeated where a parent brings in a teenage daughter pregnant. The teenager is often distressed and the parent very angry and wondering what she or he had done to deserve such an outcome in their good daughter's life. We have taken it upon ourselves to counsel with both parents and child separately at first and then together.

Because all our patients come after they have become pregnant, contraception counselling is done after they have delivered. This is the most difficult time for both parent and child as there is often the denial of the fact that their child is sexually active inspite of the evident outcome, and the fear of what she will do to either stop having sex all together or prevent getting pregnant the next time.

Doctors must be sensitive to the fears and needs of adolescents, because what happens in the consultation will affect their future use, misuse or non-use of methods. They may appear confident, but are usually ignorant, and often ambivalent about their sexual behaviour, and in need of counselling not only of a contraceptive methods.

We have tried to sensitise the parents on their daughter's behaviour. This is often the most difficult part as their seems to be a cultural denial of a daughter's behaviour. Our society has not yet become as open as Western society where daughters will confide in their parents about their sexual behaviour. Often the parents will tell us that if they allow their child to use any form of contraception it is condoning promiscuity. Girls who presented at our clinic had been sexually active from puberty with more than one partner. One girl had delivered two children both of whom are being looked after by her parents. This seems like a satisfactory arrangement for them since they refuse their daughter to be on any form of contraception.

Counselling should include consideration of the risks and consequences of early and promiscuous sexual activity. The patient should be talked to in a professional way so that she is not uncomfortable. If they are uncomfortable, they will be deterred from returning, but not from having intercourse. Encouragement for responsible behaviour, confidentially, reassurance regarding fears about methods, and clear instructions about their use will go a long way to ensuring effective compliance. Our counselling has been done following delivery or abortion. It is unfortunate that we do not see adolescents alone or with their parents for sexual counselling before such a devastating event has taken place.

Ignorance and fear of parental censure are two most powerful deterrents to their use of contraception. This is where it is important to get both parents involved early in the pregnancy or immediately after an abortion. One parent asked us if there was any drug to suppress sexual desire rather than for their

daughter to be on some form of contraception. Our experience has shown that oral contraceptives are not suited to sporadic teenage sexual behaviour nor their disorganised lifestyle, therefore injectables are more appropriate. Concomitant use of condoms is advisable to protect the cervix and prevent transmissions of STDs. IUCDs may be considered for parous teenagers in a stable relationship if they are unhappy about other methods. Postpartum or postabortal contraception offers crisis intervention and an opportunity to make medical methods more accessible and acceptable.

Studies have shown that provision of contraceptives for teenagers does not encourage or facilitate sexual activity or make the sex urge powerful, but it does prevent the physical and psychological effects of pregnancy.

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Zimbabwe: A Family Planning Profile

Dr. S. Manjanja

History of Family Planning in Zimbabwe

In 1953 Family Planning Services first became available. In 1965 the Rhodesia Family Planning Association (FPA) was formed and 1966 contraceptives were distributed through clinics and hospitals. In 1967 the first "field educators" were trained and in 1972 the first community based distributors were trained. In 1981 the FPA integrated into Ministry of Health and in 1985 the FPA was made a parastatal and renamed Zimbabwe National Family Planning Council (ZNFPC).

ZNFPC Services

There are 37 Family Planning Clinics which distribute oral contraceptives, condoms, intrauterine Devices (IUCD), and injectables. There are Referral Units in Harare and Bulawayo where, in addition to the above, tubal ligation, vasectomy and infertility counselling and investigation is done.

The Community Based Distributor

There are 700 distributors nationally. They are selected from the community and undertake a 6 week training course. Their function is to educate, motivate and screen clients for oral contraceptives.

The distributors role is to provide a regular supply of oral contraceptives, to refer clients to clinics and to monitor blood pressure and side effects.

CBD domiciliary visits take place by bicycle and the group leader has access to a motorcycle. The median number of clients seen by each distributor is 135 per month. These are mostly revisits with a few new clients.

Source and Use of Family Planning Services

Details from the Zimbabwe Demographic and Health Survey in 1988 show the following provision of Family Planning services in Zimbabwe:

25.3%	CBDs
19.1%	Local/Municipal Clinics
14.8%	MOH Facilities
13.7%	ZNFPC Clinics
2.3%	Private Doctors/Pharmacies

The Zimbabwe Reproductive Health Survey in 1984 showed that 2 out of 3 ever-in-union women had ever used contraception. 1 out of 2 ever-in-union women had experience with a modern method of contraception.

38% of currently-in-union women were practising family planning. This figure increased to 43% by 1988. 27% of currently-in-union women were relying on a modern method and by 1988 this was 36%. The pill was the most commonly adopted method. Withdrawal was the next most favoured method.

Problems/challenges facing the Family Planning Programme

The fertility decline in Zimbabwe has been slow despite increased contraceptive prevalence. There is still an "un-met need" for family planning. The heavy reliance on oral contraceptives (86% of users) may not be ideal and the issue of contraception for adolescents needs to be addressed. Other issues to consider are dealing with failures of contraception and the problems posed by HIV infection and AIDS. Logistics of supplies and equipment remains a problem with 60% of CBDs having no sphygmomanometer and 60% of clinics having no steriliser.

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