The programme has the blessing of the Ministry of Health who have provided guidance and assistance since its inception. Apart from the clearance, the Ministry offers condoms for the programme through the Regional Health Office.

Project Accomplishments

The Man to Man programme, since its inception in 1990 has headed a multi-disciplinary material development workshop, held two managers' seminars, produced promotional material, distributed > 200,000 condoms, completed programmes in more than 30 companies and provided health education to some 15,000 men, who have attended regular sessions. It has also held a social soccer tournament and received training requests from organisations that wish to have their staff oriented to the male involvement approach.

The Concept of Male Involvement

Through the experience gained through the Man-to-Man programme, male involvement has the following basic aspects:

- Initiation of dialogue on child spacing within the family
- Collaboration with spouse/partner in the choice of a child spacing method.
- Support and encouragement for a partner/spouse who is on a method.
- Being receptive and supportive by allowing their partners to practice child spacing.
- Use of any of the male methods available - the condom or vasectomy.

It must be understood that the idea is not to have men coerce their spouses to adopt child spacing, but rather to support them. The women are already for child spacing, but it would help if men were aware and more supportive.

It has been learnt that men are interested in child spacing, but they are worried that they are not involved. They have a lot of questions, doubts and beliefs about child spacing which have hitherto not been addressed. They would easily support child spacing and the requisite social responsibility if they have accurate information and they appreciate the social and economic implications of child spacing.

It is also been found that health educators may be either male or female. They should however, be desensitised and prepared to act as facilitators rather than teachers during health talks. The language used in health talks must conform to local jargon to avoid offending participants. Child spacing is not new, and hence older audience members may be able to throw some light on traditional methods, which would be the basis for the Facilitator to build on.

While many argue that Malawian men cannot accept vasectomy very few admit that these men have not been given access to information; they are not motivated and that even if they were it might be difficult to find a motivated surgeon to do the operation.

The Future

There is great scope for involving men in child spacing in Malawi. Organisations other than BLM will need to get involved. Government will now train male child spacing providers who can be encouraged to motivate fellow men.

Some MCH clinics, even public ones, are also beginning to pay attention to needs of men. A thorough orientation for staff is however required to get them prepared for the challenge. It doesn't have to be a specific programme addressing concerns for men. All service providers should learn to be more sensitive to needs of men.

The recognition of the influential position of men in the family is likely to create goodwill on which other programmes can be built.

The ever increasing list of companies interested in the programme justifies its expansion to other areas. A lot of information has been gained, which can be utilised for future programmes. With the publicity of "Man to Man" in the mass media, many people have come to know of Banja La Mtsogolo, which is also good for the extension of the programme and the child spacing cause.

Conclusion

Male involvement remains a new initiative. But one thing is clear that this is probably the way to go if joint decision making in child spacing is going to succeed. Some attitudes both among the men themselves and the service providers must change so that men feel that child spacing is also their concern and service providers feel men are not outsiders. Male medical staff should in particular pick up the challenge to start talking to their fellow men about these issues. "We should be talking man to man". Malawian men once participated in child spacing, they could still do so today if only they are informed and motivated.

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Marie Stopes International Child Spacing Clinics in Malawi

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Background

Marie Stopes International (MSI) is a UK based charitable organisation. It came into being nearly 20 years ago to build on the pioneering work of Marie Stopes in caring for women in the poor communities of London by extending the benefits of such care to families around the world. The aim of MSI is to improve the quality of lives of women, their families and their environment.

MSI is achieving this objective through implementing compassionate child spacing and health care programmes throughout the developing world and in Europe. The recent debate concerning the inclusion of population on the agenda for the Earth Summit in Brazil has promoted lively discussion about population and related issues. The United Nations has stressed that educating women and giving them access to health care and child spacing services is key to preventing the economic and ecological catastrophe which will result from massive population growth.

For those of us who have been championing this cause for many years it is very gratifying that the value of family planning to maternal and child health is now receiving the public recognition it deserves.

However, about 300 million couples in the developing world still do not have access to family planning and this figure is rising by the year. MSI is working to provide family health services to help satisfy this un-met need.

Marie Stopes International (MSI) in Malawi

Marie Stopes International first become involved in Malawi in 1987 when they were contracted by the Malawi Government's Ministry of Health to do a film on child spacing "Phindu La

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 coordihated 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