PN-AAT-316

MALAWI IBRD POPULATION SECTOR STUDY

October 8 - 21, 1984

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I. GOVERNMENT AND NON-GOVERNMENT CHILD SPACING ACTIVITIES

A. Overview of Maternal Child Health Care

The current National Health Plan (1977-1988) includes substantial emphasis on Maternal Child Health (MCH). Long range objectives include: a) lowering fetal, infant and childhood morbidity and mortality; b) improving the physical, mental and intellectual development of children; c) providing secure lives and health for mothers and children; and, d) enhancing family life.

To achieve these broad objectives, in 1973 the Ministry of Health (MOH) developed a Minimum Plan or Mini-Plan which outlined specific MCH activities to be incorporated in the program. These included establishing under-five clinics, antenatal clinics, an expanded program for immunization (EPI) and health education. At the same time, an MCH Department within the MOH was established and MCH Supervisors were appointed for each of the country's three regions to monitor MCH activities. These supervisors are assisted by District MCH Coordinators. Regional EPI/TB personnel also assist by handling the maintenance of cold chain vaccines and equipment. At present, MCH services include nutrition surveillance, immunization, health education, antenatal care, delivery, postnatal care and identification and referral of high risk pregnancies.

Targets for coverage were included in the Mini-Plan and within a relatively short period, many of the targets were being met. For example, the number of static and outreach under-five clinics increased from 848 in 1978 to 1,157 in 1983. As part of the under-five program, a relatively high

coverage for measles and BCG was reported and in October 1982, an evaluation of the National EPI Campaign (Joint MOH/WHO/DANIDA/Save the Children - EPI Evaluation) confirmed that 65-70% of children received measles vaccine and 86-87% of the target population received BCG. Progress has also been made in maternal care and the number of antenatal clinics increased from 212 in 1978 to 750 in 1983 with at least 66 percent of pregnant women attending a clinic for at least one antenatal visit.

However, despite some impressive results in MCH care, child mortality has not decreased substantially. High prevalence of both undernutrition and malnutrition are also reported, especially for the 0-4 population. An estimated 15.3% of under-ones and 31.4% of 1-4 year olds at clinics are currently being registered as underweight. (1982 MOH Statistical Reference Document - First attendance data registered at under fives clinics in 1982). Unregulated fertility, resulting in short birth intervals and early weaning, is another associated factor in continued high infant and child mortality rates. Infact recent UNICEF/WHO survey team reported that due to high multiparity, poor nutritional status of children and the lack of the knowledge and means to delay pregnancy, they would recommend that child spacing be considered a high priority in the overall MCH program.

B. Interest in Child Spacing

In 1981 the MOH organized a workshop on Health and the Family, which examined current MCH activities and made recommendations on how to improve health services for mothers and children. Recommendations included the need to institute a school health program, conduct research on infertility and introduce postnatal and child spacing services. In 1982, after

studying the recommendations of the workshop, the government decided to include child spacing services within the MCH Program. Child spacing would be made available through the health care system, strictly within the integrated context of MCH Care. At the recent International Population Conference in Mexico, the Honorable Minister of Health stated, that "the overall goal of the Child Spacing Program is to reduce maternal morbidity and mortality by allowing the mother to rest between pregnancies and to reduce infant and child mortality and morbidity". The government has further stated that introducing child spacing services does not interfere with the right of the family to have as many children as they wish and is not a tool of population control.

In response to government approval, a two year Child Spacing Operational Plan (1983-1984) was developed to outline training, education, service and research requirements of the program. In 1983, as part of a comprehensive health project, IBRD approved .9 million US Dollars to help initiate the Child Spacing Program. Activities included support for renovation of facilities at one central and 15 district hospitals including the provision of equipment and furniture. Monies and technical assistance for training and a Family Formation Survey were also included. A UNFPA Representative recently arrived in country to help coordinate child spacing activities. USAID has also provided limited support for contraceptive supplies and training and recently approved a Health Institutions Project which will support a fairly large scale training program for mid-level health workers in integrated MCH and child spacing services.

C. Initial Child Spacing Program Activities

Once the decision was made to include child spacing as part of the integrated MCH program, a National Child Spacing Coordinating Committee was developed. Committee members include MOH and other medical representatives along with the UNFPA Coordinator. The group is responsible for planning and implementing the Child Spacing Program. A three year Child Spacing Program Plan was developed which includes the following objectives:

a) Training all health workers in child spacing;

b) Community education of local leaders and couples in clinics;

c) Provision of child spacing services as an integral part of MCH care; and

d) Promotion of applied and clinical research activities in child spacing and related areas such as infertility and fertility.

In 1982-83, USAID and UNFPA provided assistance for out of country training of nurses in child Spacing. To date, over 15 have been trained and upon return, many began providing services. One problem that needs to be resolved prior to any widespread effort to train nurses in child spacing is the current confusion over whether or not nurses are permitted to perform these skills. The present stance of the Nursing Council is that oral contraceptives are prescription drugs

which nurses are not allowed to dispense and that IUD insertion is a medical procedure to be performed only by doctors. Already, it has been reported that some hospital pharmacists are reluctant to release contraceptive supplies to trained nurses until their role in child spacing is clear. Many countries have had to review and modify existing policies to enable nurses to provide services. The MOH and Nurses Council should review the current policy and in light of the new program, make the necessary changes. The development of a child spacing procedure manual is also needed to guide service providers in what to do, how to identify complications and when to refer clients.

The three central/general hospitals have been providing child spacing for a little over one year. Even though there has been no official promotion, with the opening of clinics in urban areas, the number of clients has been increasing dramatically. For example, Queen Elizabeth Hospital reported 223 users in October 1983 and in September 1984 the monthly total was 771 users, or over a 350% increase in users in one year (see Chart I). For the three main hospitals providing services, 2,648 users were reported for the six month period between April - September 1984 (See Chart II). Quite surprising is the fact that IUDS seem to be a popular method with 38 percent of all reported users within the last six month selecting this method. However this is variable, as Queen Elizabeth reported 20 percent (96) using IUDs whereas Zomba reported 55 percent (489). It is not known if IUD method selection is due to provider preference, availability or non-availability of supplies or a preference by users. Staff at Queen Elizabeth and Zomba Hospitals both expressed the need to conduct studies on the profile of child spacing clients.

Chart I

Number of New and Continuing Child Spacing Users Per Month at Queen Elizabeth Hospital - Blantyre

	1983	1984
October	223	
November	311	
December	495	
January		469
February		601
March		530
April		576
May		632
June		610
July		661
August		792
September		771

Source:
Clinic Records at Queen Elizabeth Hospital, Blantyre, October 1984.

CHART II

CUMULATIVE TOTAL OF NEW AND CONTINUING CONTRACEPTIVE USERS
BY METHOD IN THREE MALAWI HOSPITALS
APRIL - SEPTEMBER 1984
(6 Month Period)

Method	KCH	(%)	QE	(%)	Zomba	(%)	Total	(%)
Oral Contraceptives	479	(59)	771	(80)	413	(45)	1,663	(61)
IUD	336	(41)	196	(20)	489	(55)	1,021	(38)
Injectable	-0-		-0-		-0-		-0-	
Total	815		967		902		2,648	

KCH = Kamuzu Central Hospital, Lilongwe
QE = Queen Elizabeth Hospital, Blantyre
Zomba = Zomba General Hospital

Source : Service Statistics Reported by:
Mrs. R. Chinyama, MOH
Dr. S. Darfoor, UNFPA/MOH
Mrs. L. Phiri, QE Blantyre
October 10, 1984

Forms to collect information on child spacing users are being developed. Like most other countries in the region, with the recent exception of Zimbabwe, Malawi has started collecting information by calculating number of visits by method rather than the number of users. One of the early program needs will be to design a simple data collection and record system that can be used by both government and PHAM facilities

A shortage of contraceptive supplies has already created problems. Small quantities of supplies have been ordered randomily from FPIA. A complete list of contraceptives supplied by USAID can be found in Chart III. The two most popular contraceptives, Noriday and Lippes Loop IUD Size B, are completely out of stock. Charts IV and V show supplies currently in stock, average monthly distribution for the past eight months and projected supply requirements. As can be seen, except for condoms, Central Medical Stores (CMS) has less than one month's supply left in stock. Based upon emergency requests, two shipments of supplies have been sent by FPIA (Chart VI) which should alleviate this immediate supply problem. Clearly, as the program is planning a country wide expansion over the next three years, adequate supplies and buffer stocks will have to be ordered with assurances that a logistics and distribution system is in place. Requirements for 1985 were calculated based on the distribution patterns and 10% increase in usage. (See Charts VII and VIII).

Central Medical Stores (CMS) is currently handling storage and distribution of contraceptive supplies. They clear supplies through customs, store and distribute to government and mission health facilities. Commodities are ordered at Ministry of Health headquarters in Lilongwe however, there is little if any, communication between the two groups on what has been ordered, received or distributed. If CMS is expected to handle contraceptive supplies, they must be made aware of what has been ordered, from whom and expected dates of arrival. The CMS should also be contacted before the MOH places orders to determine current stock levels, usage patterns and issue points. Each service delivery point that offers services should also be aware of what supplies are available and how and when to order.

CHART III

USAID PROVIDED CONTRACEPTIVES TO MALAWI

1981 - 1984 (THREE YEAR PERIOD)

Date	Recipient	Oral Contraceptives			IUDS		Condoms	Foam/Jelly	Other
		Noriday	Norminest	Total	(all sizes)				
Oct. 81	Central Medical Stores				2,000	(500 B) (1,000 C) (500 D)			
June 82	Central Medical Stores	5,400 cycles	10,200 cycles	15,600					
March 83	Central Medical Stores	19,600 cycles	23,600 cycles	43,200	1,500	(500 B) (500 C) (500 D)			
April 83	Central Medical Stores	14,000 cycles	15,600 cycles	29,600					
May 83	Central Medical Stores	30,000 cycles	15,600 cycles	45,600			12,000		
June 83	Adventist Health Service Center Blantyre	16,800 cycles	8,400 cycles	25,200			125,000	1152/2268	1,000 pair gloves
Sept. 83	Queen Elizabeth Hospital	12,000 cycles		12,000			2,000		
July 84	Central Medical Stores				1,200	(600 C) (600 D)			
	Total	97,800 cycles	73,400 cycles	171,200	4,700	(1,000 B) (2,100 C) (1,600) D	139,000	3,420	1,000

October 1984

CHART IV

CONTRACEPTIVE USAGE
BY STOCK LEVELS IN CENTRAL MEDICAL STORES
AND REPORTED STATISTICS ON USERS
FEBRUARY - OCTOBER 1984
(8 Month Period)

Method	Stocks Distributed from CMS	Average Monthly Distribution	Currently in Stock	One year Amount needed According to Distribution from CMS	One Year Amount needed According to Reported Users in Clinics
Norminest	17,900	2,238	-0-	29,094	
Noriday	26,800	3,350	3,200	43,550	
				TOT 72,644	22,000
Lippes Loops	1,400	175	* B -0- C 400 D -0-	2,100	2,042
Condoms 55 mm colored	5,100	638	6,900	7,656	N/A

* No data available on Lippes Loops size B in CMS

CHART V

STATUS OF CONTRACEPTIVE SUPPLIES AT CENTRAL MEDICAL STORES
FEBRUARY - OCTOBER 1984
(8 Month Period)

Method	Last Quantity Received	Date	Quantity in Stock	Quantity Distributed
Oral Contraceptives	(Carryover 2900)			
Norminest	15,000	5-8-84	-0-	17,900
Noriday	30,000	5-8-84	3,200	26,800
*IUD				
Size C	600	7-10-84	400	800
Size D	600	7-10-84	-0-	600
Condoms	12,000	7-19-84	6,900	5,100
Injectables	2,000	7-4-84	-0-	2,000

* No data available on Size B

Source: Mr. Phiri, October 13, 1984,
Central Medical Stores, Blantyre.

CHART VI

USAID CONTRACEPTIVES SENT TO MALAWI
BY FPIA

Method	Oct 12, 1984	Oct 15, 1984	Total Shipped
Noriday	90,000	30,000	120,000
Norminest	30,000	30,000	60,000
CU-T		600	600
Lippes Loops			
Size B	500	5,000	5,500
Size C	300	5,000	5,300
Size D	1,300	10,000	11,300
Condoms	36,000	6,000	42,000
(colored 52 mm)		10,000	10,000
Foam with Applicators			2,268
Jelly with Applicators	2,268		
Diaphragms			
Size 65	48		48
Size 70	96		96
Size 75	144		144
Size 80	144		144
Size 85	96		96
Medical Kit No. 6 (IUD Insertion)	25		25
Medical Kit No. 3 (IUD Back-up)	25		25
Gloves (Several Dozen)			

CHART VII

* CALCULATION OF

1985 CONTRACEPTIVE REQUIREMENTS FOR MALAWI

Method	Amount Required	10% Increase	One Year Buffer Stock	Total Amount Required
Orals	72,644 cycles	7,264 cycles	72,644 cycles	152,552 cycles
IUDS	2,100 units	210 units	2,100 units	4,410 units
Condoms	7,656 pieces	765 pieces	7,656 pieces	16,077 pieces

*Based on previous year supply distribution pattern, a 10% increase in usage plus a one year buffer stock

CHART VIII

MALAWI
USAID CONTRACEPTIVE AND EQUIPMENT REQUIREMENTS
1985

Femenal	20,000 cycles
Lo-Femenal	132,552 cycles
*Lippes Loops	
Size B	2,200
Size C	2,200
Size D	4,400
*Condoms	
colored 52mm	33,000 pieces
Foaming Tablets	5,000
Diaphragms	
Size 65	48
Size 70	96
Size 75	144
Size 80	144
Size 85	96
Medical Kit No. 6 (IUD Insertion)	27
Medical Kit No. 3 (IUD Back-up)	27
Medical Kit No. 1 (Mini-Lap)	6

* Due to anticipated increase in use of these methods in 1985, amount required has been doubled.

There is another storage and distribution system apart from the CMS, which stores and distributes MCH UNICEF donated drugs. Infact, contraceptives are the only donated drug that CMS handles, at present. When determining the most appropriate system for handling contraceptives for the program, a complete review and analysis should be done of both systems to determine the one most preferable for handling supplies for the Child Spacing Program.

D. Child Spacing Program Plan

As mentioned previously, a Child Spacing Plan of Action has been developed covering the period 1985-1987. While still in draft form, the plan attempts to establish uniform training, education, service and research requirements. Activities are planned in a phased approach, starting with hospitals and working down to health centers and dispensaries. Three phases have been outlined, each covering a period of one year. Each phase includes training outputs and number of clients served. While the draft plan is a first attempt at developing the Child Spacing Program, the following are suggestions that could make the plan more complete, clearer and easier to operationalize.

1. The plan should include a clear statement on government policy toward child spacing including the overall goal and objectives of the program.

2. The plan should also describe the role of the coordinating committee and clarify who is responsible for what activity including how child spacing activities are organized within the MOH.

3. Child spacing is a service that is being added to the Ministry MCH Program. Current issues in health care, such as staffing shortages and the need for closer coordination with Mission health care programs, should be mentioned along with ways for working within existing constraints.

4. Health activities of PHAM and Ministry of Local Government should be incorporated into Child Spacing Plan. Representatives from these groups should participate on the National Coordinating Committee.

5. Community Education activities described in the plan are extremely important. A thorough needs assessment of current information, education and communication (IEC) activities and capabilities needs to be performed prior to initiating any activity. Public orientation programs and client educational sessions mentioned in the plan are only two IEC areas that should be explored. The results of the Family Formation Survey and simple focus group research techniques could give important insights into knowledge and attitudes of the community towards family size, child spacing, and fertility. With this information, a multi-media IEC strategy with targets for special audiences should be developed.

6. To date, most activity has taken place in the area of training. A number of participants have gone for out of country training and in 1985, master trainers will be trained who in turn will be responsible for setting up three in-country clinical training centers. Over the next five years it is planned that each of the 24

districts will have a training center. While all centers may not include clinical/service delivery training, according to the plan, some will. The advisability of developing so many training centers should be determined and justified. The following should be kept in mind:

a) Clinical training sites are hard to establish. Clinical space and a large volume of clients are required in order for each student to receive the clinical exposure needed to gain clinical competency in all skills.

b) Until additional space is made available (either through planned expansions or designation of additional clinic space) not any of the three major hospitals have adequate space to conduct clinical training with classes of more than 2 or 3 candidates.

c) All three training centers should not be established at the same time. One clinical training site should be opened to test the training skills of new trainers and the new curriculum. Once sufficient experience is gained, additional training sites can be developed.

d) It is not enough say one will be trained in service delivery, motivation or management. All training activities should clearly state the exact skills that are being taught and what the trainee is expected to do as a result of the training (i.e competency based training).

e) It may not be advisable, as mentioned in the Plan, to train Medical Officers, Clinical Officers and Nurse/Midwives in the same course unless they will all be expected to perform the same skills. Experience from other countries like Kenya, have shown that except for perhaps surgical services, Medical Officers and Clinical Officers will not be providing routine child spacing on a daily basis. They usually only handle referrals for complications. Their training should include an overview of child spacing and focus on management of complications.

f) Those who will be primary service providers (eg Nurses) should receive high priority for training. It has been found in countries like Uganda, that for Nurses with no previous skills, a minimum of six weeks is needed for clinical training. Also, the minimum standards for clinical competency in IUD insertion is 15 insertions.

g) If opening a number of training centers is planned, then an inventory is needed of existing training facilities, training loads, staff and accommodation, equipment and materials capabilities.

7. The next area mentioned in the plan is the organization of services, which states that once trained, personnel will provide services. In addition to the training of personnel, the following should be considered in establishing a network of child spacing service delivery points (SDP) throughout the country:

a) An inventory of existing facilities, equipment and space should be done. What is needed before starting child spacing services?

b) While supplies are mentioned, the plan does not mention the need for a reliable source of supplies and distribution system. Included here should be the need for a simple record-keeping system to track users and supplies through the program. This is a fairly urgent problem. A short term consultant is needed to help forecast supply needs and set up the distribution system.

c) The existing staffing patterns of service delivery points(SDP's) should be determined, including a functional job analyses of existing workers. Targets for training workers and initiating services in SDP's should be included in the plan. The number of SDP's is unclear as is the number in need of training.

d) The training and orientation of Medical Officers and Clinical Officers should be included. This would include management of complications and training in tubal ligation.

e) Plans for extending child spacing information and services beyond the clinic level should be described. While it is important to establish services within clinic sites first, TBA's and HSA's could certainly be trained in child spacing information and motivation fairly early in the program.

8. The last section in the plan discusses research. This section needs to be developed, as it currently only includes a list of research activities. What will take place and who will be responsible for conducting evaluation and research activities should be outlined.

In Summary, the MOH and National Child Spacing Coordinating Committee have developed a draft three year Child Spacing Plan of Action. It is a good start, however the plan needs to include the overall goal of the program including objectives and targets. The IEC section needs to include a wide range of Multi-Media Strategies and there is the need to rethink the present strategy for training. Important areas and plans for facilities, equipment and supplies need to be spelled out. The targets for number of SDP's to be reached, numbers trained and/or couples reached is unclear. Research and evaluation while mentioned, needs to be developed into activities.

Last, an implementation plan and budget is also needed. As the MOH is currently finalizing it's National Health Plan, it is recommended that the Child Spacing Program Plan be expanded from three to at least five years and be included in the larger health plan, which at present does not mention child spacing.

E. Staffing Constraints

Any new health care program, such as the introduction of child spacing services will be affected by the existing shortage of MOH staff. In 1980, 50% of the technical posts in the MOH were vacant and over half of the districts lacked a

Medical Officer. Adding additional responsibilities such as child spacing will put an added strain on existing staff, especially at district levels. The expansion of outreach is also limited by staffing constraints. Only 27% of Health Sub-Centers have more than one Enrolled Nurse Midwife and of the existing 337 Sub-Centers, 35% are dispensaries (75 percent having no Nurse Midwife) and 16% are maternities. (MSH/MOH C-1 p10). Even if it were possible to increase the number of manpower trained, staffing in rural areas will continue to be restricted due to recurrent costs of salaries and shortage of staff housing.

A staffing assessment should be done to inventory and analyze the numbers and functions of present personnel, and determine future staffing and training requirements, taking into consideration the needs of the Child Spacing Program. The USAID funded Health Institutions Project will address some of the manpower training needs by developing and implementing in-service training programs for mid-level workers in Primary Health Care and improving the capability of the MOH to train these workers. However, the real need is to conduct a functional staffing analysis, which includes determining existing and projected numbers of personnel needed and the responsibilities each will have. Once this information is known, both basic educational and in-service training programs can be modified or developed.

Plans for the development of the child spacing program will need to address the current health personnel constraints and include simple ways to teach skills that can be readily applied in the clinical area.

F. Traditional Birth Attendants and Health Serveillance Assistants

In 1978, the MOH began training Traditional Birth Attendants (TBA's) on a Pilot basis in three districts. An evaluation conducted in 1980 recommended that the training program continue and by the end of 1982, all 24 districts had trained at least 10 TBA's. To date, 367 have been trained. Public Health Nurses are responsible for training which takes place at district levels. It has been reported that the number of TBA referrals to health centers and hospitals has increased since the training, and that in some cases, TBA's have reported an increase in the number of deliveries they perform. However, a recent WHO/UNICEF evaluation reported the need to strengthen the links between TBA's and the nearest health center both in terms of training and supervision. It was also noted that follow-up has been weak due to difficulties in mobilizing female MOH staff to travel to villages and partly because MOH field staff have not been fully involved in the program. Nevertheless, the TBA is an important resource who can play an important role in providing services including child spacing.

The role that the Health Surveillance Assistant (HSA) could play in child spacing should be explored. The HSA is a male health worker who was trained in the early 70's and was successfully used for the specific purpose of combating chlorea. With the decrease in chlorea, HSA's were made into Village Sanitation and Hygiene Agents. Given the HSA's proven suitability for working at the village level, greater use should be made of these workers. They could be trained for education and case follow-up of mothers and children, especially given the limited ability of Enrolled Nurse Midwives

to travel to villages. If HSAS responsibilities were to include child spacing, it would be more acceptable if they either were either female or accompanied by a Female Community Worker. The MOH should explore the possibility of recruiting female HSA's and improving the training of HSA's so that they can make a contribution to MCH and including child spacing (MOH/MSH C-1 and UNICEF/WHO Joint Program Review, Aug 84).

G. NGO Activities in Child Spacing

The Private Hospital Association of Malawi (PHAM) and Ministry of Local Government also provide health services. PHAM facilities provide 40% of the health care in the country through 20 hospitals, 18 primary health care centers and 85 dispensaries. PHAM also operates 11 paramedical training schools representing the majority of health training institutions in the country. Under the Ministry of Local Government, District Councils have approximately 94 health units, mainly maternities. There are 80 dispensaries for staff of estates, private firms, the Army and Police. About 20 private physicians practice in Lilongwe and Blantyre. Although the interest or amount of child spacing services provided by these groups is unknown, contraceptive supplies have been distributed to doctors from at least six mission and 11 government hospitals through supplies donated by an interested physician from Blantyre.

Aside from Central Medical Stores, another means to import and distribute drugs is the Malawi Pharmacies. As part of the Press Corp, they operate three pharmacies and seven drug stores, staffed by one expatriate and seven Malawi pharmacists. There is also one privately owned pharmacy in Blantyre. A well defined drug policy does not exist in

Malawi. There is no drug legislation or formal drug registration or regulation system for imports. Malawi Pharmacies import only from large companies such as South Africa, the U.K and U.S. and informally use U.K guidelines for controlled drugs. Over the counter drug prices are controlled, with a percentage of landing costs plus dispensing fee added to the price. Unlike the CMS, Malawi Pharmacies are not required to use a tender system, which drastically cuts down on the time it takes to receive supplies. For example, it takes CMS an average of 7-16 month to receive supplies verses a 4-6 month lead time for Malawi Pharmacies. Malawi Pharmacies have been making a profit since 1977, and profits are given to shareholders and put back into the company.

In addition to individual sales, pharmacies distribute to PHAM facilities, estates and commercial farms. They have been purchasing contraceptives for the past eight years and all contraceptive are duty free. They procure 20 different brands of oral contraceptives with the most popular being Microgynon (Shering), selling for K3.02/packet and Conova 30 (Searle) selling for K1.22/ packet. A progestin only mini pill, Femulen (Searle) sells for K.3.00 / packet and is used primarily by ex-patriate lactating women. Condoms are also purchased and about 2000 pieces are sold each year. IUDS have also been sold, as was Depo-Provera before it was banned a few years ago.

While exact figures are not available, Malawi Pharmacy contraceptive sales have increased over the past 2-3 years, especially to middle and upper grade civil servants. Even though the total number of pharmacies and drug stores is small,

if supplies could be made available at other shops and outlets throughout the country and sold at an affordable price, the potential would exist for increasing contraceptive coverage through a social marketing initiative. Great potential also exists for introducing child spacing services into the health programs of some of the estates. As women employees are responsible for a lot of time lost at work due to pregnancy and health problems of their children, these companies may be very interested in offering child spacing services - as evidenced in Kenya. *

H. Recommendations

Planning

1. The Ministry of Health needs to develop a comprehensive five year child spacing program plan which includes the overall goal, specific objectives

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*The following are some groups that should be contacted to determine their activities and interest.

1. KACTA Commonwealth Development (Tobacco);
2. CHAMWAVI Group-Presidents Estates (Tobacco/Maize);
3. ADMARC-Agricultural and Development Marketing Board (All crops except Tobacco);
4. Dwangwa Sugar Estates.

and activities to carry out the program. Targets, an implementation plan and a budget should also be incorporated in the plan. Outside technical assistance of a Child Spacing Health Planner will be required to assist the MOH in finalizing this plan.

Training

2. Priority should be given to training those health personnel who will be expected to directly deliver child spacing services.

3. Each health worker expected to take an active role in child spacing needs to have a position description updated to reflect their new duties and responsibilities.

4. The MOH needs to assure that those trained in child spacing service delivery will be able to practice their new skills.

5. All members on the health care delivery team need to be trained in child spacing, this includes all physicians working in clinical settings. Protocols and a system for referral of problem cases should be established.

6. The MOH needs to assure that for "clinical training sites", there is adequate clinical space and volume of clients so trainees can learn the skills necessary to become clinically competent.

7. A continuing in-service education system for those working in child spacing should be established.

8. The basic training of health workers should include child spacing.

Supplies - Logistics

9. A system needs to be set up to assure that both the MOH and CMS are involved in ordering and receiving supplies. A full time person is needed at CMS to handle contraceptive supplies.

10. It should be determined which storage and distribution system for contraceptives is preferable, CMS or the MCH Delivery System.

11. Stock-outs have been a problem. Supplies and buffer stocks should be ordered to assure an adequate flow of contraceptives. A workable contraceptive logistics management system should be developed.

12. A simple user reporting system needs to be set up which estimates users by collecting information on the number of contraceptives by method and brand dispensed to clients.

13. When forecasting requirements, it is recommended that a one year supply plus a one year safety stock (requirements for the next year) be ordered. This will assure an adequate supply situation and avoid stock outs, hoarding and inefficient dispensing of contraceptives. This is especially important as information on users is scanty and the demand for services is not yet known. As usage levels become known, adjustments can be made accordingly.

II. INFORMATION, EDUCATION AND COMMUNICATION ACTIVITIES

A. The Health Education Unit - Ministry of Health

The overall goal of the Health Education program in the Ministry of Health is to initiate and support activities and programs which motivate individuals and communities to understand their health needs and utilize existing services. Priority areas in Health Education Programing include:

a) Designing a National Health Education Program Plan;
b) Training qualified health education workers and;
c) Organizing a National Health Education Unit within the ministry capable of planning and coordinating all health education activities in the country.

The Health Education Unit was originally developed to produce MCH materials, however its responsibilities were later changed to include coordination of the entire Health Education Program with emphasis on primary health care. Located in the old wing of Kamuzu Central Hospital in Lilongwe, the unit consists of six sections which include: a) Graphic Art; b) Radio; c) Mobile Cinema; d) Publications; e) Health Education Band/Drama; and, f) Support Services.

Graphic Arts Section

This section produces posters, flipcharts and a calendar. Material is designed and screen-printed within the section. A darkroom is available for simple black and white photography along with a screen-printing room which can handle small runs of simple posters. The materials produced are frequently of poor quality due to lack of detail, poor reproduction due to

equipment, confusing scale of items and/or complicated or wrong messages. This is primarily due to a shortage and lack of staff competency in these areas.

Radio Section

Radio Programs are designed by staff in the section and four programs are aired each week by the Malawi Broadcasting Corporation (MBC). Topics for programs are selected one year in advance based on seasonal needs and prevalence or outbreak of diseases. It is not known whether health messages reach target audiences, as there has been no evaluation of these programs. Letters from listeners are sent to staff but of course, are from a self-selected audience who can read and write. There is a need to change air time from early morning hours and to include field interviews as part of radio program development. It is planned to include selected child spacing topics in the 1985 Radio Schedule as part of the new program emphasis.

Mobile Cinema Section

The activities of this section include travel in mobile vans to villages where staff provide health education talks and show films. The section has one van for each of the three regions and each travels 3-4 times a month. Films are borrowed from the British Council and the American Cultural Center as they have few of their own. The films are frequently inappropriate to the needs of rural populations, although three films have been made for the unit, one on Bilharzia, and the others on Rural Piped Water and Malnutrition.

The section needs relevant films and slides, and there is a need to train staff in equipment and vehicle maintenance.

Publications Section

The main activity of this section is development of a bimonthly publication, Moyo Magazine. It is written by unit staff and is printed outside the section. Circulation is approximately 2000 copies and the content is geared primarily toward clinicians. Therefore, the magazine reaches only a specialized audience. There has been no feedback or evaluation done to determine its usefulness or impact. The magazine should expand its audience to include rural health workers and focus more on the general needs of these workers, including primary health care topics.

Health Education Band/Drama Section

Perhaps the most innovative health education activity of the program is the Health Education Band. Local musicians and singers compose and sing songs on health topics and perform throughout the country. Demonstrations are also part of the program and for example, after singing a song on Round Worms, a large specimen in a bottle is shown as part of the performance. The musicians perform at conventions, fairs and sing on the radio. The Band needs assistance with transport, they should work full time (at present they only work part-time) and should relocate from Zomba to the Health Education Unit headquarters in Lilongwe.

One major problem of the Health Education Unit is lack of competent staff. Although the Unit has five semi-professional and eight support staff, the positions that staff are currently holding have not actually been established. Heads of sections are filled by Health Assistants and Health Inspectors who are only given interdepartmental transfers to work in these

positions without additional salary. (Lewis P.24) The head of the unit has an office across town at the central MOH headquarters. This makes communication among staff difficult. Health Educations Officers in the country are primarily men, which makes it difficult to implement effective health education activities that focus on women, such as child spacing. A recent UNICEF evaluation of the Unit recommended that additional staff and staff development was needed in all major areas. A restructuring of programs was also recommended and described along with specific suggestions on how to upgrade the physical facilities, equipment and supplies.

B. The Extension Aids Branch - Ministry of Agriculture and Natural Resources

The Extension Aids Branch (EAB) is the largest government communications department which organizes and coordinates extensive education programs for the ministry. Its specific focus is to meet the needs of rural farmers in terms of crop production, growing cash crops and food, health and nutrition. EAB provides mass coverage through radio, development, printing and distribution of materials, production and provision of visual materials, a research and evaluation service and an extensive mobile cinema program.

Publications Section

The section produces and prints a wide variety of materials which includes flipcharts, books, textbooks and posters. The section handles over 200 different jobs annually and produces 1.5 million copies in an average year. The section also produces a bi-monthly farmers magazine in Chichewa and prints

approximately 32,000 copies. Upon request, the Publications Section develops materials for other ministries and is currently developing a book on Shistosomaisas for the MOH.

Technical Section

This section operates a Mobile Unit of Land Rovers which travel to every district in the country to show films and give puppet shows. The purpose of the Mobile Unit is to present messages on agricultural and rural development to people from all parts of the country which are effective and entertaining. The section also provides maintenance service for audio visual equipment.

Photographic Section

This section produces black and white still photography for use in development of print materials or displays. Color slides are produced and a library maintained which loans slides to training centers and other departments and ministries.

Radio Section

This section develops and produces six radio programs or a total of five hours and 12 minutes of broadcast time per week. In developing these broadcasts, EAB staff travel to rural areas to interview farmers on various agricultural topics. The programs are produced and edited by EAB staff and broadcast by Malawi Broadcasting Corporation. All programs are in Chichewa.

Cinema Section

Agricultural films are produced by the staff in this section. EAB film crews have made approximately 40 films,

which are shot locally and printed outside the country. A catalogue of available films is produced and films borrowing is encouraged. The EAB film section has assisted other ministries, and is currently assisting the MOH in producing a film on Bilharzia. Such MOH requests come through specific technical units rather than through the Health Education Unit at the Ministry.

Editorial Section

The staff in the Editorial Section have the responsibility for writing and editing all EAB materials and publications. The section also develops the scripts and produces a puppet show that is part of the cinema program. This section assures that whatever material is produced and printed by EAB is clear, simple and understandable.

Evaluation and Action Research Section

This section was established to make sure materials and program content are relevant and the best media response to deliver messages. Section staff field test materials, develop background information studies on topical areas and carry out evaluations to assess how well messages are being understood by the target audience.

The EAB was established in 1958 and has gained a lot of experience and expertise in communication program development and implementation. It is their policy to assist other departments within the Ministry of Agriculture as well as other ministries in communication and education activities.

C. General IEC Issues

Little research has been done in Malawi to determine beliefs and traditional practices of different cultural groups in relation to health and nutrition. Recently however, the Center for Social Research in collaboration with the National Statistics Office conducted a Family Formation Survey. The results will provide information on marriage, attitudes toward family size, fertility and birth history and the use of health facilities which can be used to plan specific IEC programs. The development of an effective information, education and communication (IEC) strategy requires a clear understanding of the target audiences. Results of the Family Formation Survey will give some information but in addition, small surveys, focus group discussions and evaluation of present activities should be part of the ongoing program. The MOH Health Education Unit in collaboration with other communications and research groups such as the EAB and Center for Social Research needs to develop the capability to collect baseline information, field test new materials and evaluate existing programs.

Staffing, and equipment are also constraints, but a major problem is that the Health Education Unit does not have an overall strategy. Coordination of IEC activities within the MOH is also a problem. Various departments and technical officers plan their IEC programs and activities without collaborating with each other. Coordination of all IEC activities within the MOH is necessary to prevent overlap, duplication and non-standardized messages. At the same time, the Health Education Unit should make greater use of the EAB facilities for research, printing and film production. The

EAB could also possibly arrange short-term training for Health Education Unit Staff. The EAB offers advice and assistance to other ministries. The MOH should take full advantage of local resources and expertize that already exist within country.

D. Recommendations

Recommendations primarily refer to strengthening the Health Education (HE) Unit of the Ministry of Health. Given the Ministry's new emphasis on child spacing, this Unit will provide the major IEC assistance in support of the child spacing program. Therefore, recommendation for increasing the effectiveness of this unit will likewise improve its capability to plan and implement IEC activities in support of Child Spacing.

1. The HE Unit needs qualified IEC staff. Short-term technical courses are needed for existing staff and additional staff will also be required if the Unit is to expand and become more effective. The HE Director should be physically located at the HE Unit, rather than at the MOH across town..

2. The unit needs to develop a written IEC strategy and plan. Review of this plan should take place on a routine basis to prioritize, coordinate and budget for all IEC activities within the Ministry.

3. An IEC Research and Evaluation Section is needed to collect background information (KAP Surveys), test new strategies and evaluate programs.

4. The HE Unit needs to work closer and seek assistance from the EAB, especially in the areas of research, printing and film production.

5. An IEC multi media program is needed to orient the community to child spacing. Opinion Leaders, Policy and Decision makers, Traditional and Local Community Leaders should all be informed what child spacing is, its importance as a health intervention, and where to seek services.

6. IEC and child spacing topics should be incorporated into all in-service training programs for MCH/FP workers and be included and strengthened in all basic programs for health personnel.

III. COMMUNITY DEVELOPMENT PROGRAMS

A. Female Extension Workers - Ministry of Agriculture and Natural Resources

The Ministry of Agriculture and Natural Resources has trained Female Extension Workers (FEWs) since 1969. Until recently, this included the addition of a home economics component to the farmer training program. At a workshop in 1981, it was decided to broaden the scope of the training program to include other women and development topics with an emphasis on agriculture. The syllabus was unofficially changed in 1982 to include more topics on agriculture and home economics. The course was increased from one to two years and now includes 45% Home Economics, 31% Agriculture, 17% Community Development and 7% supporting subjects. Female Extension Workers are trained at the Natural Resources College and take the same course as Agriculture Field Assistants, with the exception of additional components on family economics and

management, housing and technology, human nutrition, food and food management and child care and development. FEWs also receive two week refresher courses at the Agricultural Development Divisions (ADD) each year. Ministry staff involved in the FEW program include one person at headquarters and one or two Womens Program Officers at each of the eight ADDs. Due to limited numbers of FEWs trained, there being currently a little over 200 for the entire country, there is need to train Male Field Assistants in extension methods to help them work more effectively with women.

Once trained, the FEW's primary responsibility includes giving short two week courses to rural women at agriculture training centers. For the most part, FEWs are based at Agriculture Training Centers and as of December 1983, there were three farm institutes, 21 residential training centers and 138 day training centers. The farm institutes and residential training centers offer more extensive training and usually have plots, livestock and a kitchen. FEWs also provide extension advice to women through home visits and have recently been encouraged to extend agriculture advice through establishing group demonstration gardens. In line with the new curriculum, in their work, FEW stress growing foods and the link between nutrition and agriculture. Some of the health topics FEWs teach in their courses are control and prevention of common diseases in rural areas, sanitation, nutrition and personal hygiene. They also frequently collaborate with MCH Health Workers and teach at under-five clinics.

Although no evaluation has been done of FEW training, the program was reviewed in 1982. While it was too early to determine the impact of the new FEW training program, general

problems were highlighted which included a shortage of FEW staff, the need to expand income generating activities and the overall lack of available data specific to womens issues. The Womens Program Division in the Ministry would like to carry out an indepth evaluation of the FEW Program in 1984 - 1985.

B. Ministry of Community Development

1. Adult Functional Literacy Program

Available data show that a high percentage of the adult population in Malawi are illiterate. According to the final report of the 1977 Population Census, 77.9% of the total population aged 15 and over are illiterate in Chichewa. Illiteracy is defined as not completing four years of school. The absolute numbers are likely to be higher due to the fact that the population is increasing faster than it can be educated. The total government expenditure devoted to education has been decreasing. In 1972/73 government expenditure for education was 13% of total expenditures which decreased to 8% by 1980/81. Also, the percentage of total government capital expenditure devoted to education has been declining, since 1972/73, from 16.3% to 10.8% in 1980/81. Most capital expenditures in education come from foreign donor assistance, with only about 10-20% coming from local funds. (p.16 UNESCO/Malawi Govt Tech Report, May/June 1983).

There has been a government tendency to favor formal education of school age children over non-formal education programs. Nevertheless, with assistance from UNESCO/UNDP, the government started a pilot functional literacy project in

1979. The aim of the project is to provide an opportunity for learning and assistance to small holder farmers and rural populations which constitute 91.5% of the population. The government realizes that rural women and men should be participants in the country's development process. Literacy of rural populations is seen as an important condition to the improvement of life in rural areas.

The first phase of the project focused on establishing policies, developing and pretesting instructional materials, and staff training. Literacy courses were then introduced in three pilot ADDs. To date, 259 functional literacy centers have been developed and 12,840 trainees have participated in the project.

The initial training is for six months which includes a two hour session each afternoon. Teachers are local residents with standard eight education and are trained in trainers workshops. They are paid 10 kwacha per month for their services.

UNDP and UNESCO recently conducted an interim evaluation of the project and some of the major findings included few men attend the courses, materials have little vocational content, teaching materials are in short supply and there is little done for new literates.

While there has been a fairly good response from adult learners in project villages, 90% of the participants are women. There is a higher proportion of women illiterates (87.2% of all women age 15 and over), but 67.4% adult men are also classified

as illiterate. Some speculative reasons why more women attend courses include: a) there are more women who are illiterate; b) women attach a social value to the program; and c) men do not want to show their ignorance to women by being in a mixed group learning situation. To enlist greater participation by men in functional literacy program centers, research has to be done into the cultural traditions and values in order to understand how to induce men to participate and benefit from the program.

There is a need for better training and understanding of leaders and teachers on what functional literacy is and how to teach others. One challenge of the program has been to link literacy training to development activities and develop a curriculum that includes these elements. The content of the instructional materials flows from national development goals. Messages relate to agriculture, home economics, community participation, child care, health, religion and personal needs of individuals working in rural settings. The development and modificiation of the curriculum is still underway. A system is currently being developed for assessing learner performance.

Another concern has been what to do for post literacy follow-up for neo-literates. One workshop was recently held to develop supplementary reading materials for new readers. Writers representing various development programs identified topics that should be developed in written format for graduates. Depending upon the outcome of the first phase of the project, UNDP/UNESCO may assist the government in developing and implementing a Functional Literacy Program at the national level. However, continuing financial support from government will have to be assured. The recent government decision to have a separate

budget allocation for functional literacy activities as part of the second phase of the UNDP/UNESCO Project is a step in the right direction.

Last year, UNFPA and UNESCO developed a proposed project to introduce child spacing topics and reading materials through the pilot areas of the functional literacy project. It is not clear if the project has been approved. The project proposes to produce booklets on child spacing as reading materials for new literates. 15,000 copies would be printed and distributed to 750 literacy centers. The advantages of introducing child spacing through the Functional Literacy Program include the ability to reach men (although at present limited numbers attend) and working through an established infrastructure that has produced print material as part of its program.

2.Female Community Development Assistants

The ministry trains Community Development Assistants (CDA) in a one year training program at Magomero Training College. The CDA's primary responsibility is to supervise the work of Ministry of Local Government Home Craft Workers (HCWs) and to give training to women in rural areas. They teach courses in food, nutrition, child care, village health, sanitation, textile and clothing and development of family resources. One emphasis of their training is on how to teach these topics to rural populations. CDAs are employed by the Ministry of Community Development and they work in rural areas at the District and Area level. Approximately 210 Community Development Assistants have been trained, with 128 being male and 82 female.

C. Home Craft Workers - Ministry of Local Government

Home Craft Workers (HCWs) are female workers trained for six months at the Magomero Training Center. The curriculum is a shortened version of the CDA training program, and once trained, CDAs supervise their work. Each trainee is sponsored by local District Councils, missions or private associations and after training, (HCWs) return to their sponsoring organization. Over 1000 HCW's have been trained since the program began in 1950, however a little over half, or 529 are currently working. HCW's are trainers and conduct weekly courses for rural women reaching about 50,000 women annually. They also assist with educational activities at MCH clinics.

In 1981, a comprehensive evaluation was done of both HCWs and CDAs. The evaluation looked at recruitment, financing, basic and in-service training, teaching effectiveness, working conditions in the field, supervision and staff support and overall program effectiveness.

One finding showed a high drop out rate for both HCW and CDAs. For example, 51.6 % of trained HCWers and 33.3% of trained CDAs are not working. Unfortunately, little is known as to reasons for this. Concerning the training programs, the evaluation recommended that the curriculum of both HCWers and CDAs be revised. It was thought that too much emphasis was placed on sewing and handicrafts and not enough time was spent on food production, storage and preparation in addition to family health and sanitation. As a follow up to this recommendation, in 1982/83 an extensive review of the HCW curriculum was made. As a result, major curriculum revisions were made to include more topics on basic needs such as preventive health. The HCW

training was increased from 3 - 6 months. In light of these new changes in the HCW training program, it has also been recommended that the CDA training be reviewed, modified and extended in length.

Other evaluation recommendations centered around the need for a small budget to purchase materials for class demonstrations, the need for improved transport for CDAs and the need for formal classrooms for holding courses.

D. Summary and Recommendations

Women play an important role in decision making on the use of their land in rural areas. The Phalombe Development Project Baseline Survey conducted in 1978/79 looked at womens economic position and examined problems they were facing. It was found that 35% of households were headed by women, approximately 33% of households conducted joint farming between husband and wife and the remaining two-thirds were divided between women who are married with husbands in off farm work and women usually not married who are on their own. In 1983, an evaluation conducted by Spring found that even though the majority of work is done by women, they lack cash, land to cultivate and are often neglected by extension staff. The Phalombe survey showed that until 1982-83, women were given only minimal support in agricultural production and only 5% of credit borrowers were women. Women also rarely attend agricultural training courses and are seldom included in most agriculture projects. According to Spring, women do not become involved because they lack confidence and experience and are not aware of the opportunities available or how to take advantage of them. This is one reason that the

Womens Program was created in the Ministry of Agriculture, to give special attention and address some of womens special needs and problems.

Currently, four Ministries train women workers in community development related activities. The Ministry of Health, Local Government, Community Development and Agriculture and Natural Resources all train women in Home Economics, some aspects of health and broader issues of economic and social development. Even though the Ministry of Community Development has the primary responsibility for home economics, other ministries include it in their programs and there is the potential for overlap and duplication.

The attached chart outlines the three major categories of workers (aside from Health) that are trained and deployed. While they all include training in many of the same topics, FEWs emphasize agriculture topics (agriculture production and food utilization), whereas CDAs and HCW's emphasize home economics topics. All three categories conduct training courses, however only FEWs train in established agriculture training centers. CDAs place more emphasize on teaching methods and group learning and organize people informally for courses in rural settings. However, there are many simillarities in the training courses offered by FEWS and CDAs/HCW's even though they all have different levels of education and training.

Coordination among all Ministries and womens programs is needed. In the 1981 UNICEF evaluation of womens programs, Williams recommended such inter-Ministerial cooperation. The need to look at the needs of the consumers was mentioned. He went on to further suggest a unified approach to the training and

COMMUNITY SERVICE TRAINING PROGRAMS

FOR

WOMENS DEVELOPMENT AND TRAINING

Worker	Ministry	Where Trained	Entrance Requirements	Length Training	When Program Started	Total Numbers Trained	Duties and Responsibilities	Employment and Supervision
Female Extension Worker or Farm Home Assistants (FHAs)	Agriculture and Natural Resources	Natural Resources College	J. C. E. or M. C. E.	2 years	1969	200	Teaching rural women about Agricultural production, food utilization and Home EC in Agricultural Training Centers	-Ministry of Agriculture -Womens programs Officers (ADDs)
Community Development Assistants (CDA's)	Community Development	Magomero Community Development Training College	J. C. E.	1 year	1965	210 (128 male) (82 female)	Supervise Home Craft Workers, located in urban, districts or subdistrict, emphasis on nutrition, child health, handcrafts and sewing	-Ministry of Community Development
Home Craft Workers (HCWS)	Local Government	Magomero Community Development Training College	Standard Eight	6 months	1950	1,094. (529) (currently employed)	Teach classes to rural women focusing on Home Craft and Home implement	-Local Govrt (83%) or Parastatal and Private Organizations (17%) -Community Development Assistants

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utilization of such workers either where all workers take the same core courses and then specialize in certain areas or where each worker is trained to do something completely different from the others. Clearly, coordination is needed along with further research into the various messages and audiences reached by each worker.

The curricula of both FEWs and HCW's have recently been revised to strengthen aspects of preventive health care. Both work at MCH clinics, primarily under-five clinics, in collaboration with health workers. They enjoy this highly structured and organized work although there is little indication that they do any follow-up beyond the clinic.

The basic curricula of each of these workers should be modified to include child spacing topics. FEWs and HCW's should continue to work with health workers at MCH clinics and be encouraged to do follow-up or home visiting, when indicated. Male Farm Home Assistants and CDAs should also be taught child spacing topics with special emphasis on appropriate information to reach men.

Introducing child spacing topics into the content of the Functional Literacy Program is also recommended given the governments recent interest. This should include both the basic curriculum and development of written materials for new literates. Material should be carefully field tested to assure that appropriate messages are developed within a culturally acceptable content. Teachers will have to be trained in the child spacing content before introducing it into the program and exactly how materials will be distributed and used also needs to be determined.

References (Child Spacing Section)

Field Review of the Malawi Health Institutions Development Project (AID NO 612-0211) by Albert Henn, Barbara Kennedy and Murl Baker, February, 1984.

IBRD Malawi Basic Needs Report - Health Report No 3461, May 1981.

IBRD Malawi Health Sector Review, November 1981.

IBRD Staff Appraisal Report - Republic of Malawi Health Project, March, 1983.

Strengthening Primary Health Care, Principles, Policies and Strategies, Planning Unit/Ministry of Health and Management Science for Health, August 1984.

Statement made by the Hon. D.S. Katopola, M.P., Minister of Health, Republic of Malawi at the International Population Conference, Mexico City, August 10, 1984.

Report on the Evaluation of the UNFPA Assistance to the Maternal and Child Health Program of Malawi, February 1984.

UNICEF/WHO Joint Mission to review MCH/EPI and PHC, August 1984.

The Economics and Finance of the Health Sector, Technical Document D-1, Planning Unit, Ministry of Health and Management Sciences for Health, September, 1984.

Pharmaceutical Logistics Report No 1, Ministry of Health Malawi and Vimal S. Diaz, Management Sciences for Health.

Development of Pharmaceutical Production Units within Central Medical Stores, Technical Document B-1, Central Medical Stores, Ministry of Health and Management Sciences for Health, July 1984.

The Potential for Income Generation and Cost Saving in the Ministry of Health, Technical Document D-2, Planning Unit, Ministry of Health and Management Sciences for Health, September, 1984.

Ministry of Health Resource Analysis 1984-1995, Technical Notes on Calculation, Technical Document D-4, Planning Unit, Ministry of Health and Management Sciences for Health, September 1984.

Manpower: Current Situation, Future Needs, Issues of Management, Technical ocument A-1a, Planning Unit, Ministry of Health and Management Sciences for Health, October, 1984.

References (IEC Section)

Strengthening Primary Health Care, Principles, Policies, and Strategy, Planning Unit/Ministry of Health and Management Sciences for Health, August, 1984.

Annual Report Health Education Section, Ministry of Health, 1982.

An Overview of Health Education Activities and Proposals for Strengthening of Health Education Services in Malawi, Sam J.K. Lewis, WHO Health Education Specialist, Ministry of Health, February, 1981.

H. Ferraton, D.T. Jameson, F. Orivel, Mass Media for Agricultural Extension in Malawi, The World Bank, Population and Human Resources Division Discussion Paper, September, 1981.

Government of Malawi, Health Education Evaluation Report, Save the Children Fund and UNICEF, April, 1984.

Malawi - Report of Mission on Needs Assessment for Population Assistance, Report Number 64, UNFPA, December, 1983.

The Role of Extension Aids Branch in Rural Development, Extention Aids Branch, September, 1980.

References (Community Development Programs)

UNICEF - Assisted Womens Programs in Malawi - An Evaluation and Summary of Findings of the Homecraft Workers Program and the Female Community Development Assistants Program, Bruce T. Williams, Centre for Social Research, University of Malawi, March 1981.

The Home Management Course Program (An Evaluation Report) Presented by L.A.H. Msukwa, Director, Centre for Social Research, University of Malawi, April 1982.

Agricultural Extension Changes, It's Approach to work with Women Farmers, Phalombe Rural Development Program (ODA).

Priorities for Womens Programs, Women in Agriculture Development Project, Anita Spring, USAID, Citedze Agricultural Research Station, April, 1983.

Government of Malawi, Elimination of Illiteracy in Malawi, A Joint UNESCO Malawi Government Technical Report, May-June, 1983.

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UNITED STATES GOVERNMENT

memorandum

DATE: January 17, 1985

REPLY TO ATTN OF: Barbara Kennedy, Population Officer, REDSO/ESA

SUBJECT: Malawi IBRD Population Sector Study

TO: See Distribution

Please find a copy of the section of the subject study that I developed during my participation in the Malawi IBRD Population Sector Study in October 1984. The attached memorandum outlines the scope of work for my section of the report.

The entire report is being finalized by IBRD. After their internal reviews, I will be participating along with USAID/Malawi in IBRD discussion with government on the report findings and recommendations. It is anticipated that these discussions will take place in Malawi sometime during March 1985.

Please let me know if you have any comments or suggestions on my report or any part of the Population Sector Study.

cc: John W. Koehring, REDSO/ESA
Art M. Fell
Stuart Callison
Sheldon Cole, USAID/Malawi
Dave Garms
Larry Eicher, AFR/TR/POP
Gladys Gilbert
Nancy Yinger
John Burdick, ST/POP
Tony Boni

BK/so

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

UNITED STATES GOVERNMENT

memorandum

DATE: November 7, 1984

REPLY TO ATTN OF: Barbara Kennedy, Population Officer, REDSO/ESA

SUBJECT: Terms of Reference for Malawi Population Sector Study, October 8 - 21, 1984

TO: V. Jagdish, Team Leader, IBRD

As we discussed, the scope of work for my participation in the subject study will be to:-

1. Analyze government and private activities in family planning including a critique of future program plans;

2. Assess various IEC activities to include strengths, weaknesses and capabilities for incorporating population/family planning messages through these programs; and

3. Review some of the community-based multi-sectoral educational and service programs to determine the potential for including population/family planning activities through these programs.

BK/so

OPTIONAL FORM NO. 10
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5010-112