A different kind of family

Anushka Virahsawmy

CHAPTER 6

Health

Article 26

Information is power. Emma Kaliya, Programme Manager at Human Rights Research Council of Malawi and Chairperson of NGOGCN explaining gender equality to a woman from the community - Lilongwe, March 2012.
Photo: Loveness Jambaya Nyakujarah

KEY POINTS

- With an SGDI score of 58%, Malawi ranks eighth in the SADC region.
- Citizens gave the same score 58% based on the CSC.
- Malawi has one of the lowest rates for women using contraceptives at 36% compared to other countries in the region.
- The 2010 Total Fertility Rate (TFR) is 5.7. For women with more than secondary school education, the TFR drops to 2.1 while those with no education have a TFR of 6.9.
- Men are gradually becoming involved in family planning campaigns.
- Malawi has reduced the maternal mortality rate, but it is still high at 675 deaths out of every 100,000 live births.
- Some 17% of maternal deaths are related to abortion complications.
- Malawi has the third highest sanitation coverage in rural areas in the region after Mauritius and Seychelles.

Table 6.1: SGDI and CSC scores for health		
	SGDI	*CSC*
Scores	58%	58%
Ranks	8	8

The SGDI and CSC scores for the health are the same at 58%. The SGDI is based on the following indicators: women aged 15-49 years who report to use at least one form of modern contraceptive method, births attended by skilled personnel, and the maternal mortality rate. Citizens' perceptions are probably influenced by lack of adequate infrastructure and long distances to travel to hospitals.

Background

WHO has defined sexual health as: "a state of physical, emotional, mental, and social well-being related to sexuality. It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained the sexual rights of all persons must be respected, protected and fulfilled."[1]

The sector faces a myriad of challenges. These include: inadequate health facilities with insufficient or inadequately trained health professionals. This affects women's access to relevant services. Where services are available, several reasons contribute to reducing women's access including long distances to health facilities; negative attitudes about health personnel; lack of knowledge about available services; inability to make sexual and reproductive health choices; traditional beliefs and customs; and the high cost of some services. Malawi has in place a Sexual and Reproductive Health and Rights (SRHR) policy, which guides the provision of services. However, implementing the policy as well as monitoring and evaluation remain a challenge.

Sexual and reproduct health

By 2015 countries should develop and implement policies and programmes addressing mental, sexual and reproductive health needs of women and men.

Table 6.2: Key sexual, reproductive and health indicators		
Indicators	**Country statistic/policy**	**Comment**
Current maternal mortality rate	675 per 100,000 live births*	
% Births attended by skilled personnel	71%*	
% Contraceptive use among sexually active women aged 20-24	36.1%*	
% Contraceptive use among married women	46.1 %*	Increased from 33% in 2004 MDHS.
No. of deaths annually as a result of illegal abortions	17%	Mostly performed by unskilled personnel.
Country policy on abortion	Illegal only under certain conditions	Abortion is allowed when the mother's life is in danger.
Total coverage of sanitation facilities		
Urban coverage	80%	
Rural Coverage	33%	

*Source: *2010 Malawi Demographic and Health Survey (MDHS) Report.*

Fertility

The 2010 MDHS highlights that Total Fertility Rate (TFR), at 5.7 has dropped slightly. It was 6.0 in 2004 and 6.3 in 2000. The fertility rate is highest among women aged 20-24 years.

The TFR is correlated with education levels, as education levels increase the fertility rate decreased. For example, women with more than secondary school education have a TFR of 2.1 while those with no education have

[1] World Health Organisation (2002). The world health report 2002 Reducing risks, promoting healthy life, World Health Organisation.

a TFR of 6.9. Also women have fewer children as wealth increases.

Family planning

A nurse briefs a journalist on sexual and reproduction health.
Photo: Courtesy of NGOGCN

Malawians are aware of contraception; 98% of women and 99% of men have knowledge of at least one contraception method.

On average contraceptive use among sexually active women is 36%. However the Contraceptive Prevalence Rate (CPR) among married women using any method of contraception is 46%, an increase from 33% in the 2004 MDHS. Out of the women using contraception, 42% use a modern method of contraception and 4% use traditional methods. The modern methods used are: injectables (26%), female sterilisation (10%), pills (3%), and male condoms 2%. The CPR increases with age, increasing from 29% for the 15-19 year age groups, peaking at 54% for the 35-39 year age group, after which it declines.

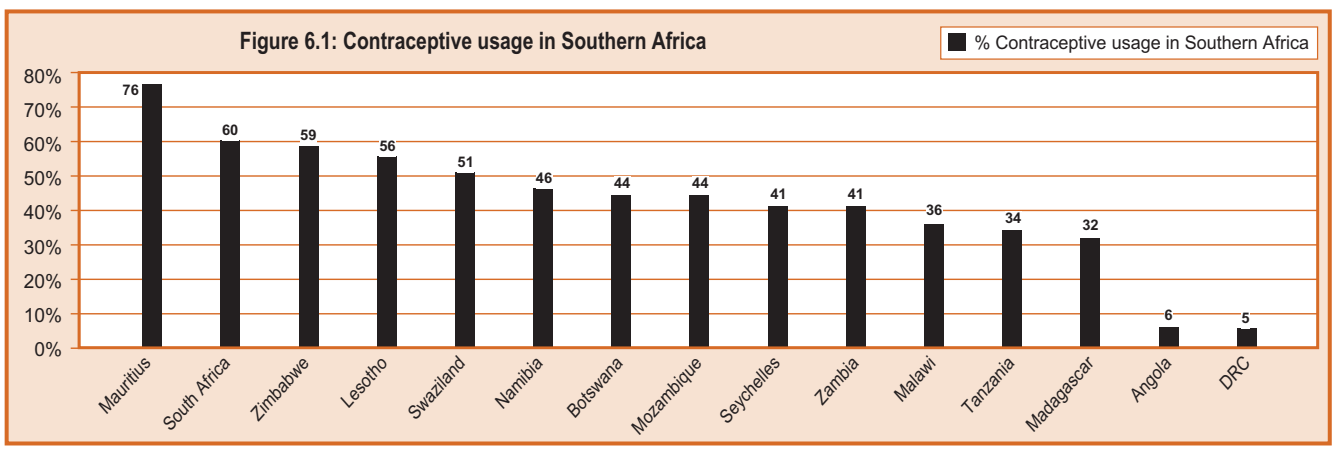
Family planning use is influenced by the home environment, age, district, education and the number of living children a woman has. Urban women are more likely than rural women to use a contraceptive method (54% compared with 45%, respectively). Rural women represent the highest proportions of women using traditional methods (13%).

As highlighted earlier, educational level influences the total fertility rate; not surprisingly, higher education is associated with a higher CPR. About 40% of women without education currently use family planning compared with 57% of women with more than a secondary education. Contraceptive use increases with the number of living children a woman has. Some 6% of women who have no children are currently using family planning, compared with 41% of women with one or two children. The CPR is highest for women with five or more at 56%. A similar pattern is observed for modern and traditional methods.

Male involvement in family planning is a new area that stakeholders are championing in Malawi. The Malawi Human Rights Resource Centre, the NGO Gender Coordination Network (NGOGCN), UNFPA, the Population Services International and Banja La Mtsogolo are the key actors in spearheading male involvement in family planning. They mobilise men to sensitise other men about the importance of letting their wives use family planning methods, and inform men about the option of a vasectomy.

Malawi has in place a Sexual and Reproductive Health and Rights (SRHR) policy, which guides the provision of services. However, implementing the policy as well as monitoring and evaluation remain a challenge.

A group of Men for Gender Equality Now (MEGEN) sensitising other men about their role in Sexual and Reproductive Health.
Photo: Emma Kaliya



Source: SADC Gender Protocol Barometer, 2012.

Figure 6.1 shows that contraceptive use remains low in Malawi (36%) making it rank in the bottom five SADC countries.

Table 6.3 shows that the use of the female condom dropped in 2010 possibly because the distribution channels of the female condom changed during that period; it was sent directly to the central medical stores. Before, UNFPA distributed the female condom directly to CBOs, NGOs and the private sector. The health sector is monitoring the situation to see if the use of the female condoms improves.

Table 6.3 Trends in use of female condom 2004 - 2012

Year	Public	Social marketing
2004 - 2005	124,000	na
2006	298,000	na
2007	528,000	na
2008	948,000	April - October: 21, 188 CARE™
2009	948,000	35,000 CARE
2010	662,000	300,000 CARE
2011	na	na
2012	na	na

Community agents help out

The Government of Malawi is implementing a number of low-cost innovative strategies aimed at increasing family planning coverage. One of these is the Community-Based Distribution Models in which community-based distribution agents have been trained to address gaps in knowledge, access to, and utilisation of, the wide range of available family planning services at community level.

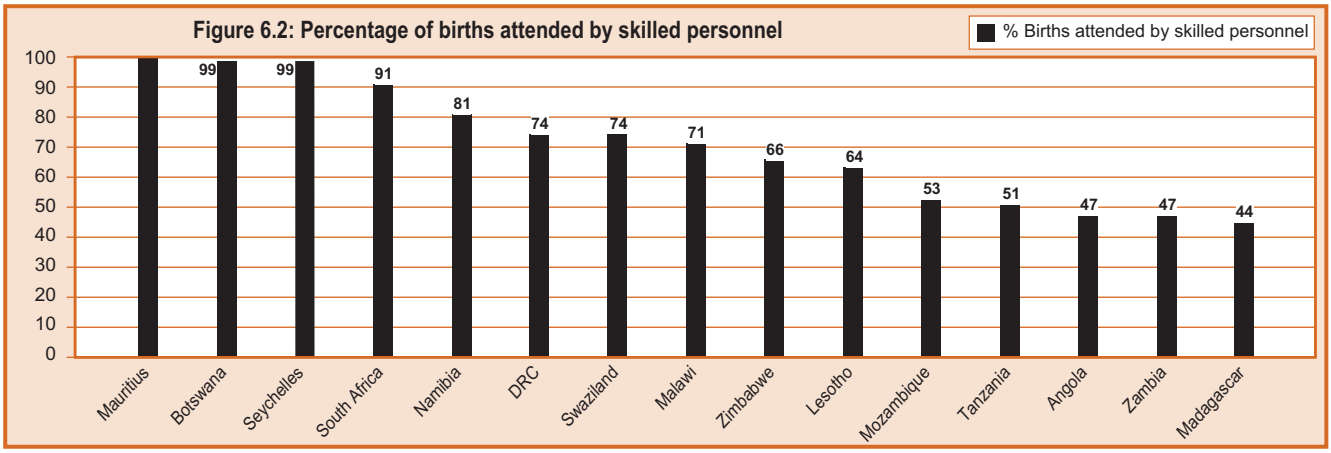
The intervention was piloted in 10 districts and was scheduled to be rolled out to the remaining 18 in 2010. The engagement of community-based distribution agents is important in relieving severe human resource shortages. Further, the government recently formulated a policy that authorises health surveillance assistants to provide Depo-Provera at community level, increasing the number of women reached with family planning information and methods, and in particular with Depo-Provera. Between 2008 and 2009 Depo-Provera was the most preferred family planning method.[2]

With technical and financial support from Management Sciences for Health, 1400 Health Surveillance Assistants have been trained and now provide injectables at community level in eight of the 28 districts.[3]

Antenatal care

Antenatal care from a trained provider is important to monitor the pregnancy as well as to reduce morbidity and mortality risks for the mother and child during pregnancy and delivery. According to the 2010 MDHS results, 97% of women who gave birth in the five years preceding the survey received antenatal care from a trained health professional at least once for their last birth. Urban women were slightly more likely than rural women to receive ANC from a health professional (98% and 96% respectively). The proportion of women who obtain antenatal care from health professionals increases with the level of education from 93% of women with no education to 100% of women with tertiary education.

Maternal mortality



Source: 2012 SADC Gender Protocol Barometer.

2 SAfAIDS, 2011.
3 Ibid.

Figure 6.2 shows that in Malawi, 71% of births were delivered by skilled personnel in a health facility. Although there are still a significant number of births that are not attended by skilled health professional, gradually more women are opting for safe deliveries. In 2005 only 57% of births were delivered in a health facility. Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother and/or baby (Van Lerberghe, W., and V. De Brouwere, 2001; WHO, 2006).

Some population groups are more likely to deliver in health facilities than others. Some 85% of births to urban mothers were attended to by a health professional and 84% were delivered in a health facility, compared with 71% and 70%, respectively of births to rural women.

Mothers' educational status has a significant impact on whether delivery is assisted by a health professional and whether the birth is delivered at a health facility. For example, 63% of births to mothers with no education were attended to by a health professional compared with 98% of births to mothers with more than a secondary education. Surprisingly, 87% of births to mothers with a secondary education occurred in a health facility compared with 82% of births to mothers with more than a secondary education.

Abortion

Induced abortion is illegal in Malawi unless the pregnancy threatens the mother's life. Notwithstanding this, Malawi has the highest abortion rate in Southern Africa at 35 abortions for every 1000 women aged 15 to 44 years.[4] The majority of unsafe abortions are carried out on young women below the age of 25 years. The early age of sexual debut and marriage (15 years) in Malawi has been identified as contributing to high incidences of early and unwanted pregnancies as well as to the high abortion rate, high maternal and infant mortality and high incidences of STIs and HIV in young people. Through its Post Abortion Care Strategy, Malawi offers post-abortion care services which are provided by trained clinical officers at district and national hospitals. In 2010 there were about 166 facilities providing PAC and the country was working towards expanding PAC into rural areas.[5]

Recent studies by the Ministry of Health and IPAS show that 17% of maternal deaths are related to abortion complications.[6] The factors contributing to the abortion related deaths are:

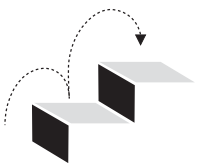
- Lack of safe abortion services
- Barriers to make choices due to religion and legal restriction
- Unwanted pregnancies
- Poverty
- Underage

Sanitation

The SADC Gender Protocol requires that by 2015 member states ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

The provision of sanitation and hygiene facilities is integral to improving women's health throughout the region. Poor sanitation results in increased spread of communicable diseases such as TB and malaria which women are particularly vulnerable. Furthermore, menstruation, pregnancy, and post-natal care become increasingly difficult for women without proper hygiene and sanitary facilities, as does caring for family and community members living with HIV. According to the World Health Organisation, almost one tenth of all global deaths can be avoided by providing clean drinking water, better sanitation and improving water resources management to provide reduce incidence of water-borne diseases and cases of accidental drowning.

WHO/UNICEF reports show that overall sanitation coverage is 51%; with rural coverage of 51% and of rural areas 49% However Table 6.2 shows that according to the 2010 MDHS sanitation coverage for urban areas and rural areas is 80% compared with 33%.



Next steps

- Malawi has made major progress in health. There is a need for:
- Intensifying the campaign to ensure all women give birth in health facilities or are attended by skilled health professionals.
- A debate around the issue of abortion.
- Promotion of the female condom.
- Greater involvement of women in sanitation programmes.
- Promotion of and raising awareness on sexual and reproductive rights from upper secondary school level.

4 Malawi Reproductive Health Unit, 2009.
5 SAfAIDS, 2011.
6 "Study of the Magnitude of unsafe abortion in Malawi, Ministry of Health -GOM (May 2011)".