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THA BASIC SURUEY TEAM REPORT
ON
POPURATION
AND FAMILY PLANNING
IN REPUBLIC OF MALAWI

JAPAN INTERNATIONAL COOPERATION AGENCY
MAY 1992

PREFACE

In view of the fact that the control of Population and Family Planning is an important subject in many of the developing countries, the Japan International Cooperation Agency (JICA) decided to conduct a basic study on the present state of Population and Family Planning in Republic of Malawi as one of its activities for 1991.

JICA sent to Republic of Malawi a study team with four members headed by, Dr. Minoru Muramatu, Expresident of Saitama College of Health, from Feburary 29 to Madrth 21, 1992.

The study team exchanged views with the officials concerned of the Government of Republic of Malawi, and conducted a field survey in Lilongwe and other parts of Malawi R.

After the study team returned to Japan, the data obtained from the field study were analyzed and the present report has been prepared.

I hope that this report will be useful for the further promotion of Japan's cooperation in Population and Family Planning problem with Republic of Malawi.

I wish to take this opportunity to express my deep appreciation to the officials concerned of the Government of Republic of Malawi for the cooperation and hospitality extended to the study team.

May, 1992

Sekai Nishino
Vice President
Japan International
Cooperation Agency

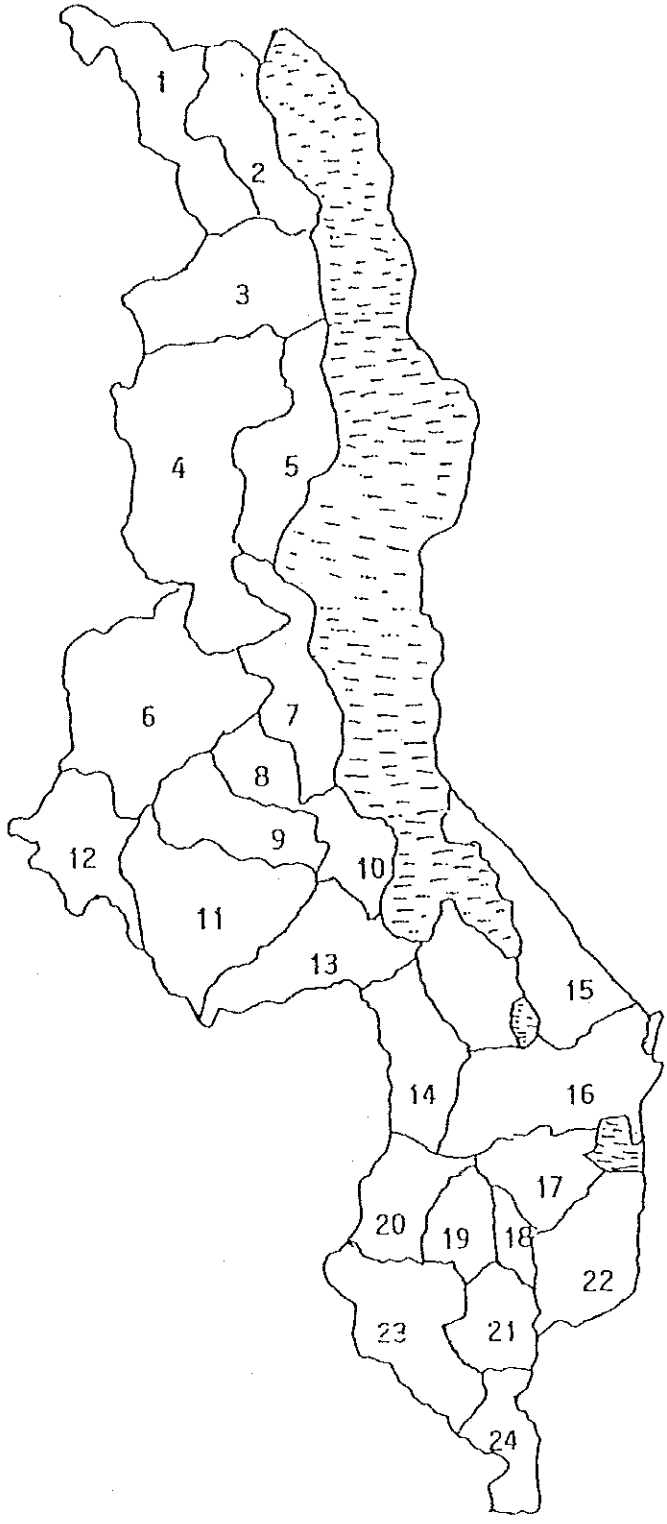
MAP OF MALAWI

1. Chitipa
2. Karonga
3. Rumphi
4. Mzimba
5. Nkhatabay
6. Kasungu
7. Nkhotakota
8. Ntchisi
9. Dowa
10. Salima
11. Lilongwe
12. Mchinji
13. Dedza
14. Ntcheu
15. Mangochi
16. Machinga
17. Zomba
18. Chiradzulu
19. Blantyre
20. Mwanza
21. Thyolo
22. Mulanje
23. Chikwawa
24. Nsanje

1～5 Northern Region

6～14 Central Region

15～24 Southern Region



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1. SOCIOECONOMIC SITUATION

A. Economic Situation

Malawi is classified among the Least Developed Countries. With an estimated GNP per capita of US$180 in 1989 (Table 1-1), the country ranks among the poorest in the world.

Malawi's economy depends heavily on agriculture. The Agriculture sector alone generates about one-third of the total GDP, produces the bulk of domestic export crops (tobacco, tea and sugar) and provides a livelihood for about 80% of the population. However, the output of crops is often affected by weather conditions such as drought, which leads to the decrease in the overall GDP. Fluctuations in tobacco and tea prices in the international market also affect the economy.

Moreover, economic and social progress has been undercut in recent years by external shocks, including; rising external transport costs due to the disruption of transport routes caused by the civil war in Mozambique, declining export prices, and an influx of approximately one million Mozambican refugees. According to the national accounts data, the economy grew at approximately 3% per annum during the 1980s, which was barely enough to keep pace with population growth. The per capita income in 1980 and 1990 remained almost the same, which means that during the past decade, the per capita income in real terms fell. This was in sharp contrast with the earlier decades when the average per capita income increased at over 2% a year.[1]

Since the early 1980s, the Government has implemented economic stabilization and structural adjustment programs, supported by IMF and World Bank credits. By and large, the immediate objective of stabilization has been achieved. Negative economic growth in 1980-1981 turned positive and continued to strengthen throughout the decade. Economic growth was over 4% in 1989 and 1990 (Table 1-2). Both the fiscal and external imbalances were reduced and the rate of inflation was brought under control.

Although the process of economic stabilization has been successful, the goal of improved social development through structural adjustment remains elusive, and poverty still prevails. In spite of vigorous adjustment programs, the basic

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Note: Main sources for this section on the economic situation are: APIC, *Socioeconomic Conditions of Malawi*, (Japanese); Materials from the Japanese Foreign Affairs Ministry and JICA; Country Program Proposals of UNDP and UNFPA (1992-1996); and Government of Malawi, *Economic Report', Statement of Development Policies: 1987-1996.*

1 UNDP, "Advisory Note on the Government of Malawi - UNDP Fifth Country Program" (1992-1996).

structure of the economy remains largely unchanged. The weakest element in the entire adjustment process is the smallholder sector where productivity is stagnating at a dismally low level.

The rapid population growth and the breadth and depth of poverty in the country have emerged as the fundamental constraints to socioeconomic development in Malawi. By the 1980s, all the best land was already under cultivation, and small-holders were forced, under the pressure of rapid population growth, to move to increasingly marginal areas and to shorten or abandon fallow periods, which led to degradation of soils, falling crop yields and widespread deforestation.

Poverty is now the focus of socioeconomic development in Malawi. More than half of the population is estimated to be living below the poverty line. Moreover, the burden of deprivation is spread unevenly among the socioeconomic groups. Poverty hits the rural population most heavily, particularly small farmers. The "Statement of Development Policies: 1987-1996" (DEVPOL) lists the reduction of poverty as one of the Government's major objectives. The fifth UNDP country program with the Government also takes up "Human Development: From Poverty to Self Reliance" as its central theme.

a. Production

The Malawian economy remains predominantly based on agriculture which accounts for about 35% of the GDP, 90% of exports and 80% of total labor force utilization. The Agriculture sector is classified into two groups: small and large-scale agriculture. The former is essentially subsistence-oriented while the latter is more commercially-oriented, producing the majority of export crops. The smallholder sector, distinguished by customary land tenure, is by far the largest, absorbing three-quarters of the labor force and producing over 70% of the value added by agriculture (Tables 1-3, 1-4).

Agricultural output has been subject to large fluctuations caused by weather conditions. Real agricultural output stagnated in 1990 compared to the growth of 2.5% recorded in 1989 due to the untimely lack of rainfall around February/March in 1990. The impact of the dry spell was felt more in the production of smallholder crops, especially maize, than in the production of estate crops. The value added by small-scale agriculture declined by 3.4% in 1990, but is forecast to grow by 11.7% in 1991 (Table 1-5).

The industrial sector (manufacturing, electricity and water, and construction) in Malawi is small, contributing about 20% of the GDP and employing only 4% of the labor force.[2] The service sector accounts for about 40% of the value added. Within this

[2] As for the estimated sectoral distribution of the Malawian labor force, refer to section C, "Employment".

sector, the most important producers are Government, distribution, transport, and financial services. (Tables 1-3, 1-4)

The outputs for the major products (mainly in agriculture and fishery) are shown in Tables 1-6 through 1-11. Maize, being the staple food, is the most important crop cultivated. However, the production of maize, which accounts for 70% of smallholder acreage[3], has shown wide fluctuations over the past ten years, mainly due to effects of weather (Table 1-8). The seriously low production levels in 1986 and 1987 necessitated food aid imports. Table 1-11 shows the estimated production against the required amount for maize, and it clearly illustrates the underlying causes of food shortage, malnutrition and poverty. Table 1-10 shows the country's fishery production. Fish, which are found in Malawi's many rivers and lakes, are the most important source of protein for Malawians.

b. Trade

Malawi operates under the typical trading pattern of developing countries, which is exporting agricultural products and in return importing manufactured goods (Tables 1-13, 1-14). Being a land-locked country, the country's trade has been severely affected by rising external transport costs, particularly since the disruption of transport routes from Mozambique.

As shown in Table 1-12 and Figure 1-A, the trade balance of Malawi has shown constant deficits, except for the year 1984 when the country had a big trade surplus. The major export products are tobacco, tea and sugar. The agricultural products share over 90% of the export value. The share of tobacco has increased from 45% in 1971 to 70% in 1990, which depicts the heavy dependence of the Malawian economy on the tobacco industry (Figure 1-B).

Malawi's major trading partners, the United Kingdom (21%), U.S.A. (13%), Japan (13%), West Germany (10%), and South Africa (10%) were the major recipients of Malawi's exports in 1989. The share of the United Kingdom has declined from 40% in 1975 to 21% in 1989. On the other hand, Japan increased its share from 1% to 13% during the same period. The major suppliers of Malawi's imports are South Africa (24%), the United Kingdom (17%), Preferential Trade Area countries (11%), West Germany (6%) and Japan (6%) (Figure 1-C).

c. Employment

Detailed data on employment conditions in Malawi are not available. This is mainly because more than 80% of the labor force is employed in the non-formal and self-employed sectors,

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[3] World Bank, *Malawi: Growth Through Poverty Reduction*, 1990.

particularly in small-scale agriculture, and the formal sector wage employment only accounts for an estimated 16%.[4]

The total number of wage workers increased steadily during the 1970s, but its increase decelerated in the 1980s. During the 5-year period from 1975 to 1980, the wage employment rose at the average rate of 6% yearly whereas the average annual growth rate decreased to 1.4% from 1980 to 1987.[5] Table 1-15 shows the structure of employment in recent years. The employment in the agriculture, forestry and fishing shares accounts for nearly one half.

Considering the fact that the total wage employment is not increasing fast enough to keep up with the rapid growth of the labor force, there is now a rising concern for the increase in unemployment. There are no recent data available on unemployment. Table 1-16 shows the data from the Labor Force Survey in 1983. According to this Table, unemployment is concentrated among the youth in urban areas, particularly among women. The highest rates were for 15-19 year olds: 19.4% for men and 39.2% for women.

Historically, Malawi has been sending many seasonal workers abroad, especially to the surrounding countries such as South Africa. It has been said that in 1974, there were over 250,000 such workers (about 10% of the labor force in Malawi). However, due to declining job opportunities abroad, it is estimated that this number fell to 40,000.[6] Furthermore, despite the fact that Malawi has a large labor force population, the country suffers from the shortage of skilled workers and experts. This lack of skilled workers and experts has become a major obstacle in the country's development efforts.

d. Income

Only very limited data are available on income. Table 1-17 and 1-18 show monthly average earnings (1987-1989) and statutory minimum daily wage rates as at 1st January, 1987-1989.

Small-scale agriculture which provides a livelihood for approximately three-quarters of Malawi's population suffers most with the lowest income during the past ten years. It has been estimated that the per capita GDP in small-scale

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[4] House, W. J. and Zimalirana, G. "Rapid Population Growth and Poverty Generation in Malawi," ILO, 1991. Based upon their study, the estimated sectoral distribution of the Malawian labor force in 1990 is : Formal sector wage employment 15.9% (agriculture 6.4%, industry 4.1% and services 5.4%), Smallholder Farmers 74.4%, Unemployed 5.4%, and Informal sector 4.3%.

[5] *ibid.*

[6] Information provided by the Ministry of Foreign Affairs, Japan.

agriculture dropped by 25% between 1980 and 1990. In the modern wage employment sector, the average wage earner in the private sector saw his/her real income drop by approximately 40% between 1980 and 1989. Employees in public services suffered even steeper cuts in real wages, thereby losing over half of their purchasing power. Likewise, the real minimum wage declined by an average of 4% per annum over the past decade.[7]

B. Socioeconomic Development Plan

a. Responsible Government Agencies

Figure 1-D shows the central government organization effective January 7, 1992. In the strict sense, there is no "Planning Commission" in Malawi. Policy-making is centered at the Office of the President and Cabinet (OPC). It coordinates policies arising through political channels as well as those which are brought forward by senior civil servants. The Department of Economic Planning and Development (EP & D), which is also located within the OPC, holds the central planning function. Sectoral senior civil servants both in OPC departments and in ministries outside the OPC also play a role in policy-making within their respective sectors, but inter-ministerial policies are handled at the OPC level. Planning, distinct from policy, is elaborated through the same structures.

The DEVPOL sets the overall objectives of the Government's Development Plan for 1987-1996. Based upon the DEVPOL, the Public Sector Investment Program (PSIP) has been designed for sectoral investment planning and coordination.

The Ministry of Finance is the overall coordinating body through which all donor assistance is channelled to the Government. All the project proposals submitted to the Ministry of Finance are sent to the Planning Unit of the EP & D for appraisal. After project proposals have been reviewed to see whether they are in line with the DEVPOL, approved projects are included under the PSIP and become open to donor assistance. Such donor funding constitutes the "development account" which is separate from the Government's recurrent account.

b. Policy and Strategy

i) National Development Goals and Strategies

Since independence in 1964, the country's development strategy has essentially been two-pronged, focusing on infrastructure and agriculture. The major investment was directed to these two areas. Recognizing its resource constraints, the

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[7] UNDP, "Advisory Note on the Government of Malawi - UNDP Fifth Country Program" (1992-1996).

Government limited expenditures on other sectors. The social sector in particular has been receiving a relatively small share.

In 1988, Malawi published the DEVPOL, setting out the country's long-term development strategies. In the DEVPOL, the challenge in the decade ahead was "to reduce poverty, ignorance and disease by the achievement of rapid and sustained economic growth."[8] Based on the experiences with earlier structural adjustment programs, which had little impact on the people's standard of living although they did improve the economy at the macro level, the Government decided to implement a more focused strategy on reducing poverty.

According to the DEVPOL, the areas of focus are: 1) the increase of production in agriculture as well as the growth of the industrial and service sectors, 2) human resource development together with the building of social infrastructure; and 3) preservation of natural resources and environment. The priority areas and their respective strategies are as follows:

Agriculture:
In agriculture, the main goal is "to increase the yield of maize grown by smallholders so that the sub-sector can more efficiently realize the nation's food requirements and devote the land and labor resources thereby released from food production to the production of greater volumes of cash crops."[9] Policy focus in this sector is on food sufficiency, improvement in productivity, and increased access to credit and inputs. Much of this effort will be directed towards maize, but smallholders will also be encouraged to become involved in the production of other crops such as legumes, cashew nuts, burley tobacco, livestock, and in particular, groundnuts.

Industrial and Service sectors:
Though agriculture will continue to dominate the economy, the growth of the industrial and service sectors is seen as a prerequisite for sustainable prosperity. These sectors will have to employ a larger proportion of the rapidly expanding labor force. The Government aims at promoting growth of these sectors through more active encouragement of foreign investment and Malawian entrepreneurship, especially small-scale entrepreneurs. The Government emphasizes "the creation of a general climate which encourages enterprise and investment, both domestic and foreign."[10]

Social Services sector:
The DEVPOL states: "Although there are clear limits to the growth of government expenditure, the Social Services sector

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[8] Department of Economic Planning and Development, *Statement of Development Policies 1987-1996* (DEVPOL).
[9] *ibid.*
[10] Government of Malawi, DEVPOL.

will receive an increasingly large share than has been the case hitherto, both in investment and recurrent resources." The priority in education is to improve the coverage and quality of primary education. The issues concerning the quality of education will be addressed in terms of physical investment, teacher training, curriculum development, teaching aids, inspection and supervision. As for health services, PHC is considered as the key goal. The number of peripheral health facilities will be significantly increased. Particular attention will be paid to the provision of services to mothers and children. AIDS creates a major challenge to the Health sector and new actions to alert the population of the dangers of the disease will be taken.

Natural Resources and Environment:
Forests supply 90% of Malawi's fuel requirements. According to the Ministry of Forestry and Natural Resources, Malawi experienced a wood deficit of 1.6 million cubic meters in 1983, and this is projected to grow to a 7.6 million cubic meter deficit by 1995.[11] Further, the consumption of fuel and the expansion of arable farmland is such that the hectarage of forests is estimated to be declining by 3.5% a year, and much more sharply in certain areas.[12] The Government recognizes this as one of the major concerns and calls for necessary actions. The policy focus will include: identifying damaged or threatened areas and implementing actions to rehabilitate or protect them, encouraging tree planting, increasing the efficiency of wood consumption, and promoting alternative types of fuel for both domestic and industrial use.

In order to undertake the above-mentioned development activities, the Government emphasizes the importance of "capacity building" at all levels. The DEVPOL states explicitly that "unlike in the past, emphasis will be put more on spreading development in each district."[13] Therefore, a policy of selective decentralization will be pursued and the role of local authorities and communities will be strengthened.

ii) Investment by Sector

Table 1-19 and Figures 1-E and 1-F show the Government's budgetary operations. Although the overall budget remains in deficit over the years, there has been improvement during the past decade with the decrease of overall deficit as percent of GDP from 11.7% in 1981/1982 to 3.3% in 1991/1992 (estimates), owing to the increased revenue and the strict controls on expenditure.

The major investment has been made on infrastructure, and investment in social services remained at a low level.

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[11] UNFPA, "Proposed Third Country Population Programme of Malawi" (1992-1996).
[12] Government of Malawi, DEVPOL.
[13] *ibid.*

Throughout the 1980s, the country budgeted less than 5% of the national income for social services. This is extremely low by international standards. The education budget in particular is lagging behind. Whereas sub-Saharan African countries allocate an average of 17% of their budget to education, the sector receives less than 10% in Malawi.[14]

Figures 1-E and 1-F show the share of social services both in the recurrent and development accounts. Although the investment in the social sectors has doubled over the years as seen in the development accounts, its share still remains low compared to the Agriculture and Infrastructure sectors. Furthermore, the share of social services in the recurrent budget decreased from 22.4% in 1977/78 to 18.9% in 1989/1990. Meanwhile, the share of public debt servicing doubled during the ten-year period. In recent years, the country has spent nearly twice as much on debt servicing as on social services. The debt burden is obviously exerting a crippling effect on socioeconomic development in Malawi.

For the allocation of resources over the period 1987-1996 covered by the DEVPOL, the Government has been regarding the Social Services sector as a priority area. The provision of social services in the recurrent expenditure is forecast to grow by 5.7% a year in real terms: education by 5.7% and health by 6.4%. These growth rates, if achieved, will alter the distribution of recurrent expenditure among services. According to the Government projection, the share of social services in the recurrent expenditure is expected to rise from 18.9% in 1989/90 to 28.3% in 1996/97.[15]

iii) Trends of Foreign Assistance

In financing its development activities, Malawi has been heavily dependent on foreign assistance. In many cases, professional and technical personnel from abroad dispatched under technical cooperation schemes have played very important roles in all sectors by filling up vacant posts.

Table 1-20 shows the trend of foreign assistance during the past five years. In 1990, the total disbursement was $341.7 million with 48% bilateral and 52% multi-lateral. 61% were in the form of grants and the remaining 39% were loans (Figure 1-G, Table 1-21). With regard to the type of assistance, 44% of the total disbursements was for capital projects and programs; 33% for import support; and 23% for technical cooperation (Table 1-22, Figure 1-H).

The data on sectoral shares show that in 1990, the largest share of total aid flows went to the Transport sector. This was a major increase in its share, compared to 1989. The Agricultural sector was the second biggest recipient of aid as

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14 *ibid.*

15 Government of Malawi, DEVPOL.

in 1989, getting about one fifth of the total. Import support (Finance and Trade), Industry & Mining and Education continued to be important sectors receiving assistance both from bilateral as well as multi-lateral donors. The Health sector accounted for only 9%.(Table 1-23, Figure 1-I)

Table 1-24 and Figure 1-J show the major government institutions which received external assistance. The Ministry of Finance continued to receive the largest share of total aid flows to Malawi (about 29%). This represents the import support program assisted by various donors, both bilateral and multi-lateral. The Ministries of Agriculture and Works received substantial support from the donors, with 15.3% and 15.2% of total aid received, respectively.

The major bilateral donors were Britain, Germany, Japan and the United States. Britain and Germany provided 26.5% and 25.7% of the total bilateral aid in 1990, all in grant form. They were followed by the United States, Japan, France, and Canada, which provided 13.5%, 9.7%, 6.9% and 6.6% of total bilateral aid, respectively (Table 1-25, Figure 1-K).

Among the multi-lateral donor agencies, aid from the World Bank amounted to 58% of the total disbursements in 1990. The European Communities, ADF and UNDP were the other important multi-lateral donors, providing 19%, 8.3% and 7.7% of the total multi-lateral aid, respectively. The European Communities provided most of its assistance as grants. (Table 1-25, 1-26, Figure 1-K).

C. Country Background*

a. Geography

Malawi is a small country in the southeastern Africa, located west of Lake Malawi, the third largest lake in Africa. It has an area of 119,140 square kilometers of which 20% is water. It is landlocked, by Mozambique in the south and east, Zambia to the west, and Tanzania to the east and north. Topography is immensely varied, from the Rift Valley floor almost at sea level to mountains rising to 3,000 meters.

The country is divided administratively into three regions. The Southern Region is hilly, relatively densely populated. It is where a high proportion of commercial and industrial activities take place. It contains Blantyre, Malawi's major commercial center and largest city, and the old administrative capital Zomba. The Parliament still holds its sessions in Zomba. The Central Region is a fertile, well-populated plain with the new administrative capital, Lilongwe as its center. The government ministries were relocated to Lilongwe by 1979, and since then, the new capital has expanded rapidly. The Northern Region is mountainous, relatively infertile, and sparsely populated. The major center is Mzuzu.

Malawi's climate is generally sub-tropical with three seasons: a cool dry period from mid-April to mid-August, a hot period during which relatively little humidity builds up between August and mid-November, and a period of tropical rains between November and April.

b. History

Hominid remains and stone implements have been identified in Malawi dating back more than one million years, and it is believed that early humans inhabited the vicinity of Lake Malawi 50,000-60,000 years ago. Human remains at a site dated abut 8000 B.C. show physical characteristics similar to peoples living today in the "Horn of Africa".

Although the Portuguese reached the area in the 16th century, the first significant Western contact was the arrival of David Livingston along the shore of Lake Malawi in 1859. Subsequently, Scottish churches established missions in Malawi. One of their objectives was to end the slave trade that was being carried out there as late as the end of the 19th century. In 1878, a number of traders, mostly from Glasgow, formed the African Lakes Company to supply goods and services to the

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Note The major sources for this section are: APIC, *Socioeconomic Conditions of Malawi*, (Japanese version), 1985; materials from the Japanese Foreign Affairs Ministry and JICA; and the Government of Malawi, DEVPOL.

missionaries. Then other missionaries, traders, hunters and planters soon followed.

In 1883, the town of Blantyre was constructed, which provided a basis for the British rule in the area. In the same year, a consul of the British Government was accredited to the "Kings and Chiefs of Central Africa," and in 1891, the British established the Nyasaland Protectorate (Nyasa is the Chichewa word for "lake"). The British remained in control during the first half of the 1900s. During this period, a number of Malawian attempts were made towards independence but they ended in failure. In 1944, the Nyasaland African Congress (NAC) was formed by Malawians, but in the beginning, it was only supported by educated African elites and its organization was rather weak.

During the 1950s, pressure for independence increased when Nyasaland joined with Northern and Southern Rhodesia in 1953 to form the Federation of Rhodesia and Nyasaland. In July 1958, Dr. H. Kamuzu Banda returned to the country after spending many years in the U.S., the United Kingdom, and Ghana. He assumed leadership of the NAC, which later became the Malawi Congress Party (MCP). In 1959, Banda was sent to Gwelo Prison for his political activities but was released in 1960 which enabled him to attend the constitutional conference in London.

On April 15, 1961, the MCP won an overwhelming victory in the elections. In a second constitutional conference in London in November 1962, the British Government agreed to give Nyasaland self-governing status the following year.

Dr. Banda became Prime Minister on February 1, 1963, although the British still controlled Malawi's financial, security and judicial systems. A new constitution took effect in May 1963, providing for a virtually complete internal self-government. The Federation of Rhodesia and Nyasaland was dissolved on December 31, 1963 and Malawi became fully independent under its new name as a member of the Commonwealth on July 6, 1964. Two years later in 1966, Malawi adopted a new constitution and became a republic with Dr. Banda as its first President.

Government and Political System

Type: "Republic"
Independence obtained on July 6, 1964
Constitution: 1966

Head of State:
Dr. Hastings Kamuzu BANDA (Prime Minister in 1964, President 1966, Life President since 1971)

The administrative system adopted by the Government of Malawi is a greatly modified version of the British system. According to the 1966 constitution, the President is elected every 5 years by MCP officials and tribal chiefs. In 1970, however, by

a unanimous resolution of the MCP convention, Dr. Banda was proclaimed the Life President.

Legislation is enacted by the unicameral National Assembly (Parliament). The Parliament is currently made up of 101 elected representatives and presidentially appointed members. Malawi has only one authorized political party, the Malawi Congress Party (MCP). The National Assembly elections are held every five years by universal adult citizen suffrage (adults over 18). The most recent election was in 1987.

Malawi has two judicial systems: the magisterial courts, headed by a three-member Supreme Court, and "traditional courts" to deal with customary laws.

Malawi has three levels of public administration: the Central Government, the Local governments and Traditional Authorities. Local governments are found in each of the 24 districts and in the 3 regions, administered respectively by district commissioners and regional administrators. All are appointed by the Central Government.

The Traditional Authorities system has the following hierarchy: village headmen, group village headmen, chiefs, and, in some areas, Paramount Chiefs. Appointment is normally hereditary but is subject to confirmation by the Government. Traditional Authorities look into customary laws operating within their spheres of influence. They are reached through the district commissioners and they are responsible for collecting taxes and settling disputes.

d. Ethnic Groups, Religion and Languages

i) Ethnic Groups

Malawi derives its name from the Maravi, a Bantu people who came from the southern Congo about 600 years ago. Upon reaching the area north of Lake Malawi, the Maravis divided into two branches. One branch, the ancestors of the present-day Chewas, moved south to the west bank of the lake, and the other, the ancestors of the Nyanjas, moved down the east bank to the southern part of the country.

By A.D. 1500, the two divisions of the tribe had established a kingdom stretching from north of today's Nkhotakota to the Zambezi River in the south and from Lake Malawi in the east to the Luangwa River in Zambia in the west.

In recent years, ethnic and tribal distinctions have diminished. Despite some clear differences, no major friction currently exists between tribal groups and the concept of a Malawian nationality has begun to take hold.

The Chewas constitute 90% of the population of the Central Region; the Nyanja tribe predominates in the south and the Tumbuka in the north. In addition, significant numbers of the Tongas live in the north; Ngonis -- an offshoot of the Zulus

who came from South Africa in the early 1800s -- live in the lower Northern and lower Central regions; and the Yao, who are mostly Muslim, live along the southeastern border by Mozambique.

Only a small number of non-Africans (Asian and European origin) live in Malawi (0.3% of the total population in the 1977 Census). They are mainly concentrated in the major urban centers.

ii) Religion

No exact population figures are available by religion. However, the estimates are: Christians about 35%, Muslims 12%, and African traditional religions for the rest.[16]

iii) Language

The official language is English and the national language is Chichewa. However, other languages and dialects are also spoken, e.g. Chitumbuka, Chiyao, Chilomwe.

D. Social System and Customs

a. Family

In Malawi, there are two family systems: matrilineal and patrilineal. All ethnic groups in Malawi may be broadly placed into one or the other of these two systems. The matrilineal societies are: Chewa, Yao and Lomwe. The patrilineal societies are: Nkhonde, Lambya, Tumbuka, Ngoni and Sena. The Tongas tend to practice both systems. On the whole, the Northern Region is largely patrilineal and the Southern and the greater part of the Central Region are matrilineal.

In the Northern Region, villages consist normally of patrilineages: i.e. brothers, their wives, unmarried daughters and sons. Women born into the patrilineage depart at marriage to live in their husbands' homes. Inheritance and property ownership all follow the patrilineal line. On the other hand, throughout most of the Southern Region and the greater part of the Central Region, matrilineal systems provide the basis for village membership. Husbands generally reside in the wife's village. Land ownership, property inheritance and family structure are governed matrilineally. Great emphasis is placed on women producing children for their lineage. The traditional control of the father is never very strong. In the matrilineal society, the key male responsibility in any family is given to

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16 APIC, *Socioeconomic Conditions of Malawi*, (Japanese version), 1985.

the uncles, brothers or male relatives of the women rather than to their husbands.[17]

The desire for a large family is still very strong in Malawi. According to the 1984 Family Formation Survey, the mean desired number of children was 6.3 for men and 6.0 for women. The figure was slightly higher in rural than in urban. The current estimated total fertility rate is 7.6.

b. Inheritance Law and System

There are also two systems concerning inheritance, matrilineal and patrilineal.

The mission was unable to obtain the information on the overall system and laws concerning inheritance.

The following procedures are taken under the customary law, particularly for women in the case of their husbands' death:

In the case that there is a Will, the property must always be distributed as directed by the Will. If there is no Will, the property will be distributed depending on where the marriage was arranged. If the marriage was arranged in any of the districts in the Central Region and any of the districts in the Southern Region except Nsanje, the law directs distribution as follows:

> When the husband dies, all the household belongings which the wife used before the death of the husband become the wife's. These include the doors and windows, roofs, etc. of the house provided she wishes to continue to reside there.
>
> 2/5 of the estate left by the husband will be distributed between the wife, the children of the deceased and other direct dependents. The share to this property will be equal unless special reasons exist. The law recognizes the following as special reasons.
> - any wishes expressed by the deceased
> - any assistance rendered by the deceased to some person in his life
> - the contribution made by the widow to the estate
> - the marital status of the beneficiaries, etc.

If the marriage was arranged in any of the districts in the Northern Region or in Nsanje, the property would be distributed as follows.

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[17] Demographic Unit, University of Malawi, *Report of Workshop on the Value of Children and Child Spacing Practices in Malawi*, 1987.

All the household belongings which the wife used before the husband died will be the wife's.

Half of the estate will be shared between the wife and her children fathered by the deceased as well as other direct dependents.

The remaining half (1/2) is distributed between the relatives of the deceased who are entitled to a share under customary law.

If the marriage was made under the Marriage Act, the distribution of the husband's property assuming he made no will would be as follows:

The wife as the surviving spouse will be entitled to receive the first K10,000 from the estate.

The remainder of the property shall be divided equally between the wife and the children of the deceased husband. The children include both legitimate and illegitimate children of the husband.

If the husband left no children, the wife would be entitled to the remainder of the property provided that the husband left no parents or siblings. If the husband left parents and siblings, the wife would be entitled to half of the estate and they would take the other half.

It is common in some areas of the country that upon the death of the husband, the wife is required to select from among her husband's close relations (brothers or cousins) a new husband. She is however free to decline. Under the matrilineal tradition, if she was living in the husband's village, she will be required to leave. She has the right to take her children with her. In the patrilineal tradition, even if she declines to accept a new husband, she is entitled to continue living in the husband's village and to receive support from members of his family.[18]

c. Marriage System

In Malawi, there are various types of marriages. These are:
i) marriages under the Marriage Act,
ii) marriages under customary law,
iii) Asiatic marriages.

i) Marriage under the Marriage Act
The Marriage Act was enacted by the Parliament of Malawi (Laws of Malawi, Chapter 25). Some of the concepts were borrowed from England. Under this Act, a man and a woman may contract marriage 21 days after causing banns to be published. Banns

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[18] Ministry of Community Development.

are merely notices informing the public of the forthcoming marriage. The marriage must however be celebrated within 3 months of the publication of the banns.

The notice is given by completing the appropriate forms. These forms can be obtained from the Registrar General who is the Registrar of Marriages, and also from District Commissioners who act as agents. There is a requirement under the Act for parental consent to be given for this type of marriage if a person is under the age of 21. Parental consent is however not necessary in the case of widows or widowers even if they are under 21. These marriages require celebration in a licensed place and in a place where the public has free access.

ii) Customary Marriages
There are two traditions as mentioned above: the patrilineal and matrilineal. In general, the customary laws of the woman's birthplace apply. However, the two parties are free to discuss and to expressly agree on which set of customary laws is to be adopted. If there is no expressed agreement, the courts will inquire into the procedures which were adopted in contracting the marriage. Generally under customary laws, persons who are closely related may not get married to each other, but there are exceptions according to region.

In customary marriages, there appears to be a strict requirement that a particular individual should give consent to a marriage. But by common practice or courtesy, some key members of both families must be informed of the intended marriage. All customary law marriages are potentially polygamous.

iii) Asiatic Marriages
Persons of Asian origin who are not Christians may, under the Asiatic Act (Marriage, Divorce and Succession), marry under the laws of the religion they profess. All they are required to do is to follow whatever is customarily done and accepted by persons of the same religion in Malawi. Upon persons of Asiatic origin contracting a marriage, the priest who is officiating issues a certificate which must be signed by both himself and the couple. The duplicate of the certificate is sent to the Registrar of Marriages.[19]

d. System concerning Births, Deaths and Child Bearing

Vital Registration

Malawi has no universal vital registration system. There is a legislation under the Registrar General which makes the registration of births, deaths and marriages compulsory for the non-African population and voluntary for the African

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[19] Ministry of Community Development, and the Marriage Act from the *Laws of Malawi*.

population. Therefore, only very insignificant proportions of total births, deaths and marriages are registered.

Under the present system, in order to register a birth, a parent or another person on his/her behalf must obtain and complete a birth report form obtainable from the Registrar or a District Commissioner. Information on the parents, i.e. names, addresses and professions are entered on the form. The name of the child and place of birth are also entered. The person completing the form, called the informant, also gives his or her details. This form is then submitted to the District Commissioner or the Registrar with a fee. All this must be done within three months of the birth of the child. When the Registrar receives the birth report, he will issue a birth certificate and sends it to the parents or the informant.

A death is registered similarly by completing and sending to the Registrar or a District Commissioner a death report with a fee. If the death occurred in a hospital, the medical officials would be requested to complete the death report. If the death occurred outside a hospital, the reporter can be someone who witnessed the death. The death certificate will be sent or given to the informant by the Registrar.

In villages, the Traditional Authorities usually keep track of what is happening within their sphere including births, deaths and marriage. There has been a discussion to institute a vital registration system utilizing the existing system of Traditional Authorities. However, considering the cost and manpower required, the establishment of a universal vital registration system for Africans is not a priority issue on the Government's agenda.

e. Maternity Leave

For female civil servants, there is a regulation granting a paid maternity leave. In response to the child spacing initiatives and the promotion of safe motherhood, the Government has recently approved the granting of Maternity Leave limited to only once every three years. As a result, the amended Malawi Public Service Regulation 1:541, which took effect from 1st April 1991, states the following:

> "a female civil servant may be granted paid maternity leave up to 90 consecutive days for purpose of confinement before or after delivery...[but] no paid maternity leave shall be granted to a female civil servant unless three years have elapsed from the date of the [last] child's birthday."[20]

Although the percentage of female civil servants constitutes only a small fraction, the Government has publicized the change

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[20] Department of Personnel Management and Training, "The Malawi Public Service Regulation 1:541," amendment.

of this regulation widely, hoping to set a model for other employers in the private sector to follow.

E Education

a. Formal Education System

The education system of Malawi is basically composed of primary school (8 years from Standard 1 to 8) and secondary school (4 years from Form 1 to 4). Higher institutions of learning include the University of Malawi as well as Technical Schools and Primary School Teacher Training institutions. Education is not compulsory under the present system.

The University of Malawi, which was established in October 1964, is presently composed of five colleges: Chancellor College, Polytechnic, Bunda College of Agriculture, Kamuzu College of Nursing and the College of Medicine.

As shown in Table 1-27, there has been a general increase in enrollment at all levels of the formal education system since 1965. During the past ten years (1980/81-1989/90), primary education enrollment rose by 63.7%, secondary enrollment by 62.9%, primary teacher training by 65.8%, vocational/technical training by 14.2% and university enrollment by 55.9%.

In general, primary school enrollment is about 53% (the percentage of the number of children enrolled in primary school within the total estimated population aged 6 to 13 years as of 1988/89).[21] Despite rising primary school enrollments since the 1970s, there are large regional disparities. Net enrollments are markedly higher in urban and in the northern part of the country.[22]

There is also a high percentage of drop-outs and repeaters. The inability to pay school fees is a major reason for dropping out. As shown in Tables 1-28 and 1-29, only a limited number of children complete primary education to receive the Primary School Leaving Certificate (PSLC). Although primary school lasts 8 years, it takes an average of 16 years for a child to complete the cycle.[23] Only an estimated 5.7% of those who complete Standard 8 or 8.1% of those with PSLC go onto secondary school, which is about 4% of the eligible age group (Table 1-29).

There has been a modest but steady increase in girls' enrollment in primary schools over the past decade, from 30% of total enrollments in 1980 to 44% in 1987 (Table 1-30).

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[21] Government of Malawi and UNFPA, *A Report on Population Programme Review and Strategy Development for Malawi*, 1991.
[22] House, William J.and Zimalirana, George, "Rapid Population Growth and Poverty Generation in Malawi," ILO, 1991.
[23] Government of Malawi and UNFPA, 1991.

Statistics show that girls continue to drop out of primary school earlier and in greater numbers than boys. After Standard 1, about 29% of girls drop out of primary school compared to 23% of boys. After Standard 6, approximately 23% of girls leave school.[24] Inability to pay is the major reason for drop-outs of girls as well as the lack of guidance, prejudiced parent/teacher attitudes, or, among older girls, pregnancies.

From 1992, the Government has abolished tuition fees only for Standard 1. As a result, it is reported that the enrollment has risen 2 to 3 times. The Government set the target of increasing the primary school enrollment to 70% by 1995/96. In 1991, the USAID initiated support for formal education by paying the school fees for all non-repeating female students in Standards 2-8.

There are also serious deficiencies in the quality of education. As shown in Table 1-31, the number of qualified teachers does not match the rising enrollment, with an average qualified teacher:pupil ratio of about 80:1. There is also an acute shortage of physical facilities, textbooks, exercise books and supplementary reading materials.

Education is seen as a necessary input to the attainment of certain national development goals. The Government has now committed itself to increasing the education's share of the recurrent budget from less than 10% to 15% by 1995/1996.[25] Its share was 9.1% in 1988/1989.[26] However, the share of the Education sector in the GDP at market prices has been declining over time. At 3.0% in 1980/81, the share went down to only 2.4% of the GDP in 1989/1990.[27] Nearly one half (48.1%) of the recurrent expenditure on education was spent on primary school education, followed by 16.9% on university and 11.7% on secondary schools in 1989/1990.[28]

b. Literacy Rate

The majority of the total population is illiterate. Table 1-32 shows the changes in the literacy rate from three previous census results. At the time of Independence in 1964, the literacy rate was said to be only 10%, mainly applying to men.[29] Since then, much progress has been made as seen by the literacy rate of 41.6% in 1987.

From the girls' low school attendance rate, one can easily deduce that the literacy rate for women is much lower than that

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[24] House and Zimalirana, 1991.
[25] Government of Malawi, DEVPOL.
[26] Government of Malawi, *Economic Report 1991.*
[27] House and Zimalirana, 1991.
[28] Ministry of Education and Culture, *Education Statistics, 1990.*
[29] House and Zimalirana, 1991.

of men; it was 52.4% for men and 31.6% for women in 1987. There are geographical differences in literacy rates. Generally, they are higher in the Northern Region than in the Central and Southern Regions.

F. Medical System

Health services are provided mainly through two channels; the Ministry of Health (MOH) and the Private Hospitals Association of Malawi (PHAM). PHAM facilities are responsible for 40 to 45% of the country's health services. There are also private health practitioners, private company or estate financed health facilities for employees, and those run by other government agencies such as the army and the police. Details will be discussed later in Chapter 3.

Health services provided at the MOH facilities are free except for those who can afford to pay and request for paid services. The services provided by the PHAM facilities and private practitioners are provided on a fee-charging basis. Due to the rising medical cost and financial constraints, the Government is presently considering the introduction of a cost-sharing scheme. However, this raises a controversial issue as it might deprive the poor people of health services.

The mission was unable to obtain information regarding medical insurance systems in Malawi. There is no public medical insurance scheme; only private ones are available.

G. Women's Issues

General Conditions

Women in Malawi, especially rural women, are particularly disadvantaged. Most Malawian women live in rural areas where they are preoccupied with growing enough food for their families under the circumstances of increasing land pressure and widespread poverty.

Women get married at age 17 on the average, and nearly 85% of women get married before age 20.[30] On average, women bear 7.6 children, one quarter of whom die before age 5. Over 50% of children under 5 are malnourished. Life expectancy at birth for women is 47 years old.[31]

The literacy rate for women is 31.6% (Table 1-32). Although most girls enter school, only about 3% of girls reach secondary

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[30] Ministry of Health, *Family Formation Survey 1984*.
[31] World Bank, *Women and Development in Malawi: Constraints and Actions*, 1991.

school due to high drop-out rates and shortage of schools available.[32]

Employment opportunities are limited, and most women are subsistence smallholder farmers. As explained earlier, wage employment in the formal sector constitutes only about 16% of the labor force. Table 1-33 shows that between 1984 and 1986, only about 15% of those employed in the formal sector are women. These women are concentrated in a narrow range of generally low-paying jobs.

In the Agriculture sector, the number and proportion of women farmers who have no husbands or whose husbands have migrated to find work are large and increasing. As shown in Table 1-34, almost 30% of rural smallholder households were headed by women, and they often suffer from seasonal labor shortages, have poorer harvests and hence lower incomes per capita.

The productivity of female farmers is generally lower due to their limited access to agricultural services, inputs and credit, making it less likely that they will adopt high-yielding packages and other agricultural innovations. For example, as shown in Table 1-35, women are much less likely than men to take agricultural credit. In response to the efforts of the Ministry of Agriculture, the participation of women in the credit system has shown much improvement in recent years.

Women in Government

Women's participation in national policy-making and planning is limited by the extremely low representation of women in high level government jobs, especially outside the traditionally "female-oriented" fields such as welfare, home economics, health and education. Presently three deputy ministers are women. Only fourteen of the 112 members of the Parliament are women.[33]

Women are also very poorly represented in local government. Educational requirements are a barrier to election to the local councils for most women. There is a much stronger presence of women in village committees although this varies by area and committee function. Low representation of women in local governments and among party executives militates against the consideration of gender issues in decision-making. As long as the proportion of literate women remains low, their status and influence on policy issues is likely to remain limited.

Institutional Arrangements for WID

i) The National Commission for Women in Development (NCWID)

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32 *ibid.*
33 *ibid.*

Established in 1984, it provides a policy-level institutional mechanism for assisting women and integrating them into the mainstream of development. NCWID, which is under the Chairmanship of the Ministry of Community Services, has a coordinating and catalyst role in the implementation of activities directed to improving women's status which are undertaken by individual ministries, parastatals and non-governmental organizations. Several committees have been formed to focus on different areas: Education and Training, Family Health and Welfare, Employment, Legal, Planning, Research and Evaluation, Agriculture and Natural Resources, and Small and Medium Scale Enterprises.

In the actual implementation stages, it has been noted that the NCWID has several weaknesses. For example:
1) as an administrative unit of the MOCS, it cannot raise and administer funds independently, thus, it lacks resources to assist and motivate members;
2) only the MOCS and the MOA women's programs have institutional capacity to deal with WID issues; and
3) its objectives are not clearly defined nor is there a detailed agenda or work plan.[34]

The Legal Committee reviewed the country report submitted to the UN Committee for the Convention on the Elimination of All Forms of Discrimination Against Women in 1990. A handbook on laws related to women is presently being prepared by the Committee with the support of UNFPA and the U.S. Government.

ii) Chitukuko Cha Amayi Malawi (CCAM)
This body was established in 1985 as a women's development organization under the Malawi Congress Party, distinct from the Women's League of the Party (WL). There are CCAM committees in each of the 24 districts, the chairperson of each also chairs the district WL committee. Apart from promoting and expanding WID activities, CCAM sees its role in the mobilization of women, e.g. in agriculture by encouraging them to grow more crops, in education by encouraging them to attend functional literacy classes, and in forestry through tree planting and nursery raising. Lately CCAM has been making efforts to promote income-generation activities by rural women's groups.

iii) The Ministry of Women and Children's Affairs
In early 1992, the Ministry of Women and Children's Affairs has been set up by the Government, attached to the Ministry of Community Services in response to the plight of women and children.

H. Other Social Indicators

Tables 1-36 to 1-38 show other indicators concerning the development in the social sector, such as source of drinking

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[34] Government of Malawi and UNFPA, 1991.

water, types of toilet facility and the availability of radios, comparing data from 1984 and 1987.

a. Source of Drinking Water

Source of drinking water has a very important bearing on the health and hygiene of the people. There are differences between urban and rural areas. According to the 1987 Census, the major source of drinking water in rural areas is well (47.4%), followed by river, spring, and lake or reservoir, while in urban areas piped water in and outside the dwelling unit accounted for 78.5% (Table 1-36).

b. Toilet Facilities

As for toilet facilities, the most used toilet facility is pit latrine/bucket both for urban (72%) and rural (62.9%) areas. However, while 23% of people surveyed in urban areas have flush toilets, 35.8% in rural areas have no toilet facilities at all (Table 1-37).

c. Households with Radios

Owning a radio in Malawi is still difficult for most of the population. Approximately one out of five households has a functioning radio set. There is a big gap between rural and urban areas: 15.4% for the rural areas against 44.7% for the urban areas in 1987 (Table 1-38). The Malawi Broadcasting Corporation transmits a single-channel 19-hour broadcast every day that can be received by 70% of the country. The main constraint to radio ownership appears to be the high cost of radio sets: at a minimum of one month's average urban wage, and one and a half months' rural wage.[35]

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35 *ibid.*

2. POPULATION-RELATED ISSUES

A. Change in Population Composition

a. Population Growth

Since the attainment of Independence and the establishment of the National Statistical Office in 1964, Malawi has had three comprehensive population censuses, one in 1966, one in 1977 and the most recent one in 1987, for which only the Preliminary Report and Volume 1 of the Summary of Final Results have been published (as of March 1992). The remaining four volumes, containing fertility and mortality tabulations, economic activity, housing conditions, and migration, plus the methodological and analytical reports were not available to the consultants of this mission at the time of their visit.

Since there is no compulsory and universal vital registration system for the African population in Malawi, many of the births, deaths and marriages go unreported. The most recent vital rates can only be estimated by extrapolation from the results of the 1977 census and some of the surveys conducted in the early 1980s. Moreover, since 1986, it is said that about one million Mozambican refugees have crossed the borders into Malawi and are now settled in camps. However, these people have not been enumerated in the 1987 census, and demographic information concerning this large group of settlers is not readily available. As can be deduced from the tables appearing later in this chapter under foreign immigration, there has always been a steady flow of immigrants from the neighboring countries of Malawi, namely Mozambique, Zambia and Tanzania. Although the breakdown of these figures is not available, one could assume that most of the immigrants come from Mozambique, since Malawi shares both its western and southern borders with Mozambique.

Table 2-1 shows the growth of the total population from 1901-1987. The history of census taking in Malawi goes back to 1891, but the African population was included for the first time only in 1901. Pre-independence censuses were conducted in 1911, 1921, 1926, 1931, 1945 and 1956. The census count of 1926 was considered a gross underestimate as can be seen from the very low (1.5) and very high (4.4) annual growth rates between the periods 1921-26 and 1926-31. The 1956 census was excluded because the African population was estimated and not enumerated.

In any case, the population growth rate of Malawi seems to have been in the range of 2-2.5% per annum for 1901-45, and since 1945, it has been experiencing a steady and faster rate of growth, the major cause of which can be attributed to the improvement of health facilities and hence lower mortality rates. The influx of immigrants from neighboring countries and the rising number of returning Malawians from abroad have also been contributing to the increase.

b. Population Growth by Sex, Region and District

Table 2-2 shows the population increase by sex and district. Between 1977 and 1987, the population had increased by 44%, or at a rate of 3.7% per annum. The female population grew slightly more slowly at 3.6% per annum. The high increase seen during this intercensal period in Machinga, Chikwawa and Nsanje maybe due to Mozambican immigrants from across the border as well as general rural to rural migration, both intra-regional and inter-regional.

Fig. 2-A shows that according to United Nations projections, the population will continue to increase and at a faster rate in the future, given the high levels of fertility and falling mortality. Table 2-3 shows the actual population figures enumerated in the last three censuses, and the respective population densities by region and district. Out of Malawi's total surface area of 118,484 sq. kms., 24,208 sq. kms. (about 20%) are taken up by Lake Malawi and other bodies of water. Therefore, Malawi's population density is high even by African standards. The Northern Region is comparatively sparse; the Central Region has several areas of high density especially in the southern part, and the highest densities are found in the Shire highlands of the Southern Region and around the commercial city of Blantyre.

The crude rate of natural increase indicates how much the population would grow if there were no migration. Based on the differences between CBRs and CDRs calculated from the number of births and deaths in the 12 months prior to the 1987 census, Table 2-4 shows that the highest natural rate of increase was found in Mchinji and Mwanza districts, while the lowest was seen in Karonga district.

Tables 2-5 to 2-8 demonstrate that during the time of the 1966 census, there was a large number of migrant male workers, who resided abroad because of better job opportunities, as indicated by a sex ratio of 90 males per 100 females. The 1987 sex composition was similar to that in 1977 (93 males per 100 females in 1977 and 94 in 1987), after the return of those workers to Malawi due to decreasing employment opportunities abroad.

According to the figures in Table 2-6, 50% of the population enumerated in the 1987 census resided in the Southern Region, 39% in the Central Region and 11% in the Northern Region. The distribution in 1977 was the same as that of 1987. Looking at the districts, Lilongwe had the largest population, followed by Mulanje, Blantyre, Machinga/Mangochi, and Zomba/Mzimba/Thyolo. Chitipa and Rumphi in the Northern Region had the fewest inhabitants.

c. Population Distribution by Age

The distribution of the population by age (Table 2-9) shows the proportion of under ones and under fives in the total population. The high percentages indicate the heavy burden

being placed on the health delivery system, particularly in MCH services whose target groups cover these age groups.

The population pyramids for 1966, 1977, 1987, 2002 and 2025 are shown under Fig. 2-B, followed by the actual figures tabulated in Tables 2-10 to 2-14. The projection for 2002 indicates that one-fifth of the population will be under five, if mortality declines slowly and fertility remains constant.

A point also to be noted here, which is of interest, is that the dependency ratios (the number of persons aged less than 15 years plus those aged 65 years or more per 100 persons aged 15-64 years) of 1966, 1977 and 1987 are at high levels of 92, 97 and 101 respectively.

d. Population by Race

The ethnic groups residing in Malawi have been divided largely into African, European (ancestors originating in Europe, the Americas, Israel, Russia, Australia or New Zealand) and Asian for the purpose of enumeration. In the 1930s, the influx of Asians increased and the ratio of Europeans to Asians reversed. However, the high ratio of African to non-African has been consistent over the years (Tables 2-15, 2-16).

e. Population by Religion

No figures are available from any of the censuses concerning the breakdown of the total population by religion, but according to a UNFPA report, there are purported to be about 1 million Muslims, 1.95 million Catholics, about 2 million members of other medium-sized Christian denominations such as Anglicans, Seventh-Day Adventists and Baptists, in addition to several smaller Christian groups with memberships ranging from as small as 1,500 to nearly 60,000.[36]

f. Labor Force

Unfortunately, this category of data from the latest census has not yet been published, therefore some of the figures are projections based on the 1977 rates. Table 2-17 shows the age specific participation rate (ASPR), defined as the percentage working to total population in a specific age group.

For the total population, the ASPR was lowest in the age group 10-14 and highest in the age group 45-54. About two-thirds of those 65 and over were participating in economic activities. Except for the age group 15-19, the ASPR was consistently higher in the males. By region, the lowest rates were found in the north. Urban areas showed lower rates than rural areas in all regions, except for the age group 45-54 in the Northern Region. The male ASPRs in the urban areas were considerably higher than those of females. However, the difference between

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36 *ibid.*

the ASPRs in rural and urban areas for females was larger than the corresponding difference for males.[37]

Tables 2-18 and 2-19 illustrate the magnitude of the employment problem facing Malawi as the size of the population and labor force will increase by nearly 40% in the decade 1987-1997. The projection is fairly reliable since the labor force in the 1990s has already been born. Planners need to be alerted to the fact that the employment problem will continue well into the next century, and even grow in terms of its absolute magnitude. Inevitably, such supply pressure in the labor market will exert a strong downward influence on the overall level of wages as competition for jobs among those displaced from their own land will tend to suppress any tendency for real wages to increase.[38]

g. Urbanization

Fig. 2-C & D and Table 2-20 shows the trend of urbanization in Malawi. At present, the official policy of the government is to adjust spatial distribution by means of curbing rural-to-urban migration, modifying the rural and urban configuration of settlements, and redressing regional imbalances in economic development and population distribution. The capital was moved from Zomba to Lilongwe in 1975 to promote more balanced economic development. The National Rural Development Program was adopted in 1978 to create integrated rural development programs and rural growth centers to reduce rural-to-urban migration.[39]

The rate of urbanization in Malawi, at around 11% urban in 1987, was lower than in the neighboring countries because jobs were difficult to find, even for skilled workers in the cities and the cost of living was very high (e.g. rent). Urban growth has been mostly concentrated in the centers of Blantyre, Lilongwe, Zomba and Mzuzu.

B. Population Dynamics

a. Fertility

i) Crude Birth Rate

The 1977 census reports that the CBR for the period 1976/77 was about 55.3 per 1000 population per year. This figure has been calculated with adjustments which compensate for the substantial under-reporting of births. The rural CBR was determined to have been around 55.4, and the urban CBR at 53.7. Based on Table 2-4, the highest CBR from the 1987 census was

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[37] Government of Malawi, *Malawi Population Census 1977*, Analytical Report, Vol. I (Population Characteristics), 1984.

[38] House, William J. and Zimalirana G. "Population Dynamics, Employment Implications and Labor Market Considerations in Malawi," 1992.

[39] United Nations, *World Population Policies Vol II*, 1989.

found in Mchinji in the Central Region, at 48.4 per 1000. Blantyre had the lowest CBR (35.9) but also the lowest CDR (9.4).

ii) Total Fertility Rate
As a general rule in Malawi, childbearing begins by 18 or 19 years. Although 18-24 months of breastfeeding is recommended at the health facilities, postpartum amenorrhea is relatively short, on average 9 months, and postpartum abstinence even shorter, on average 6 months. It is therefore not surprising that nearly a quarter of birth intervals in 1991 were found to be shorter than 2 years, and 60% less than 3 years.[40]

Basically, there has not been any fluctuation in fertility over the past two decades. Fertility in Malawi has been extremely high and stable, at a TFR of 7.6 in both 1977 and 1982 (Table 2-22, 2-23). From the Family Formation Survey of 1984, the calculated TFR was even higher at 7.72 (Table 2-24). Urban fertility was slightly lower than the rural: 7.21 versus 7.62 in 1977. In terms of geographic distribution, there was an overall pattern of higher fertility in the heart of the Central Region, in the extreme South and in the Northern Region highlands. Fertility was generally below average in the Southern highlands, lakeshore areas and in the extreme north of the country.[41]

Only 27% of women and 35% of men in the reproductive ages reported knowledge of a CS method (modern and/or traditional) in the 1984 Family Formation Survey, conducted the same year as the initiation of the national CS program. The use of modern CS methods are estimated to be currently around 3%, but levels will have to be much higher if a significant impact on fertility is to be achieved in the future.

b. Mortality

i) Crude Death Rate
Mortality decline in the 1970s was slow (Table 2-25), but it appears to have accelerated between the mid 1970s and mid 1980s, perhaps due to the establishment of a comprehensive primary health care network in the mid 1970s. Referring again to Table 2-4 for 1987 data, Ntchisi and Ntcheu districts in the Central Region were found to have the highest CDR based on the number of deaths 12 months prior to the 1987 census.

Considering the urban/rural differentials, in 1977, the CDR in urban Malawi was significantly lower in all regions (Table 2-26), and was experiencing a faster decline. Mortality differentials by sex were within the normal range; females enjoyed a generally lower mortality than males amounting to about a 2-3 year advantage in life expectancy. Table 2-27

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[40] Government of Malawi and UNFPA, 1991.
[41] *ibid.*

showing the age-specific death rates highlights the extremely high rate of under five childhood mortality.

With the recent emergence of the AIDS epidemic, the net mortality decline over the next decade maybe stalled. Although national data on HIV prevalence is not yet available, it is evident that since the first clinical diagnosis of AIDS in 1985, the epidemic has been spreading at alarming speed and intensity especially among urban residents and those living or working along major roads. Given these conditions, urban mortality may rise rapidly, not to mention infant mortality. The rise of TB incidence around the country, of late, maybe one indication; moreover, a majority of hospital in-patients are reported to be HIV positive upon admission with other illnesses. The demographic impact of AIDS in the following decades cannot be predicted with any accuracy unless more information about its infection rates becomes available.

ii) Infant Mortality Rate
Even in the early 1970s, the national IMR was reported to be as high as 190 per 1000 live births, with a third of all children dying before the age of 5. This was a significant drop compared to about 200 in the 1960s. In Table 2-30, data from 1987 points to the fact that the IMR ranged from 106 (Chitipa) to 191 (Nsanje).

According to the MOH, the official IMR for Malawi was 151 in 1986, a number which was considerably higher than other east and southern African countries.[42] The lack of a vital registration system leads one to believe that the actual IMR must have been and is still much higher, as there are a significant number of infant deaths which go unreported, particularly when so many deliveries take place at home.

It is also said that rural IMR is twice that of the urban. Since nearly 90% of the population is rural, this means that over 95% of all infant deaths are in the rural areas. If this ratio holds true for rural children aged between one and four, then the number of deaths among rural children under five accounts for more than half of the total mortality in Malawi.[43]

iii) Neonatal Mortality Rate
MOH data regarding age-specific mortality within the under fives are very limited. The data that have been collected in the past strongly suggested that about one-quarter of the under-five mortalities occured in the first months of life, another one quarter or more between the second and twelfth months, and the remaining one-half in the first to fourth year.[44] The only figures available for neo-natal mortality are listed regionally in Table 2-29.

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[42] Ministry of Health, *The National Health Plan of Malawi 1986-1995.*
[43] *ibid.*
[44] *ibid.*

iv) Maternal Mortality Rate

UNFPA reported that research in Malawi has demonstrated an MMR ranging from 100-460 deaths per 100,000 live births, although the official rate accepted by the MOH is 250. In view of the TFR at 7.6, the life time risk for Malawian women of dying from pregnancy complications is 1 in 32. Maternal mortality was high even though women on the average each had more than three ante-natal visits during the period of pregnancy. The main causes of maternal deaths were considered to be illegal abortions (particularly in teenage mothers), obstructed labor, puerperal sepsis and hemorrhage (refer to Table 2-33). In general, women arrived at the health facilities too late, due to reasons such as a lack of transport and dependency on traditional medicine, and the care which they did receive was often less than adequate to save their lives.[45]

Table 2-29 also lists the number of maternal deaths and the MMRs between 1980 and 1989 by region. The highest rates were found in the Northern Region (Table 2-30). The MOH has been placing more emphasis on safe motherhood and expanded MCH services to remedy the situation.

v) Average life expectancy

UNICEF figures in Table 2-31 indicate that life expectancy showed a marked improvement in the late 70s to early 80s after a primary health care system was installed, but since then, no major changes have been seen, probably due to the prevailing high levels of IMR. Looking at the 1976/77 data in Table 2-32, once a child reached 5 years of age, his or her life expectancy rose by more than a decade, implying that the higher incidence of deaths in the under fives was significantly lowering the life expectancy figures at birth.

c. Cause of Death

In Malawi, malnutrition (rate of 56.5%, compared to 37% for Kenya and 28% for Zimbabwe) underlies all illnesses and therefore results in high mortality levels.[46] Undernutrition and diarrhea in children results in wastage and begins a vicious cycle that increases their susceptibility to a host of other diseases. Higher morbidity and mortality rates for diarrhea are seen particularly in December and January, during the pre-harvest days of the wet season.

The data presented in Table 2-33 give an incomplete picture of the actual situation, since the in-patient reporting rate from various health facilities in the country is only around 70% according to the MOH.

Malaria has been highly prevalent in all age groups and in every part of the country except at the highest altitudes.

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[45] Government of Malawi and UNFPA, 1991.

[46] World Bank, Staff Appraisal Report, 1991.

From the resultes of a survey conducted in 1984, the MOH reported that a significant level of chloroquine resistance was found in some of the common parasites. Although the EPI program in Malawi has been very successful, the coverage is still not high enough to alleviate the problem of measles. According to the MOH, measles cases are usually under-reported because mothers traditionally tend not to seek assistance for it.

d. Marriage

Marriage for women in Malawi is early, stable, nearly universal and mainly monogamous. Men in Malawi tend to marry at later ages than women, and on average, men are more than five years older than women when they marry.[47] Remarrying is common and rapid following widowhood or divorce, and about one fifth of men over 40 have more than one wife.[48] According to the report from the 1984 Family Formation Survey, one quarter of Malawian women were in a polygamous union. The prevalence of polygamy declined with increasing levels of education and urbanization, but the concept is generally well accepted in Malawian society, even as a form of maintaining the traditional practice of postpartum abstinence (more details in Chapter 4).

i) Marital status
With reference to Tables 2-34 and 2-35, the proportion of married men was higher than that of women, because men were less likely to be widowed, more likely to remarry or to have more than one wife. The "never married" category in Table 2-36 mainly consisted of those in the 15-19 age group who may have delayed their marriage due to higher educational levels.

ii) Marital age
According to Tables 2-34 and 35, marriage for women was most common between the ages of 15 and 18. 62% of Malawian women aged 15-49 were married for the first time before they turned 18. The mean age of first marriage for ever-married women aged 20-49 was therefore 17 years. The only factor that seemed to affect marital age was education and not the area of residence, since the urban/rural differential was less than one year.

e. Migration

Unfortunately, no data from the 1987 census on migration was available at the time the mission visited Malawi. Therefore, the following analyses had to be based only on the results of the 1966 and 1977 censuses.

i) International migration
In former decades, there was a significant number of Malawian laborers seeking employment in Zimbabwe, South Africa and

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[47] Ministry of Health, *1984 Family Formation Survey Volume 1*, "Survey Description and Background Characteristics," 1987.
[48] Government of Malawi and UNFPA, 1991.

Zambia. During the 1970s-1980s, flows to all of these countries decreased substantially in response to the dwindling employment opportunities. As of mid-1987, the official policy was to maintain emigration at the current levels. Emigration of workers on contract to South Africa, which was terminated by the Government of Malawi for some years during the 1970s, was resumed with a bilateral agreement in 1977, establishing an annual recruitment quota of about 2,400 workers. [49]

An opposite flow of refugees in recent years into the Southern and south Central Regions of Malawi from Mozambique has steadily increased, amounting to about 300,000 at the time of the 1987 census and an estimated 1,000,000 at present of whom 70% are women and children, putting considerable pressure on arable land and a heavy burden on the health facilities in those areas. However, as previously discussed, this population is not enumerated in the censuses. The Government is keen on repatriating the refugees, through policies such as ensuring that Portuguese, their official language, is taught in schools to Mozambican children. But given the absence of sociocultural disparities between the refugees and Malawians, and the relatively stable living conditions sponsored by the UNHCR (United Nations High Commission for Refugees), it is not very likely that they would move back voluntarily to Mozambique in the near future.

Looking at Table 2-39, in 1966, there were 294,500 persons in Malawi who were born abroad, amounting to 7.3% of the total enumerated population. Female immigrants outnumbered their male counterparts. Of the lifetime immigrants, the bulk (97%) came from countries in Africa. As many as 81% of the immigrants were from the bordering countries of Mozambique, Zambia and Tanzania. Comparing the census results of 1966 and 1977, a slight decrease was seen in the volume of immigration into Malawi, and the share of immigrants from neighboring countries among total immigrants declined from 81.4% to 72.3%. However, the share from other countries in Africa, not counting the neighboring ones, increased from 15.5% in 1966 to 25.3% in 1977.

The distribution of immigrants by age given in Table 2-41 shows that 50% of the immigrants were below age 24, and male immigrants were on the average slightly older than their female counterparts.

Table 2-42 shows that 22,625 people were resident outside Malawi exactly one year before the census. The majority of Malawians who migrated originated from the rural areas. Among the Malawi born immigrants, the people in the Northern Region migrated the most, considering the fact that that region has the smallest population of all the regions.

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[49] United Nations, *World Population Policies vol II*, 1989.

Table 2-43 points out that the median age for the foreign born population residing in Malawi at the time of the 1977 census was 33 years, compared to about 17 years for the Malawi born population. The fact that almost one-fifth of the lifetime immigrants in 1977 were in the over 60 age group indicates the stable nature of immigration into Malawi over history.

Finally, the changes from 1978-1987 in the migrant worker population to South African mines are presented in Table 2-44 as reference.

ii) Internal migration
More than half of all internal migration has been historically rural to rural, including outflows from the Northern Region to the more fertile areas in the Shire highlands and inflows into the growth points of Central Region such as Kasungu and Mchinji districts. [50]

By 1977, the incidence of internal migration in Malawi compared with 1966 appears to have increased. In 1977, about 17.2% of the total population born and living in Malawi were enumerated outside their district of birth. Another important shift in the pattern of internal migration for lifetime migrants between 1966 and 1977 may be noted in the migration across regional boundaries. The districts in the Northern Region continued to net-loss people to districts in other regions. On the other hand, the Southern Region experienced a reversed trend, from a net-gaining region by 1966, to a net-losing region by 1977. The Central Region was the only gaining region by 1977.[51]

Table 2-45 shows the districts with the top five net-gain or net-loss in population. Although the capital was moved from Zomba to Lilongwe in 1975, Zomba did not make the top five districts with net-loss in 1977, and Lilongwe fell from second place to fourth place in net-gain during 1966 and 1977. It can be said that urban to rural migration has perhaps been more common in Malawi than the trend of rural to urban migration seen in other developing countries.

f. Population Projection

No matter what kind of population projection one uses, and even under the severe threat of the AIDS epidemic and the most optimistic scenario of rapid fertility decline, all evidence points to the fact that Malawi will face substantial population growth in the coming decades.

The dependency ratio of children to adults of working age will continue to rise beyond the current high levels, reaching perhaps 1,012 per 1,000 by the year 2002 (Table 2-46). A crisis of land scarcity for agriculture causing widespread

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[50] World Bank, *Population Sector Study*, 1991.
[51] Government of Malawi, *Malawi Population Census 1977 Vol.1*, Analytical Report, 1984.

poverty and malnutrition is imminent within the next twenty years, as the population will have doubled if the current growth rate continues. There will be severe shortages of fuelwood, high pressures on the employment market, and a marked decrease in per capita expenditure on social services if the budget allocations to those sectors remain unchanged. With the speed of decrease in mortality rates surpassing those of fertility, the rate of natural increase will rise into the next century (Table 2-47). The proportion of women in reproductive ages will be over one-half of the total female population by 2025 (Table 2-48). Unless major changes in fertility patterns are brought about by population policies, and stronger commitment is achieved from all sectors and at all levels to lowering population growth, Malawi will remain one of the least economically developed countries in the world.

3. HEALTH SERVICE

A. Policy on Health and Medical Services

Soon after the Alma Ata declaration for primary health care (PHC) in 1978, the Malawi Government adopted this as the most effective strategy for achieving the "health for all by 2000" goal. Since then, the emphasis has been on fostering community participation through mobilization and motivation, and the multisectoral sharing of responsibility among different Government ministries as well as the private sector and NGOs to improve the health delivery system. Thanks to those efforts, although many of the health indicators are still sub-standard in Malawi, the childhood immunization program (EPI) was found to have registered remarkably positive results compared to other equally underdeveloped nations in an evaluation done in 1983.

In view of these achievements, the Grand Alliance for the children of Malawi was launched in October 20, 1988 by the Life President Dr. Hastings Kamuzu Banda. This declaration committed Malawi to universal child immunization and TTV for pregnant women by the end of 1989, the 25th anniversary of national independence. Since the strategy for implementation of immunization is through the PHC network, other non-immunizable childhood diseases and malnutrition can also be brought into the open and given attention as a result of the social mobilization stimulus for EPI.

a. Policy and Strategies

The National Health Policy of Malawi, under the current National Health Plan for 1986-1995, stresses the need "to raise the level of health of all Malawians through reduction in the incidence of illness and occurrence of death in the population by developing a sound service delivery system capable of promoting health, preventing, reducing and curing disease, protecting life, and fostering the general well being and increased productivity."[52]

The first Health Plan (1965-1969) launched shortly after independence concentrated primarily on the development of curative services and nursing manpower. A new 15-year Health Plan (1973-1988) identified major priorities such as the development of basic health services, control of communicable diseases, expansion of curative services, manpower development and improvement in the organization of the MOH. This plan was amended in 1975 and 1978, with a shift of emphasis to expansion of MCH services (including nutrition and CS) and the introduction of a pilot PHC program.[53]

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[52] Office of the President and Cabinet, Department of Economic Planning and Development, *Statement of Development Policies 1987-1996 (DEVPOL)*.

[53] World Bank, *Staff Appraisal Report*, 1991.

As a follow-up to some of the achievements thus far, the National Health Plan for 1986-1995 set the following long-term goals:

To achieve a drop in early childhood mortality of 33.3% over a five-year period; to achieve an improvement in maternal health; and to impact on the extent and severity of illness due to major causes of morbidity [among persons] 5 years of age and over through the PHC approach and/or core health services.[54]

To accomplish these goals, six specific objectives have been developed[55]:
1. To improve coverage through a rational network of available and acceptable facilities and services.
2. To establish effective mechanisms for MOH manpower development and deployment.
3. To improve the managerial processes of the expanded health delivery system.
4. To expand the range and quality of services directed at maternal health, children under age 12 months, and the children between 1-4 years by addressing priority diseases.
5. To improve the health status generally by strengthening relevant programs.
6. To improve the nutritional status of mothers and young children as a basic strategy.

The strategies to be followed in pursuit of these policies, according to the above-mentioned six objectives, will be:

For Objective 1
Further establish the community role in PHC.
Extend the presence of health centers and rural hospitals.
Strengthen the hospital system.
Strengthen the integration of services at district level.

For Objective 2
Strengthen MOH program of personnel development.
Establish responsibility in the health planning section for manpower planning.

For Objective 3
Review drug policy and legislation.
Strengthen the management processes for drug production and delivery system.
Introduce improved management systems and programs of training to strengthen personnel management and supervision throughout the health delivery system.
Strengthen the planning process of the MOH.
Strengthen financial planning and control procedures.

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[54] Ministry of Health, *The National Health Plan of Malawi, 1986-1995.*
[55] *ibid.*

Provide and/or strengthen information basis adequate for effective planning, management and evaluation.

For Objective 4
Strengthen family health services.

For Objective 5
Strengthen selected disease control services through a complementary community and facility-based approach.
Strengthen Environmental Health Services.
Strengthen the Health Education Component so that it is capable of promoting healthy behavior which will make maximum impact on the major health problems of the country.

For Objective 6
To improve the nutritional status through a multisectoral approach.

CS has not been included as one of the objectives mentioned above. However, it is clear that despite the lack of an explicit population policy, CS is fully recognized by the authorities as a crucial health-related measure for Malawi to curb population growth in order to achieve socioeconomic development for the improvement of living standards of the people. The program and policies of CS in Malawi in relation to population issues will be dealt with in detail in the following chapter.

b. Targets and Goals
The Government has established the following targets for 1986-1995:

-reduction of IMR from a national average of 151/1,000 to 100/1,000 live births;
-reduction of 0-4 cumulative mortality from 330/1000 to 210/1000 population;
-reduction of maternal mortality from 160 to 100 per 10,000 births;
-increase in the contraceptive prevalence rate to 10%.[56]

So far, these priority activities are being undertaken by the MOH and other related organizations according to the following policies:

(1) Increasing the coverage of peripheral health services, strengthening district health services, and upgrading existing health centers, district and central hospitals;
(2) Expanding the capacity of training facilities for manpower development;
(3) Increasing technical assistance for district levels, such as through support in the management of health information, pharmaceutical production, laboratory, services, etc.

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[56] World Bank, *Staff Appraisal Report*, 1991.

(4) Strengthening MCH/CS services for family health through technical assistance, IEC, training, provision of supplies, vehicles, etc.
(5) Improving efforts in disease prevention programs such as malaria, bilharzia, TB, and environmental health education;
(6) Strengthening nutrition programs.

c. Finance

According to the DEVPOL, capital expenditure by the MOH over the decade is estimated to be at MK176.7 million in 1986 prices. Gross recurrent expenditure in 1986 was estimated at just over MK45 million. The net increase in recurrent costs was forecasted to be at an average of approximately 7% a year over the decade (1987-1996), reaching approximately MK71 million by 1996.[57]

Financial resources from the Treasury are available to the health sector through the MOH, PHAM, and other local Government bodies. Of these, the financial resources of the MOH are the largest, making up over 85% of the total, according to the National Health Plan. Latest figures on the breakdown were not available to the mission for presentation in this report.

All healthcare services provided by the MOH are basically free in Malawi, except for the nominal fees charged in special paying wards and dispensaries at the central hospitals . World Bank reports that the revenue from private patient fees amounted to about MK0.75 million, or roughly 1% of the MOH budget in 1990/91.[58] Health facilities not under the MOH such as those belonging to PHAM and the Ministry of Local Government (explained later in the chapter) do charge fees for their services. The MOH does not have a plan to start a fee-charging system in the near future, although discussion on the issue of cost-sharing is underway among the various health provider groups because a difference in the fee systems is creating a distortion in health service utilization patterns.

The government expenditure from 1967-1991 and the percentage of health expenditures are tabulated in Tables 3-1, 2 and 3. The two most recent figures in 3-1 and 3-2 are World Bank estimates. In Table 3-4, we can see that the growth of the capital development account has been erratic over the years, while the recurrent account saw a more steady growth, except for a fall between 1987 and 1988. The development account, which will be elaborated further in the next paragraph, relies heavily on external donor assistance, therefore its amount largely fluctuates depending upon how many projects are being supported that particular year.

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[57] Office of the President and Cabinet, *DEVPOL*.
[58] World Bank, *Staff Appraisal Report*, 1991.

*Development account

External assistance to the Government in the form of foreign loans and grants and some local contributions make up the MOH's "development account", used primarily for capital expenditures. Although preventive health is being actively integrated into curative services, most of the development expenditures in Malawi are still related to curative medicine, with most scheduled allocations being for physical infrastructure, such as the renovations of district hospitals and building of health centers.

In Table 3-5, the health development expenditure is listed against the total development expenditure by the Government between 1981/82 and 1991/92.

The MOH development budget will have to continue increasing in the future to accommodate the manpower development program which will supply the much needed staff to the expanded outreach and peripheral health facilities.

*Recurrent account

The first five years of the health plan (1986-1990) is based on the assumption that there will be no real growth in the MOH's recurrent budget. Recognizing the budgetary constraints, much emphasis is placed on improved cost recovery and cost effectiveness. At the same time, emphasis is placed on the consolidation of existing services and expansion of priority health programs which have low recurrent cost or manpower implications.[59]

The recurrent budget includes salaries, which take up the largest share, plus costs for drugs, costs to run hospitals, equipments, vehicles, etc. and is district-specific. The development budget is project-specific; it covers fees to initiate projects and is therefore only supplied for a specific period of time. When donor assistance to the items under this budget are terminated, the Government must transfer them to the recurrent budget.

Government revenues which are allocated by the Treasury to the MOH are placed into the MOH recurrent account. In 1985/86, the Treasury contributed about 68% of the recurrent budget, and the rest was income from medical fees and external sources.[60] External support is mostly in the form of drugs and medical personnel.

According to the Economic Report (Table 3-6), the MOH's recurrent expenditures rose from MK18.7 million in 1981/82 to an estimated MK111.3 million in 1989/90. The percentages spent

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[59] World Bank, "Staff Appraisal Report, Republic of Malawi, Family Health Project" (draft), 1986.
[60] *ibid.*

on health are listed in Table 3-7. Even though the expenditures have been increasing, the share of health expenditure within total Government expenditures has not changed significantly in the past decade. In view of the high natural rate of increase causing the population to double every 20 years, the actual recurrent expenditure per capita would in fact be falling. Moreover, expenditures have consistently exceeded approved budgets in the past, due to the increased operating costs of existing services and the recurrent costs of new projects being developed.

The Government fully recognizes the importance of improved health services for enhanced labor productivity, the links between better social indicators and reduced fertility levels, and the need to reduce morbidity and mortality rates to curb population growth. However, under the current situation, giving increased priority to the social sectors financially may still be very difficult.

Tables 3-8 and 3-9 show the breakdown of MOH expenditures in 1987/88 and 1991/92, pointing out that a disproportionate proportion of the budget is going to the three major hospitals, or the domain of curative care. This is considered inappropriate particularly at a time when the MOH is trying to decentralize the health delivery system.

As seen from all these tables, the mission found that information from various sources concerning finances in the Health sector differs widely, and a variety of figures exist even for the same category. Therefore, even though the figures from different sources do not match, they were all included in this report as reference.

d. Foreign Assistance

From 1990 figures (see Table 1-23 in Chapter 1), foreign assistance to the Health sector was 5.2%, which was significantly lower than the other sectors. Table 3-10 shows the breakdown of foreign aid to the Health sector. Below are brief descriptions of some of the programs being undertaken by the major donors in the Health sector. Foreign donor support specifically for MCH and CS projects are described in Chapter 5.

(i) The World Bank

The main priorities of the health reform program under World Bank support outlined by the Government are the following:

Strengthening of basic health services; upgrading of support services for healthcare; improvement of efficiency in PHN (Population, Health and Nutrition Sector) facilities and programs, with particular attention to reducing costs at hospitals; improvement of policies determining how PHN services are financed, with particular attention to patient fees and cost sharing; strengthening, as part of all the above, the

decentralization and division of labor of responsibilities in PHN service delivery[61].

In the population sector, the World Bank's participation in population activities has been mostly through the First and Second Family Health Projects which were US$7.5 and US$12.7 million respectively. These two health projects contributed to modernizing the health infrastructure upon which any health delivery programs depend. The PHN Sector Credit was negotiated between the Government and the World Bank in February 1991 and launched in July. This Credit includes components such as PHC/MCH, CS, malaria, AIDS, nutrition, women in development, as well as renovations of infrastructure.[62]

(ii) African Development Bank (ADB)
ADB's support in the Health sector was started in 1983 at the same time as the World Bank. The ADB has already financed two health projects, providing support for the reconstruction of health centers and district hospitals. The ADB is also financing the expansion of the Kamuzu College of Nursing aimed at increasing the number of much needed RNs. The ADB supports a five-year activity in WID, including credit schemes, IEC and institutional strengthening, with the MOCS, CCAM and the National Commission for Women in Development.

(iii) WHO
WHO has collaborated with the Malawian Government in the following main areas:
disease control and prevention for example in Trypanosomiasis, malaria, diarrheal diseases, and sexually transmitted diseases including AIDS.
water and sanitation
technical information support
logistic support, such as vehicles, audiovisual aids, drugs, laboratory equipments, etc.
manpower development and support through fellowships for training both domestic and abroad
research development and training
essential drugs and vaccine program
technical and material support for primary health care activities.

There is currently a WHO technical consultant (medical adviser) dispatched to the MOH through funding by the UNFPA.

(iv) UNICEF
The on-going 1988-92 UNICEF program directs its assistance to the sectors of health, education, nutrition, and NGO support. Although there are no specific components on population and CS, lowering mortality through EPI, program activities such as training for TBAs, mobilization of primary school teachers and villagers to promote preventive health for children, women's

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[61] World Bank, "Staff Appraisal Report (draft)," 1986.
[62] Government of Malawi and UNFPA, 1991.

income-generating schemes etc. will all have broad impacts on population and development issues.

As mentioned earlier, the EPI coverage in Malawi has been very high. Recent data on coverage are presented in Figs. 3-A, 3-B and Table 3-11.

The EPI plan of action has the following objectives:
(1) Eradication of poliomyelitis by the year 2000
(2) Elimination of neonatal tetanus by 1995
(3) By 1996, reduction in measles deaths by 50% and reduction in cases of measles by 50% over pre-immunization levels.

Now, the problems facing the EPI program include the rising cost of vaccines by 30-40%, the low involvement of the school system, the still low coverage of TTV for pregnant women and WRA (women of reproductive age), the shortage of staff, and the lack of functional transportation.

With the Government, other donors and NGOs, UNICEF is completing a "Situation Analysis on Poverty" as a basis for its next program. UNICEF's proposed total funding for the 1992-1996 program is US$56.85 million, of which $16.5 million will come from general resources.

The major components of UNICEF's 1992-1996 program are:
1) Primary Health Care Program; focusing on safe motherhood and child health, EPI, malaria control, community financing of PHC, AIDS control, and micro-nutrient deficiencies;
2) Community development through area-based nutritional capacity building and community child care;
3) Urban area-based program, including child survival, water and sanitation, household food security and income generation and education;
4) Food security, nutrition policy analysis and surveillance;
5) Education program focusing primary/adult literacy and non-formal education for the youth;
6) Strengthening the social mobilization infrastructure;
7) Water and environmental sanitation program;
8) Refugee women and children program.

(v) U.S. Government/USAID
USAID is involved in human resources and development, in the supply of almost 100% of the contraceptives currently needed, and in logistics support, family health, AIDS, training of health surveillance assistants (HSAs) and grassroots healthcare workers, IEC activities, etc. An 8-year bilateral Family Health and AIDS project is scheduled to be launched in mid-1992 with an estimated total budget of $45 million.

(vi) British Government/ODA
ODA has provided technical and material support to census data processing activities and is now working with the National Statistical Office in provision of computer equipment and training. ODA also funds part of the salaries of British doctors in Malawi, fellowships for medical students and

supported the establishment of the new medical school in Malawi.

(vii) Others
Other foreign governments which support health activities in Malawi include South Africa, Canada, Germany, Denmark, Japan and the Netherlands just to name a few. Due to the severe shortage of Malawian medical doctors and health administrators, the foreign doctors who are dispatched usually serve both as clinical as well as administrative staff at various levels of the health system.

B. Health System

The main providers of health services in Malawi are the three agencies: MOH, PHAM, and MOLG. PHAM, although mainly religious missions, receives one third of its funding from the MOH. Other providers include private health practitioners, private company or estate facilities for employees, and government agencies such as the police and army.

There is a three-tier health care delivery system which consists of central, specialized and district hospitals at the tertiary level; rural hospitals (primary health centers) and health centers at the secondary level, and static and mobile clinics provided through the health centers as well as village health posts (or village health committees) at the community level, where dispensaries and maternities are also found. Dispensaries do not perform deliveries but do provide antenatal services.

Tables 3-12 and 3-13 present data from 1987 concerning health institutions, the number of beds, and the distribution by region and district. Table 3-14 shows health facilities and number of beds by controlling agency and by district for 1990.

In 1986, 20% of all health facilities were situated in the Northern Region, 33% in the Central Region and 47% in the Southern Region for populations of 860,000, 2,785,000 and 3,432,000 respectively.[63] Accessibility to health services in Malawi is defined as living within 8 km of a fixed health facility and it is officially reported that about 80-85% of the population now have access. However, there are many areas of the country still underserved by health facilities, and also some regional variations with regard to the distribution and coverage of health facilities. "Accessibility" also depends on factors such as transportation, the frequency and timing of services being provided, and the ability of patients to pay fees when necessary.

Generally speaking, the tertiary level facilities (especially the central hospitals) in Malawi are seeing a disproportionately large number of patients when compared to

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[63] World Bank, "Staff Appraisal Report (draft)," 1986.

the peripheral facilities, due to the uneven distribution of MOH resources among them. More appropriate allocations as well as policies to strengthen the secondary and primary levels of health care are urgently needed.

a. Central Level

The Principal Secretary is the senior manager in the MOH who is responsible for both the technical and administrative branches (Fig. 3-C). On the administrative side, the Deputy Secretary is responsible for the administrative units such as finance, personnel, administration and internal audit. The Chief of Health Services has overall responsibility for all technical services (Fig. 3-D). He is assisted by the Deputy Chief of Health Services and other technical staff.

Under the MOH, the health care delivery system has three levels, regional, district and peripheral. As at 1991, the MOH ran 2 central hospitals (Kamuzu Central Hospital at Lilongwe, and Queen Elizabeth Central Hospital in Blantyre), 1 general hospital in Zomba and special hospitals (which offer specialized services including mental health services and in-patient care for leprosy and TB cases) at the regional level. At the district level, there were 21 district hospitals (one for each district plus the three central hospitals which serve as district hospitals for their respective districts). At the peripheral level, 113 health centers, 9 maternity units, 93 dispensaries and 15 health posts were in operation.

The peripheral health facilities have a daily patient load of between 100-200.[64] Central hospitals provide specialist referral care for their relevant regions. The Kamuzu Central Hospital (KCH) serves both the Central and the Northern regions, and also serves as the health center and the district hospital for Lilongwe district (it covers a population of 3.5 million). The Queen Elizabeth Central Hospital (QECH) covers the Southern Region and the Blantyre district, sharing with a smaller number of specialists posted at Zomba General Hospital.

The mission was given the opportunity to visit the KCH. KCH was opened in October 1977, with aid from the Danish Government. Only the first phase was implemented so the available space is only half of what was intended. Its budget is about K6.5 million a year. There are about 4,000 out-patients a day, and although there are only 640 beds, there are sometimes as many as 1,500 in-patients. About 40% are referred from districts. About 2,500 adult out-patients are seen per day, and 1,500 children attend the under 5 clinic. The hospital is divided into two and situated in separate locations: the new wing, and the Bottom Hospital which contains an X-ray department, Laboratory, Nursery, antenatal and postnatal clinics giving CS services, operating theater, TB wards for males, females and children, psychiatric unit for males and females, Malawi vs. polio (orthopedic ward) for males, females and children, and an

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[64] World Bank, *Staff Appraisal Report*, 1991.

out-patient department. The mission was told that there are about 20-30 deliveries a day of which 2-3 require caesarian sections, and 11 delivery beds.

In KCH, there are 26 specialists and 7 clinical officers running the following departments: Medicine (5 specialists and 2 government officers), Surgery (5 specialists), Orthopedic surgery (3 specialists), Pediatrics (3 specialists), OB/GYN (3 specialists), Dermatology (1 specialist), and Radiology. Only 10 of the doctors are Malawian. There are two wards and two out-patient departments: one fee-charging and one free of charge.

There are 12 staff members in the laboratory which had the following divisions: Biochemistry, Bacteriology, Parasitology, Serology, and Hematology. The laboratory examines specimens from the out-patient department as well as outside clinics.

Drugs are purchased from the Central Medical Store. Some drugs are also supplied to KCH by donors such as the German, Canadian, South African and British Governments, but not necessarily based on the hospital's request.

Much of the hospital's equipment needs to be replaced, repaired or replenished. Because a variety of donors make contributions, the equipment in the health facilities in Malawi is not standardized. Since repair and maintenance require extra effort, much broken equipment ends up lying idle.

b. Regional Level

The system of Regional Health Officers (RHOs) began two years ago. The Northern Region had no RHO as of March 1992. Ideally, the RHO should oversee all district health facilities including those outside of the MOH system. In reality, however, the RHOs (and DHOs) have very little authority over non-MOH health providers, as MOH has not taken leadership to explain its policies and guidelines of decentralization of power to the RHOs, DHOs and the service providers concerned.

From January 1 1992, a system of reporting from DHOs to RHOs and RHOs to the CHSU (the epidemiology and HIS center of the MOH) began. Before, CHSU received information directly from the DHOs and annual summaries were returned to them as feedback.

Some of the forms currently being used to collect patient information from health facilities are attached as Appendix V. These include:

1. The Child Health Card (U5 Card) for growth monitoring and EPI record
2. Two types of TBA recording forms
3. Tetanus Toxoid Card
4. Child Spacing Client Recording Card

Each of the country's three regions has a Regional Health Team comprising of a Regional Public Health Inspector and a Regional

MCH Coordinator who report directly to their respective units at the MOH.

c. District Level

The District Health Officer (DHO) is responsible for all health services in the district, and he/she is the chairperson of the district PHC Committee (explained later in the Chapter). The District Management Team consists of the DHO, matron, inspectors, chief clinical officers and other peripheral staff. They visit health centers once a month for clinical visits and once every 6 weeks for supervisory purposes.

There is one district hospital in each district sited at the district center. These are referral centers for health centers but also serve local town populations. The services offered include:

(1) various curative services at both in-patient and ambulatory levels;
(2) preventive services;
(3) relevant support medical and non-medical services such as laboratory, radiography and laundry.

During the mission's visit to the Salima District Hospital (serving a population of 26,000) in the Central Region, the following information was gathered. Usually for district hospitals, the DHO who is a medical doctor heads the medical section and below him/her, a Chief Clinical Officer. In the nursing department, there is a Matron, several registered nurses and enrolled nurse midwives. For environmental health, there are Senior Health Inspectors (District Health Inspectors), Health Assistants (HAs), and Health Surveillance Assistants (HSAs). For administration, there is a hospital secretary, accountant and clerks.

There are 5 wards in the Salima District Hospital: Pediatrics (both surgical and medical), Maternity, Male, Female and TB. There are 168 beds but a bed occupancy of about 226 per day. The main causes for hospitalization are malaria, meningitis, and TB. The number of out-patients including MCH can be around 300 per day during peak years, and there are an average of 145 deliveries a month. There are 9 vehicles of which only 6 are running. These cars go to the health centers for ambulatory, immunization, and MCH activities. DHIs use motorcycles for preventive health, and at the village level, bicycles are used.

The static U5, antenatal and CS clinics are held every day. The outreach clinic is held three times a week, operated by the same staff running the static U5 clinic.

d. Community Level

The health center forms the nucleus of area PHC covering a population of about 10,000 and consisting of 10 to 15 villages. The health center is usually headed by the medical assistant, with ideally at least one HA, 2 ENMs, 1 HSA, one Community Health Nurse, one Female Ward Attendant (as assistant to

nurses), and other periphery staff such as servants, ground staff laborers and watchmen.

The services offered at a health center include:

- Curative services to treat common diseases;
- MCH services;
- Improvement of nutritional status via growth monitoring and nutrition clinics;
- Micronutrient supplementation especially for mothers;
- Disease control;
- Proper management of health services in the area.

Outreach services are provided weekly or fortnightly from some health facilities. Usually, the mobile team consists of 5-7 members including a SRN, ENM, HSA, and domestic assistants. A mobile clinic is set up based on requests from the communities and after village leaders have been consulted.

A primary health center (or "rural hospital") is meant to serve a population of 50,000. The primary health center usually includes a Clinical Officer and even an SRN/Midwife apart from the staff available at the health centers.

The PHC approach adopted by Malawi in all 24 districts since 1988 consists of training district area and health center staff in concepts, community sensitization and the establishment of village health committees. Village health committees are sub-committees under the village PHC committees, which execute activities under the area PHC committees. Most of the activities of village health committees are being funded by donors including international NGOs. The committees are endorsed by the area chairmen of the political party.

The HSAs are in charge of supervising health volunteers, who are key members of the village health committee. The health volunteers receive 2 weeks training to learn growth monitoring, nutrition, health education, treatment of diarrhea and malaria, advantages of CS, how to fill the U5 cards, etc. The TBAs identified by the village health committee and sent for training also become active members, and community workers in other sectors such as the agricultural extension workers also play a role in health promotion activities.

ORGANIZATIONAL STRUCTURE OF MALAWI'S PHC SYSTEM

National PHC Committee
|
National PHC Technical Subcommittee
|
Regional PHC Committee
|
District PHC Committee
|
Area PHC Committee
|
Village PHC Committee