

# Population Programmes and Policies for the 1990's: National Family Welfare Council of Malawi

Mrs. R. Chinyama

## Introduction

The National Family Welfare Council of Malawi is a statutory body under the Ministry of Women and Children Affairs and Community Services. Established by an Act of Parliament No. 20 of 1990. The Council's major objective is to contribute to improved welfare and living conditions of the entire Malawi people in accordance with their ability to provide for their families' basic and other needs.

The Council will work towards the achievement of a situation where child spacing will be accepted, recognised, practised, promoted and propagated as a critical factor in the socio-economic development and well-being of every Malawian. One major expected output is to increase people's awareness of the benefits of child spacing, thereby contributing to increasing the demand for services.

Another important output will be improving the quality and delivery of child spacing services, as well as increasing the overall contraceptive prevalence rate, and enabling families to freely make their own decisions regarding spacing and family size. The ultimate aim will be to improve the welfare and living conditions of women and children in particular and, indeed, the entire population. In pursuance of this mission the council will work in collaboration and partnership with Government, Non-Governmental Organisations (NGOs), the private sector and communities.

## Goals

- To improve the standard of living and quality of life of Malawian families;
- To address the negative socio-economic and other effects of rapid population growth on the country's resources and on sustainable development.
- To improve the health of women and children; and
- To significantly contribute to the identification of unmet need in the national child spacing programme, and to address these needs through strengthening of population IEC activities of various service providers/implementing agencies.

## Short and Medium-term objectives

- Establish the Council on a sustainable basis by 1996;
- Continually appraise the demand for, and delivery of child spacing activities among all service providers; the Government, CHAM and the private sector;
- Develop realistic and achievable national family welfare strategies by 1996;
- Have, by 1994, developed a management plan with attainable objectives, priorities for support and action (to the Council and all service providers) with emphasis on activity coordination, advocacy and service roles of the Council;
- Have, by the end of 1996, a coordinated national child spacing strategy for programme implementation which will provide information and access to quality child spacing services to at least 35% of the Malawian population; and
- Increase the contraceptive prevalence rate from an estimated 5% in 1991 to at least 15% in 1996.

## Activities

The Council's main activities will be in three key areas: coordination, service delivery, and advocacy.

## Coordination

Coordination functions will include developing a comprehensive national child spacing service delivery strategy which will serve to coordinate service delivery at national level, among a growing number of public and private sector providers, and

in doing so, increase access to child spacing services. The Council will also ensure service delivery services which are safe, acceptable, efficient and consistent with clients' and target group's preferences.

Additionally, it will set realistic service delivery targets consistent with current and anticipated supply of, and demand for child spacing services, to which national demographic and development goals can be related. The NFWCM will ensure maximum use of resources by avoiding duplication of effort among various service providers.

## Service Delivery

In promoting service delivery, one major function of the Council will be to serve as a resource for information, technical assistance and on-the-job training in a range of technical and programmatic areas related to child spacing service delivery. These include: policy formulation, programme and project design, counselling, quality assurance, medical and clinical aspects of contraception, new contraceptive technologies, and programme evaluation. Service provided by the Council will lead to improvements in the quality and safety of child spacing services, as well as to an increase in the use of contraceptives. The Council will initiate and promote new approaches (on pilot basis) to service delivery in order to satisfy existing and new demands on services.

## Advocacy

The NFWCM will be in the forefront in advocating and advancing the case for child spacing. Two basic dimensions to the Council's advocacy work will be: first, to promote positive changes in attitudes and policies which will increase access to child spacing services, and second, to promote suitable Government, Council and donor discussions with a view to identifying more resources for service delivery. The Council will also publicise benefits of child spacing to individuals, families, communities and the nation at large, act to reduce cultural, legal, political and religious constraints to expanding child spacing services, and undertake those activities which increase human and financial resources devoted to child spacing service delivery. Some of the specific tasks to be undertaken will be:

- continuing the education and sensitisation of policy and decision makers, opinion and church leaders, and other influential people regarding child spacing, population and development activities, using a variety of media; and
- policy development for service expansion to advocate modifications in strategies and policies which will facilitate the expansion of child spacing services and promote reproductive health.

## Management Structure

The Council's management set-up comprises of a Secretariat governed by a Board of Directors.

1 Chairman

1 representative of Chitukuko Cha Amai m'Malawi (CCAM)

1 representative of Council for Non-Governmental Organisations in Malawi (CONGOMA)

1 representative of Episcopal Conference of Malawi (ECM)

1 representative of Christian Council of Malawi (CCM)

1 representative of Christian Hospitals Association (CHAM)

1 representative from Muslim Association of Malawi

1 representative of Malawi Broadcasting Corporation (MBC)

4 members from the public

6 Ex Officio Members from related ministries and departments.

The Council's principal officer is the Executive Secretary who is in-charge of five technical departments of the Council, namely: Service Delivery; Training; Information, Education and Communication (IEC), Research and Evaluation; and Administration and Finance.

These departments are assisted by three technical committees which are appointed by the Council. The Quality Assurance/Control Committee assists the service delivery

department; the Education Committee assists the IEC and Training departments; and the Policies and Procedures Committee assists the Research and Evaluation, Administration and Finance departments.

**Funding**

The Council's establishment has drawn the attention of major donors like the World Bank, United States Agency for International Development (USAID), United Nations Population Fund (UNFPA), and the British Overseas Development Administration (ODA). These donors have pledged a total of nearly K4 million for the first two years for activities which include recruitment of staff, construction of offices, purchase of vehicles and equipment, training, staff development and technical assistance.

Besides this donor funding, the Government is also fully committed to financially and materially supporting the Council on a sustainable basis. In this context, a subvention for start-up costs has already been provided this financial year, and adequate provision has been made in the Public Sector Investment Programme (PSIP) for the next five years. An annual provision of about K300,000 has been made during this period.

**Partners And Collaborators**

The Council will derive its strength from building partnerships and collaborating with child spacing providers in Government, NGOs and the private sector. This will involve providing technical assistance, facilitating the sharing of experiences, expertise, materials, equipment and facilities, supporting their capacity building programmes, continuous review of programmes and approaches, providing opportunities for training, technology up-dates, and encouraging operational research in areas requiring special attention and more information. To achieve the goals of the child spacing programme, it will be necessary to make child spacing the responsibility of every Malawian.

**Conclusion**

The National Family Welfare Council of Malawi exists to serve and support your efforts to provide and improve child spacing services for the Malawian population. The Council is aware of the competition between curative and promotive health, and the dilemma health personnel face in trying to save lives of the very sick on one hand, and in providing services to prevent sickness and other risks, on the other hand. We recognise that there are no easy solutions to these problems, but we are here to do our part, to ensure that all children born to Malawian families hence forth are desired assured survival and that those who are undesired do not make their way here.

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**Status of Women and Population**

Mrs. C. Benbow-Ross

Women are at the heart of development... women's importance in development has received much attention over the past 15 years with major international conferences and country-level programmes and projects. But there's been far less continuing action to repair the situation of development's over-stressed heart.

Everywhere women have two jobs, around the home and outside it. Much of this work is unrecognized and these workers expect - and get - minimal to no support. Their health suffers, their work suffers, their children suffer.

Most women have few choices in life outside marriage and children. They have large families because that is expected of them. Certainly this is true in Malawi where, according to a 1992 World Population Data Sheet, the total fertility rate - the average

number of children born to a woman - is 7.7 in 1992, the second highest in the world after Ruanda. Investing in women means widening their choice of strategies and reducing their dependence on children for status and support. Empowering women to practice family planning is one of the most important of these investments because it represents the freedom from which other freedoms flow.

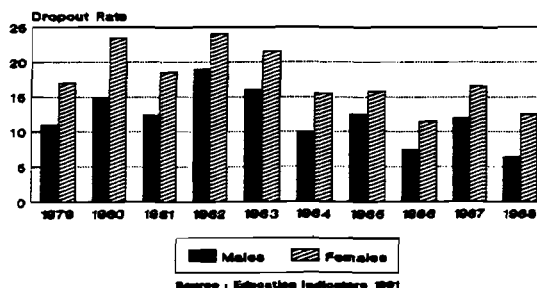


And it works the other way round... enhancing women's means of social and economic self-determination leads to smaller families.

This morning I'll be reviewing with you why this is true, what are some of the factors, the sources of insecurity, that have contributed to women's continuing dilemma of high fertility and low status. The United Nations Population Fund, the organization I represent, knows that to lower fertility, a country needs an active family planning programme reaching into communities in an atmosphere of Government support and preferably a population policy. The Medical Association of Malawi acknowledges this by selecting child spacing as its theme for this Scientific Meeting. We applaud the Association for doing so and hope to work with you to create and expand an active family planning programme in Malawi. The purpose of my presentation this morning is to demonstrate that improved women's status is important in reaching our joint goals of lowering average family size and lowering maternal morbidity and mortality.

Let's look first at women's traditional sources of insecurity. One is marrying young. Around 50 per cent of African women marry by the age of 18 according to World Fertility Survey data. In Malawi the median age at marriage is 17.4, 17 in rural areas. This early marriage leads to early and usually frequent child bearing. Many of these young brides marry men quite a bit older; these gaps have consequences, among them the likelihood of being widowed. Widows are 25 per cent of the adult female population in Africa. Though she will have done her share, if not more, of supporting the family throughout marriage, it is motherhood not marriage which will support her later life, thus a reason for more children.

Primary School Dropout Rate in Malawi, By Sex, 1979 to 1988



Discrimination against girls is another traditional source of insecurity. Eight out of nine cultures who express a preference want more sons than daughters. Families view men as greater potential contributors to family income and to old age security. Discrimination is particularly visible in employment and, closely

related to this, in education. In Malawi, girls' primary school dropout rates are consistently higher than boys, leading to a situation where many more boys who start primary school finish Standard 8. Parents with little income are less willing to invest in girls' education; girls work as domestic labour at an early age. These poorly educated girls are much less likely to find paid employment or marry educated men so that discrimination against girls as a poor investment continues. And the girl views marriage and childbirth as her only route to status.

Cycles of malnutrition are a major source of insecurity which have contributed to poor health of mothers. Malnourished and undernourished girls will have little reserves for motherhood - as you all know, an overworked, underfed pregnant woman is more likely to have a small, weak baby. Indeed in Malawi the high numbers of undernourished mothers leads to low birth weight in approximately 20 per cent of babies born. The vicious cycle of poverty and frequent child bearing often leads to even worse nutritional status later in a woman's life made more serious by an increasingly heavy workload, the loss of iron stores through menstruation and the combined demands of child bearing.

Adolescent pregnancy, both in and out of marriage, heightens women's insecurity. Around the world the teenage mother and her baby face a worse combination of risks to their health than any other age group. 15 to 19 year old mothers are twice as likely to die in childbirth as mothers aged between 20 and 24, and babies born to teenage mothers are more than twice as likely to die in their first year of life. One reason for high and increasing rates of adolescent pregnancy is that family planning programmes are usually directed at married women; worldwide three-quarters of girls under 15, and half of those 16 or over have no access to family planning information. One study in Zaire found that the typical hospital patient being treated for a septic abortion is a 15 to 16 year old, unmarried school girl who had never used contraception. More than health is at stake here; a teenage mother has much less chance of continuing her education, of becoming anything other than a mother, and usually a mother many times.

And probably a mother in danger. Maternal mortality, an insecurity for both women and their children, is too often overlooked in Government statistics. One out of every 21 African women will die as a result of pregnancy or childbirth yet one in every 6400 North American women will die this way. WHO estimates that at least a half-million women die annually from pregnancy-related causes, and that for every death, 10 to 15 women are handicapped. While these figures are alarming, experts privately agree that accurate data collection might show the actual death toll to be twice as high. Youngest and oldest mothers are most at risk; over 35 year old mothers are 2.5 times more likely to die as a result of childbirth. Many previous pregnancies also greatly increases risks of the next one. The leading cause of maternal death worldwide, post-partum haemorrhage, is most common in women who have already had several closely spaced pregnancies.

These are the "old" sources contributing to women's' insecurity. The new, "modern" sources of insecurity include environmental instability... it is women who walk the extra distance for fuelwood and water and who must decide whether to use manure for firewood or fertilizer; migration... it is women who are left behind with few, if any remittances; and, a related one, female headed households, the world's poorest and a fairly recent phenomena. In Malawi, 30% of rural smallholder households are female headed. Female headed households have smaller land holdings than men; over 70% with holdings of less than 1 hectare compared to 50% for men. Nearly twice as many female as male headed households have holdings smaller than half a hectare.

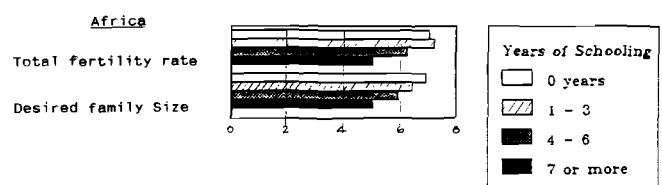
It's a bleak picture and women's status won't be raised overnight. Yet surely participants in this Meeting know how to right some of these wrongs, steps to break the cycle of insecurities. Among these steps two of the most fundamental are family planning and women's education.

By family planning we mean services available at all times at all hospitals, health centres and outreach health services. Services which are people-oriented where the client is listened to. Health and family planning services where the health care givers respect the clients (both her and his) concerns about safety as well as the time constraints imposed by her many obligations... services where the health care providers know it is part of their job to change men's attitudes to family planning. There is indication that, even where women's position is changed only in one aspect - that of access to quality family planning services, they will take advantage as they have in parts of rural Bangladesh and as they've started to do in Kenya.

But for many women who would like to delay or stop child bearing, assurance is needed, assurance about what they can expect for themselves and their children. This assurance springs from many aspects of life - for a woman, partially from her status within the family and before the law, the quality of overall health care available and particularly from her education.

Every large-scale survey from any region of the world has demonstrated that education of women is one of the most universal and reliable predictors, both of their own fertility and of their children's health. In Africa in the past few years as female education has increased and family planning services have been improved and expanded, the patterns have begun to resemble these patterns elsewhere. African women's total fertility and the number of children wanted varies a great deal with education, those with no education having and desiring about 2 more children than those with 7 or more years of school. This is perhaps unwelcome news for you medical clinicians, but research from 46 developing countries discovered that a one per cent rise in women's literacy had three times the positive effect on child mortality as a one per cent rise in the number of doctors. It may not be so much what girls and women learn but simply that they have been to school or to literacy classes, at all ... they've put their foot in the door of the modern world. Here in Malawi a 1991 report evaluated the National Adult Literacy Programme, concluding that the literacy students, 90 per cent of them women, have developed "an ability to play new roles in their communities, a perception of a new social order and creation of new aspirations."

Women's Education Affects  
Total and Desired Fertility



Source: Schultz: 1989

Educating women may mean better health even without health services, but benefits are increased greatly if those services are available too. One donor in Malawi is paying the school fees of all non-repeater primary school girl students; in a country with Malawi's poverty level, this opportunity, if support continues, could make an enormous difference in many sectors, including health and family planning. And be prepared - expanding the provision of quality family planning services is something you will all be involved in, and it works together with expanded female education. But these educated women may speed up the process... research shows that educated women, even very poor ones, are likely to insist on quality health care, including quality family planning services.

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