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Beginning a Family and Adopting a Healthy Lifestyle: Situation Analysis for Malawi

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This policy brief examines two primary transitions facing adolescents—beginning a family and adopting a healthy lifestyle—and their long-term effect on adolescents and their communities as well as on Malawi's potential to harness a demographic dividend.

Decisions Made in Adolescence Affect Health, Human Development and Economic Development

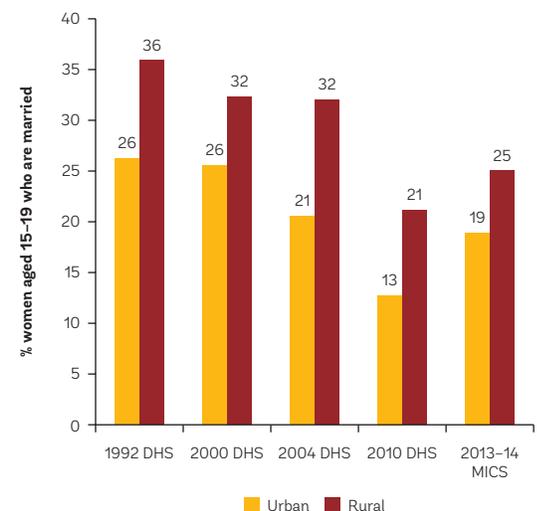
Decisions made during youth have long-term impacts on human development, which is key to poverty alleviation and economic development. During adolescence, two of the primary transitions are beginning a family and adopting a healthy lifestyle. Youth face many choices and challenges around these key decisions, such as when to initiate sex, when to marry, when to have children, whether to engage in risky behaviors, and what foods to consume—all of which affect their future health and future opportunities. Adolescent girls also face risks related to gender-based violence (GBV). Consequences of these early decisions can have long-lasting effects on adolescents and their communities, potentially increasing public health costs and slowing the accumulation of human capital.

Trends in Marriage, Fertility, Nutrition, and Health

Early marriage is common in Malawi: 28 percent of surveyed adolescent girls between the ages of 15 and 19 reported being currently or previously married (MICS 2013–14). Overall, the prevalence of adolescent

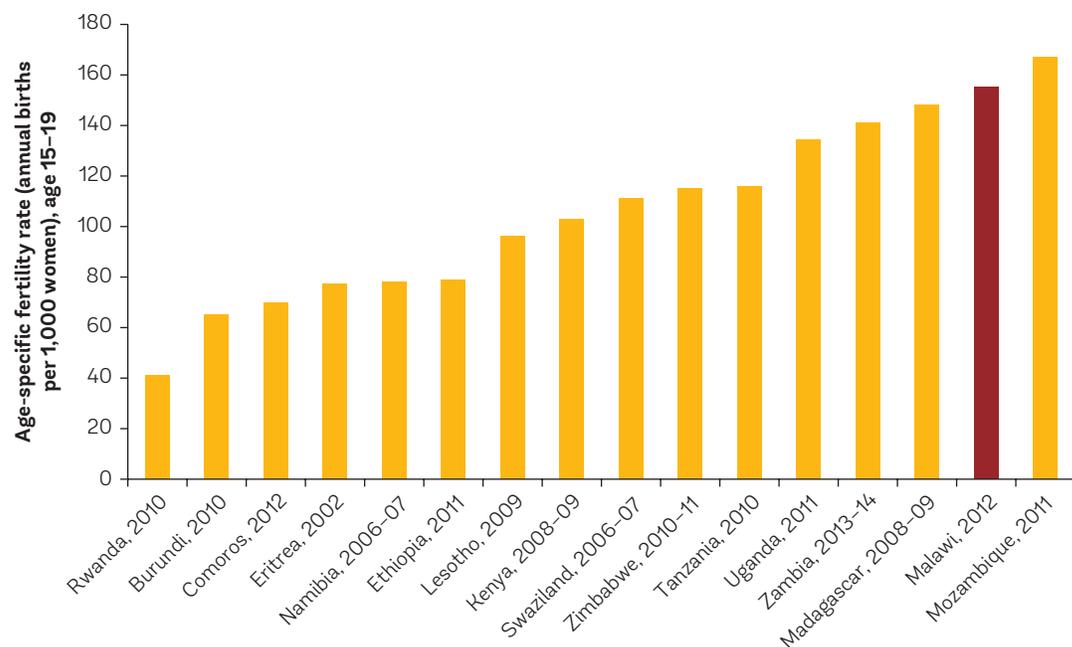
marriage has declined somewhat since 1992, when it was 35 percent. The median age at first marriage was 17 years (MICS 2013–14), which represents very little change since 1992 when it was 17.8 years (DHS). Early marriage is more common in rural than in urban areas: the percentage of currently-married adolescent girls is 25 percent in rural areas compared to 19 percent in urban areas (MICS 2013–14; p-value on t-test < 0.01) (figure 1). Median age at first sexual intercourse in 2010 (DHS) was 17.2 years; this age has changed little since 2000 (when it was 16.8 years).

Figure 1. Share of Adolescent Girls Who Are Married in Malawi, by Rural-Urban Location, 1996–2013/14



Source: Demographic and Health Surveys and MICS.

Figure 2. Fertility Rate of Adolescents (15–19 Years of Age) in Eastern and Southern Africa, Various Years, 2008–2013/14



Source: Most recent Demographic and Health Survey.

30%

The percent of adolescent girls in Malawi are pregnant or already a mother.

26%

The percent of **married** adolescent girls in Malawi use modern contraceptives.

50%

The percent of **unmarried** sexually active adolescent girls in Malawi use modern contraceptives.

Fertility has declined only slowly, and adolescent fertility remains one of the highest in Eastern and Southern Africa (figure 2).

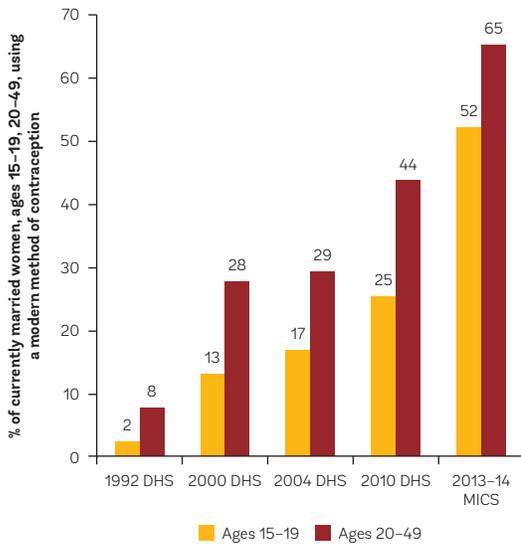
Fertility has declined overall (albeit slowly): the average number of children a woman would have over her lifetime if she had children at the current rates of fertility is now 5 children (2013–14 MICS) compared to 6.7 children in 1992 (DHS). However, adolescent childbearing remains an issue in Malawi. The median age when a woman gives birth in Malawi is now 19 years (DHS 2010, MICS 2013–14 MICS), representing no change since 1992. Similarly, the adolescent fertility rate has barely changed over the 1992 to 2010 DHS reporting period, in both urban and rural areas. The fertility rate for girls 15–19 years of age who live in rural areas was 162 in 2010 (versus 165 in 1992) and in urban areas it was 125 in 2010 (versus 134 in 1992). Approximately one-third—30 percent—of adolescent girls are pregnant or already a mother (MICS 2013–14). Moreover, the proportion of adolescents who have given birth or are pregnant is higher in rural than in urban areas, at 32 and 24 percent, respectively, and this difference is statistically significantly (p -value < 0.01) (2013–14 MICS). Additionally, (as explored in Bakilana, Moucheraud, McConnell, and Hasan 2016), early childbearing puts children born to adolescent mothers at elevated risk for death, illness, and poor nutrition. Variation also exists by region: 26 percent in Northern and Central compared to 35 percent in Southern. Furthermore, while fertility

preferences of adolescents declined from an ideal of 4.3 children in 1992 to 3.4 children in 2000, there has hardly been any change since then (3.2 in 2004 and 2010). Given projected fertility and age patterns, approximately 18% of all births in Malawi (between the years 2015 and 2050) will be to adolescent mothers.

Use of modern contraception remains lower among married adolescent girls than among older women (figure 3). Between 1992 and 2010, modern contraceptive prevalence rate (mCPR) increased from 8 to 44 percent among married women above age 20, compared with 2 and 26 percent, respectively, of married adolescent girls (DHS). Among unmarried sexually active adolescents, the mCPR is 50 percent. Even when controlling for key demographic and socioeconomic factors, adolescents were approximately 50 percent less likely than women aged 20–49 to use modern contraception.¹ Unmet need—the proportion of currently married women who want to stop or space childbearing but are not using contraception (or who are pregnant with a mistimed or unwanted pregnancy)—has declined among

¹ Results of a multivariate regression model using data from the 2013–14 MICS, on whether the current use of modern methods of family planning is associated with adolescence, current marital status, religion, region of residence, urban or rural residence, and household wealth quintile; the model was restricted to women who were not pregnant but who were ever sexually active. Full findings are available from the authors upon request.

Figure 3. Use of Modern Contraceptive Methods by Married Women in Malawi, by Age, 1992–2010 DHS, 2013–14 MICS



Source: Demographic and Health Surveys and MICS.

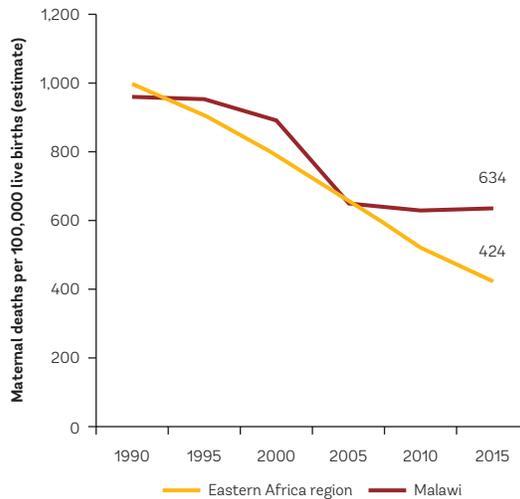
married women in Malawi, although bigger gains were seen among women over age 20 than among adolescents (DHS), indicating that there is room for more progress in reaching adolescent girls.

Maternal mortality declined in Malawi but has more or less plateaued since 2005 (figure 4). The maternal mortality ratio (MMR) was estimated to be 634 maternal deaths per 100,000 live births in 2015, which represents a 34 percent decline since 1990 (when the ratio was 957) (WHO et al. 2015). While substantial, the decline was insufficient to meet the fifth Millennium Development Goal target. Progress in Malawi also more or less stagnated after 2005, versus the Eastern Africa regional average MMR which continued its decline.

The percentage of recent births that were attended by a skilled provider (doctor, nurse, or midwife) increased for all women, from 53 percent in 1992 (DHS) to 86 percent in 2013–14 (MICS)²; for adolescents, it is now 90 percent and this is significantly higher than for women over age 20 (p-value < 0.01), among whom it is 86 percent. Even when controlling for key demographic and socioeconomic factors, adolescents were approximately 40 percent more likely than women over age 20 to have had a

² Skilled birth attendance is calculated for births in the 3 years prior to the survey for DHS and for births in the 2 years prior to the survey for MICS. A more recent timeframe generally results in higher proportions for skilled attendance given the secular increase overall during the time period.

Figure 4. Estimated Maternal Mortality Ratio in Malawi, 1990–2015



Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization; 2015.

skilled attendant at recent birth.³ However, there is evidence of inequity—higher proportions of women in urban areas (93 percent) use skilled delivery than women in rural areas (85 percent) according to the 2013–14 MICS, and this is a statistically significant difference (p-value < 0.01). There is a similar difference between urban and rural adolescents (p-value 0.07). The rates also differ by regions (86 percent in Central and Southern, and 92 percent in Northern).

In contrast to skilled attendance at birth, use of the recommended antenatal care (ANC), however, has been declining, with only 44 percent of women receiving four or more ANC visits prior to delivery (2013–14 MICS), compared 62 percent in 1992 (DHS). This decline in ANC visits suggests that interventions delivered during ANC visits such as tetanus toxoid vaccination, screening for and treatment of infections, identification of warning signs during pregnancy, and nutrition counseling are not reaching those who need them—all of these are important for not only maternal health and nutrition but also early childhood development.

Undernutrition among adolescents is a concern, as a sizable proportion of adolescents are classified as thin or anemic. According to the 2010 DHS, 81 percent

³ Results of a multivariate regression model using data from the 2013–14 MICS, on whether a recent birth (during the preceding 2 years) was attended by a doctor, nurse or midwife, is associated with adolescence, current marital status, religion, region of residence, urban or rural residence, and household wealth quintile. Full findings are available from the authors upon request.

4.2%

The percent of adolescent girls in Malawi are HIV positive.

of adolescent girls are classified as having a normal body mass index (BMI), 13 percent have a below-normal BMI, while 6 percent are classified as overweight or obese. In addition, 28 percent of adolescent girls were classified as anemic, and among adolescent girls who were pregnant, the figure is substantially higher at 41 percent, compared to 38 percent of pregnant women 20 years of age or older (DHS 2010) (p -value on difference 0.1) (figure 5). Low pre-pregnancy BMI, short stature, and anemia can cause physical and emotional health problems, and maternal underweight is a leading risk factor for preventable deaths and disease. For example, pregnant adolescent girls with a low BMI may be at increased risk for pregnancy and obstetric complications and poor birth outcomes, including obstructed labor, prematurity and low birthweight. Anemia during pregnancy is associated with low birth weight of the child.

Adolescent girls are exposed to risky sexual behaviors, with 4.2 percent of girls age 15–19 being HIV positive—and yet they have less autonomy over their health care decisions. HIV prevalence is almost four times as high among young women (ages 15–24 years) in urban areas compared to those in rural areas (11.2 percent and 3.7 percent, respectively, in 2010). Adolescents were more likely to have received an HIV test during the preceding 12 months than other age groups (among ever sexually active women, 74 percent of adolescents and 51 percent of women older than age 20 years had received an HIV test over the preceding year, p value on difference < 0.01) (MICS 2013–14). Adolescents were also more likely to have used a condom during their last sexual encounter than women older

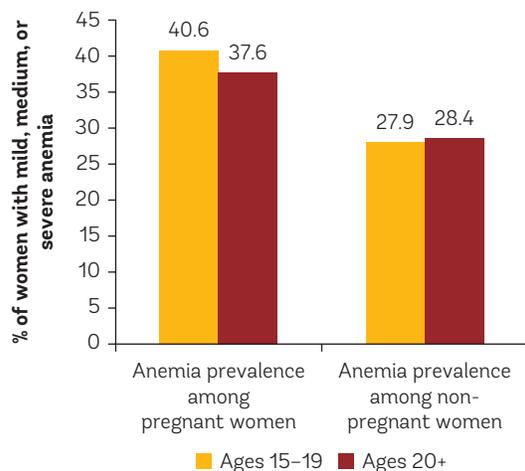
than age 20 years (29 percent versus 12 percent, respectively; $p < 0.01$) (MICS 2013–14). However, adolescents were less likely to report being the final decision maker (solely or jointly) about their own health care than older women: 47 percent versus 56 percent ($p < 0.01$) (2010 DHS). There were statistically significant differences in reporting decision-making power for health care by women's educational status: only 48 percent of women with no education reported being the final decision maker, versus 54 percent of women with primary level education and 69 percent of women with secondary education and beyond (2010 DHS).

Policy Framework in Malawi

Malawi has policies that aim to address the health of women and adolescent girls, both around fertility and healthy behaviors. The multisectoral National Population Policy includes among its aims the enhanced scale-up of health and social services that help address population challenges, particularly family planning, education, and empowerment of youth and women. The National Health Policy, the Health Sector Strategic Plan, and the Sexual Reproductive Health and Rights (SRHR) Strategy aim to address sexual and reproductive health and rights (including family planning) of women, men, and young people. Women's empowerment, voice and agency in decision-making, and GBV are intricately linked with adolescent pregnancies and use of contraception and should be taken into consideration in designing and implementing programmatic responses. The National Youth Policy also specifically addresses youth-relevant topics including comprehensive SRH education, and the minimization of early marriage and of GBV. Health is one of the priority areas of the Gender Policy and its Implementation and M&E Plan.

While the policies in place attempt to comprehensively address the health and nutrition needs of adolescent girls, effective translation of policies and subsequent implementation remains a challenge. A policy space analysis indicates that there has been progress in implementation, including high-level support from the government on SRH issues, creation of technical working groups and other coordination bodies for various partners working on SRH, capacity-building for adolescent SRH, creation of youth-friendly health service centers, clearly articulate program goals, a well-developed M&E framework, and rigorous monitoring efforts and mechanisms to revise policies and programs based on results. In fact, these policies in Malawi specifically include several approaches recommended by

Figure 5. Prevalence of anemia among pregnant and non-pregnant women, by age group, 2010



Source: Demographic and Health Survey 2010.

the global literature base, including promotion of family planning by community health workers (Health Surveillance Assistants), comprehensive sex education that includes messages about HIV prevention, training of health workers to strengthen SRH service delivery, and creation of youth-friendly family planning services. However, impediments to fully successful implementation remain.

Stakeholders reported insufficient budgetary allocations for planned activities in the SRHR Strategy with only a small percentage of budget earmarked, indicating inadequate government financial commitment to these issues. This has implications for sufficient capacity to address adolescent SRH and further institutional development as well as technical groups not having enough financing to have optimal impact. Furthermore, high-level government support is not matched by all stakeholders, including opposition to adolescent SRH issues from the Ministry of Education, religious and community leaders.

In addition, the multi-sectoral Population and Youth Policies, which are also related to adolescent health and nutrition, have benefited from visible support from the President and feature in development plans as well as across ministerial plans and budgets. Both policies have created new central institutions, and the NYP has created units throughout Malawi, which have the potential to serve as a platform for program implementation by partners within and outside government. The policies are accompanied by strategic/operational/action plans, which include clear program goals and M&E frameworks. However, they are under-resourced and experience staffing shortages, jeopardizing effective implementation. Furthermore, the low visibility of the National Population Policy may contribute to its overall challenges with staffing.

Key Findings and Conclusions

Substantial gaps remain to be addressed regarding key decisions made by adolescents about starting families and adopting healthy lifestyles:

- Early marriage remains common with 28 percent of adolescent girls married.

- Malawi has one of the highest adolescent fertility rates in Eastern and Southern Africa with little change since 1992, and 30 percent of girls are already mothers or pregnant.
- Married adolescent girls use modern contraception less than other married women.
- Undernutrition is a concern as adolescent girls are often thin or anemic.
- Adolescent girls engage in risky sexual behaviors and have less autonomy over decision making regarding healthcare, putting them at risk for illness and death.

While there have been some improvements for adolescents with regard to starting a family and adopting a healthy lifestyle, further implementation progress is necessary to help them to make better decisions and prepare them to be healthy, productive, and contributing members of society. Only by addressing sexual and reproductive health, nutrition, and risky sexual behaviors will the negative long-term effects of decisions made during adolescence be averted and the demographic dividend be harnessed in Malawi.

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