Malawi

Demographic and Health Survey

2004

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National Statistical Office
Zomba, Malawi

ORC Macro
Calverton, Maryland, USA

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This report summarises the findings of the 2004 Malawi Demographic and Health Survey (MDHS), which was carried out by the Malawi National Statistical Office (NSO). Most of the funds for the local costs of the survey were provided by multiple donors through the National AIDS Commission. The Department for International Development (DfID) of the British Government, UNICEF, and UNFPA also provided funds for the survey. The United States Agency for International Development (USAID) provided technical assistance through ORC Macro. Technical assistance for the HIV testing was provided by the Centers for Disease Control and Prevention.

The MDHS is part of the worldwide Demographic and Health Surveys (DHS) programme funded by the United States Agency for International Development (USAID). The programme is designed to collect data on fertility, family planning, maternal and child health, nutrition, and HIV/AIDS. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

Additional information about the survey may be obtained from the Demography and Social Statistics Division (DSS), National Statistical Office, Chimbiya Road, P.O. Box 333, Zomba, Malawi (Telephone: 265-1-524-377, 265-1-524-111 (switchboard); Fax: 265-1-525-130, E-mail: demography@statistics.gov.mw; Internet: www.nso.malawi.net).

Additional information about the DHS programme may be obtained from MEASURE DHS, ORC Macro, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, U.S.A. (Telephone: 301.572.0200; Fax: 301.572.0999; E-mail: reports@orcmacro.com; Internet: www.measuredhs.com)

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FOREWORD

This final report presents the major findings of the 2004 Malawi Demographic and Health Survey (MDHS). The 2004 MDHS survey is the third survey of its kind to be conducted in Malawi; the first MDHS was in 1992 and the second was in 2000. The 2004 MDHS included, for the first time, testing of blood samples to provide national rates for anaemia and HIV. The fieldwork was carried out by the National Statistical Office (NSO) in collaboration with the Ministry of Health from October 2004 to January 2005. In 1996, a similar survey on Knowledge, Attitudes, and Practices in Health (MKAPH) was conducted. All four surveys were designed to provide information on indicators of maternal and child health in Malawi.

The primary objective of the 2004 MDHS was to provide up-to-date information for policymakers, planners, researchers, and programme managers that would allow guidance in the development, monitoring, and evaluation of health programmes in Malawi. Specifically, the 2004 MDHS collected information on fertility levels, nuptiality, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of mothers and children, childhood illnesses and mortality, use of maternal and child health services, malaria, maternal mortality, HIV/AIDS-related knowledge and behaviours. The survey will also provide the national level estimates of HIV prevalence for women age 15-49 and men age 15-54, and anaemia status of women age 15-49 and children age 6-59 months.

The 2004 MDHS results present evidence of a decline in maternal mortality rate as compared to the 2000 MDHS; decrease in fertility rates, an increase in the use of family planning methods and a decline in infant and under-five mortality since the 1992 MDHS. However, the disparity between knowledge and use of family planning remains high. Some of these are critical issues and need to be addressed without delay.

The NSO would like to acknowledge the efforts of a number of organisations and individuals who contributed immensely to the success of the survey. First, we would like to acknowledge the financial assistance from the National AIDS Commission (NAC), United States Agency for International Development (USAID), the Department for International Development (DFID), United Kingdom, and the United Nations Children's Fund (UNICEF/Malawi), the Centers for Disease Control and Prevention (CDC), NORAD (Norway), CIDA (Canada), and UNFPA.

We would also like to acknowledge ORC Macro for technical backstopping, and the assistance of the staff of the National Statistical Office, the Ministry of Health and Population, Department of Population Services in the Ministry of Economic Planning and Development, all members of the steering committee and various technical working groups. We also appreciate the work done by the Community Health Services Unit (CHSU), and especially commend the laboratory team assigned to work on the blood samples for their tireless efforts in getting the testing done successfully.

Finally, we are grateful to the survey respondents who generously gave their time to provide the information that forms the basis of this report.

Charles Machinjili
Commissioner for Statistics

SUMMARY OF FINDINGS

The 2004 Malawi Demographic and Health Survey (MDHS) is a nationally representative survey of 11,698 women age 15-49 and 3,261 men age 15-54. The main purpose of the 2004 MDHS is to provide policymakers and programme managers with detailed information on fertility, family planning, childhood and adult mortality, maternal and child health, as well as knowledge of and attitudes related to HIV/AIDS and other sexually transmitted infections (STIs). The 2004 MDHS is designed to provide data to monitor the population and health situation in Malawi as a followup of the 1992 and 2000 MDHS surveys, and the 1996 Malawi Knowledge, Attitudes, and Practices in Health Survey. New features of the 2004 MDHS include the collection of information on use of mosquito nets, domestic violence, anaemia testing of women and children under 5, and HIV testing of adults.

The 2004 MDHS survey was implemented by the National Statistical Office (NSO). The Ministry of Health and Population, the National AIDS Commission (NAC), the National Economic Council, and the Ministry of Gender contributed to the development of the questionnaires for the survey. Most of the funds for the local costs of the survey were provided by multiple donors through the NAC. The United States Agency for International Development (USAID) provided additional funds for the technical assistance through ORC Macro. The Department for International Development (DfID) of the British Government, the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA) also provided funds for the survey. The Centers of Disease Control and Prevention provided technical assistance in HIV testing.

The survey used a two-stage sample based on the 1998 Census of Population and Housing and was designed to produce estimates for key indicators for ten large districts in addition to estimates for national, regional, and urban-rural domains. Fieldwork for the 2004 MDHS was carried out by 22 mobile interviewing teams. Data collection commenced on 4 October 2004 and was completed on 31 January 2005.

FERTILITY

Fertility Levels and Trends. While there has been a significant decline in fertility in the past two decades from 7.6 children in the early 1980s to 6.0 children per woman in the early 2000s, compared with selected countries in Eastern and Southern Africa, such as Zambia, Tanzania, Mozambique, Kenya, and Uganda, the total fertility rate (TFR) in Malawi is high, lower only than Uganda (6.9).

Fertility Differentials. Fertility varies substantially across residence. Urban women have, on average, more than two children fewer than rural women (4.2 and 6.4, respectively). While the TFR in the Central Region is 6.4, in the Southern and Northern Regions it is only 5.8 and 5.6 births per woman, respectively. Among the ten oversampled districts, TFR varies from 4.8 births per woman in Blantyre to 7.2 births per woman in Mangochi.

As expected, fertility is strongly associated with education and wealth status. The TFR decreases dramatically from 6.9 for women with no education to 3.8 for women with at least some secondary education. The TFR for women in the lowest (poorest) quintile is 7.1 births per woman, compared with 4.1 births for women in the highest (richest) quintile.

Unplanned Fertility. Despite increasing use of contraception, the 2004 MDHS data indicate that unplanned pregnancies are common in Malawi. Twenty percent of births in the five years preceding the survey are not wanted and 21 percent are mistimed (wanted later). The percentage of recent births that are not wanted increased from 14 percent in 1992 to 22 percent in 2000, and declined to 20 percent in 2004.

Fertility Preferences. The 2004 MDHS finding indicates that 35 percent of women wanted no more children and therefore want to limit the family size at its current level, and 6 percent had already been sterilised. Thirty-eight percent of men also report wanting no more children. There has been a decline in fertility preferences among currently married women since 2000. The average ideal family size for all women was 5.0 children in 2000 and was 4.1 in 2004. For all men, ideal family size declined from 4.8 children in 2000 to 4.0 in 2004.

FAMILY PLANNING

Knowledge of Contraception. Knowledge of family planning is nearly universal, with 97 percent of women age 15-49 and 97 percent of men age 15-54 knowing at least one modern method of family planning. The most widely known modern methods of contraception among all women are injectables (93 percent), the pill and male condom (90 percent each), and female sterilisation (83 percent). The male condom is the most widely known contraceptive method (72 percent) among women with no sexual experience. These findings are similar to those in the 2000 MDHS.

Use of Contraception. One in three married women (33 percent) in Malawi is using a method of family planning. Most of these women are using a modern method (28 percent). Injectables, female sterilisation, and the pill are the most commonly used contraceptive methods, used by 18, 6, and 2 percent of married women, respectively. The most commonly used methods for sexually active unmarried women are injectables (11 percent) and male condoms (10 percent).

Trends in Contraceptive Use. Contraceptive use among married women in Malawi has increased slightly from 31 percent in 2000 to 33 percent in 2004. This is a much slower increase than between 1992 and 2000 (13 and 31 percent, respectively). There is a notable rise in the use of modern methods from 7 percent in 1992 to 28 percent in 2004, mostly because of a sharp increase in the use of injectables and female sterilisation. The use of male condoms remained unchanged at 2 percent.

Differentials in Contraceptive Use. Use of a modern contraceptive method is higher among currently married women in urban areas than women in rural areas (35 and 27 percent, respectively). The highest levels of use of modern family planning methods are in Lilongwe and Blantyre (each 34 percent), and the lowest levels are in Mangochi (17 percent) and Salima (20 percent).

Use of modern family planning methods is slightly higher in the Central Region (30 percent) and the Northern Region (29 percent) than in the Southern Region (27 percent). The same pattern was seen in the 2000 MDHS. Use of traditional methods is more common in the Northern Region (13 percent) than in the other regions (3 percent or less). In the Northern Region, withdrawal is the traditional method most commonly used (10 percent).

Modern contraceptive methods increase with the woman's education and wealth status. Twenty-two percent of married women in the lowest wealth quintile use a modern family planning method, and the corresponding proportion for those in the highest wealth quintile is 38 percent.

Source of Modern Methods. In Malawi, 67 percent of current users of modern methods obtain their methods from a public facility. This is about the same proportion captured in the 2000 MDHS (68 percent). Thirteen percent of all current users get their methods from religious (mission) facilities, 4 percent from the private medical sector, and 17 percent from other sources including nongovernmental organizations (NGOs), where Banja La Mtsogolo is the most commonly used source (13 percent).

Contraceptive Discontinuation Rates. Thirty-six percent of contraceptive users discontinue use of a method within a year after beginning to use the method. The 12-month discontinuation rate for modern contraceptives is highest for the male condom (62 percent), followed by the pill (52 percent) and injectables (33 percent). Eight percent of the users report that they stopped using a method because of the desire to get pregnant. Twenty percent gave other reasons for discontinuing.

Unmet Need for Family Planning. Unmet need for family planning services is defined as the percentage of currently married women who either do not want any more children or want to wait before having their next birth, but are not using any method of family planning. The 2004 MDHS shows that 28 percent of married women have an unmet need for family planning services: 17 percent for spacing births and 10 percent for limiting births. The total demand for family planning among married women increased from 60 percent in 2000 to 62 percent in 2004.

MATERNAL HEALTH

Antenatal Care. There has been little change in the coverage of antenatal care (ANC) from a medical professional since 2000 (93 percent in 2004 compared with 91 percent in 2000). Most women receive ANC from a nurse or a midwife (82 percent), although 10 percent go to a doctor or a clinical officer. A small proportion (2 percent) receives ANC from a traditional birth attendant, and 5 percent do not receive any ANC. Only 8 percent of women initiated ANC before the fourth month of pregnancy, a marginal increase from 7 percent in the 2000 MDHS.

Eighty-five percent of women received at least one tetanus toxoid injection during pregnancy for their most recent birth in the five years preceding the survey. The coverage of tetanus toxoid injection has not changed since 1992 (85-86 percent). Two in three women had two or more doses of tetanus toxoid injections. This figure is lower than that reported in the 1992 MDHS (73 percent).

With regard to malaria prevention during pregnancy, the 2004 MDHS data show that 81 percent of pregnant women took an antimalarial drug and 43 percent of women received two or more doses of intermittent preventive treatment (IPT), at least once during an ANC visit.

Delivery Care. The majority of births were attended by medical professionals, 50 percent by a nurse or midwife, 6 percent by a doctor/clinical officer, and only 1 percent by a patient attendant. There has been a slight increase in the proportion of births that are attended by a doctor/clinical officer from 4 percent in 2000 to 6 percent in 2004. The role of traditional birth attendants in assisting delivery also increased from 23 percent in 2000 to 26 percent in 2004. Similar to that recorded in the 2000 MDHS, 3 percent of births in the five years preceding the survey were delivered by C–section.

Postnatal Care. Postnatal care is recommended to start immediately after the birth of the baby and placenta to 42 days after delivery. The 2004 MDHS shows that seven in ten women did not receive postnatal care. Among those who had postnatal care (31 percent), 21 percent received care within two days of delivery. Few women had a

checkup 3-6 days after delivery, and 8 percent received care between the first and sixth week after delivery.

Adult and Maternal Mortality. Comparison of data from the 2000 and 2004 MDHS surveys indicates that mortality for both women and men has remained at the same levels since 1997 (11-12 deaths per 1,000). Data on the survival of respondents' sisters were used to calculate a maternal mortality ratio for the 7-year period before the survey, centered in mid-2001. Using direct estimation procedures, the maternal mortality ratio (MMR) is estimated to be 984 maternal deaths per 100,000 live births. The MMR based on the 2000 MDHS is significantly higher than that calculated from the 1992 MDHS (620 maternal deaths per 100,000 live births), but lower than the rate from the 2000 MDHS survey of 1,120 maternal deaths per 100,000 live births. It is unlikely that maternal mortality has changed so dramatically up and then down again, especially because the reference periods for the estimates overlap each other. MMRs measured in this way are subject to very high sampling errors and cannot adequately indicate short-term trends.

CHILD HEALTH

Childhood Mortality. Data from the 2004 MDHS show that for the 2000-2004 period, the infant mortality rate is 76 per 1,000 live births, child mortality is 62 per 1,000, and the under-five mortality rate is 133 per 1,000 live births. This means that about one in every eight children born in Malawi dies before reaching their fifth birthday. The estimate of under-five mortality calculated from the 1992 MDHS data (for the period 1988-1992) is 234 and from the 2000 MDHS data (1996-2000) is 189 per 1,000 live births. These figures suggest that the decline between 2000 and 2004 is faster than between 1992 and 2000 (29 and 19 percent, respectively). During the 15-year period preceding the survey, the estimates of neonatal mortality show a decline of 36 percent (from 42 to 27 per 1,000 live births).

Childhood Vaccination Coverage. In the 2004 MDHS, mothers were able to show a health card with immunisation data for 74 percent of children age 12-23 months. This is lower than that recorded in 1992 and 2000 (86 and 81 percent, respectively). Sixty-four percent of children 12-23 months are fully vaccinated against six major childhood illnesses (tuberculosis, diphtheria, pertussis, tetanus, polio, and measles). Nine in ten of these children have been vaccinated against tuberculosis, 95 percent received polio 1 and DPT 1. Comparison with estimates of coverage of specific vaccines based on the 1992 and 2000 MDHS data show that the immunisation coverage for children has declined over time.

Child Illness and Treatment. Acute respiratory infections (ARI), diarrhoea, and malaria are common causes of child death. In the two weeks before the survey, 19 percent of children under five years of age were ill with a cough and short, rapid breathing, 37 percent of children had fever, and 22 percent of children experienced diarrhoea. Among children with symptoms of ARI and/or fever, 20 percent were taken to a health facility, as were 36 percent of children with diarrhoea. Cough and diarrhoea are highest among children age 6-11 months. More than half (61 percent) of children with diarrhoea were treated with ORS (solution prepared from oral rehydration salts), 70 percent were given either ORS or increased fluids, and 18 percent received no treatment. Among children with fever, 57 percent were given an antimalarial drug, and 46 percent were given the drug on the same day or the following day. One in five children under age five years slept under a mosquito net the night before the survey, and most of them (18 percent) slept under an insecticide-treated net.

NUTRITION

Breastfeeding Practices. Breastfeeding is nearly universal in Malawi. Ninety-eight percent of children are breastfed for some period of time. The median duration of breastfeeding in Malawi in 2004 is 23.2 months, one month shorter than in 2000. The median duration of exclusive breastfeeding is 2.5 months, whereas the median for predominant breastfeeding is 4.8 months, twice as long as that recorded in 2000. More than half (53 percent) of children under six months are exclusively breastfed compared with 45 percent in the 2000 MDHS. Bottle-feeding is uncommon in Malawi. Use of feeding bottles in children under age six months has remained at the same level as in the 2000 MDHS (3 percent).

Intake of Vitamin A. The Ministry of Health's policy is to supplement children age 6-59 months with a dose of vitamin A capsules once every six months. The 2004 MDHS shows that 65 percent of children under age three had consumed foods rich in vitamin A in the seven days preceding the survey and 65 percent of children had received a vitamin A capsule in the last six months before the survey. Furthermore, 41 percent of women received a vitamin A supplement during the postnatal period. This is the same level as that recorded in the 2000 MDHS.

Nutritional Status of Children. The 2004 MDHS shows that the nutritional status of children under five has not improved since 1992. At the national level, 48 percent of children under five in Malawi are stunted, or too short for their age, 5 percent of children are wasted or too thin, and 22 percent are underweight. For the first time in Malawi, the DHS collected blood samples to be tested for haemoglobin level, a measurement of anaemia. The survey found that 73 percent of children age 6-59 months are anaemic: 26 percent have mild anaemia, 42 percent have moderate anaemia, and 5 percent have severe anaemia.

Nutritional Status of Women. The nutritional status of women in Malawi has remained constant since 2000; the mean height of mothers is 156 centimetres. The cut-off point, below which a woman is considered at risk, is between 140 and 150 centimetres. Three percent of women are less than 145 centimetres in height., The 2004 MDHS used the body mass index (BMI)—defined as weight in kilograms divided by height squared in metres, to assess thinness and obesity. A cut off point of 18.5 is used to define chronic energy deficiency. The mean BMI among the weighed and measured women in the 2004 MDHS is 22, with 77 percent of women classified as normal (BMI 18.5-24.9) and 9 percent are considered thin (BMI below 18.5). Fourteen percent of women in Malawi are classified as overweight or obese (BMI 25.0 or higher). The survey also found that 45 percent of women are anaemic: 33 percent have mild anaemia, 11 percent have moderate anaemia, and 2 percent have severe anaemia.

HIV/AIDS

Awareness of AIDS. Knowledge of AIDS among women and men in Malawi is almost universal. This is true across age group, urban-rural residence, marital status, wealth index, and education. Nearly half of women and six in ten men can identify the two most common misconceptions about the transmission of HIV—HIV can be transmitted by mosquito bites, and HIV can be transmitted by supernatural means—and know that a healthy-looking person can have the AIDS virus.

Attitudes Towards Persons with HIV. To gauge stigma associated with AIDS, the 2004 MDHS asked respondents who had heard of HIV/AIDS about their attitudes towards people with HIV. These questions include whether respondents would be willing to take care of orphaned children of family member who died of HIV, whether they would buy fresh vegetables from a shopkeeper who is

infected with HIV, and whether they believe an HIV-positive female teacher should be allowed to keep on teaching. Almost all women and men age 15-49 (94 and 97 percent, respectively) say that they are willing to take care of orphaned children of a family member who died of AIDS. About two in three women and 84 percent of men say they would buy fresh vegetables from a shopkeeper who is HIV-positive. Two in three women and 80 percent of men say that an HIV-positive female teacher should be allowed to keep teaching. Sixty-five percent of women and 48 percent of men say that they would not necessarily fear disclosure of a family member's HIV-positive status. Looking at all of the stigmas attached to persons with AIDS, 31 percent of women age 15-49 and 30 percent of men age 15-49 expressed acceptance of all four measures of stigma.

HIV-Related Behavioural Indicators. Three in four women agree that HIV can be transmitted by breastfeeding, while about four in ten said the risk of mother-to-child transmission (MTCT) can be reduced by the mother taking drugs during pregnancy, and 37 percent reported both, that HIV can be transmitted by breastfeeding and the risk of MTCT can be reduced by the mother taking special drugs during pregnancy. Sixty-seven percent of men say that HIV can be transmitted by breastfeeding, 35 percent say that the risk of MTCT can be reduced by the mother taking drugs during pregnancy, and 29 percent report that HIV can be transmitted by breastfeeding and that the risk of MTCT can be reduced by taking special drugs during pregnancy.

Delaying the age at which young persons become sexually active is an important strategy for reducing the risk of contracting a sexually transmitted infection (STI). In Malawi, 15 percent of women age 15-24 and 14 percent of men age 15-24 have had sex by age 15.

Sexual intercourse with a nonmarital or noncohabiting partner is associated with an increase in the risk of contracting an STI. Eight percent of women and 27 percent of men engaged in higher-risk sexual behaviour in the last 12 months. Higher-risk sexual behaviour is even more common among youth age 15-24. Fourteen percent of young women and 62 percent of young men age 15-24 engaged in higher-risk sexual activity in the 12 months preceding the survey. Only 39 percent of young women and 46 percent of young men reported using a condom at last higher-risk sexual intercourse.

HIV Testing. To gauge the coverage of HIV testing, respondents in the 2004 MDHS were asked if they had ever been tested to see if they have the AIDS virus. Those who had been tested were asked when they were last tested, whether they had asked for the test or were required to take it, and whether they received their results. Thirteen percent of women age 15-49 and 15 percent of men age 15-49 have been tested for HIV and received the test results. Additionally, 2 percent of women and 2 percent of men were tested but never received the result.

HIV Prevalence. One in three households in the 2004 MDHS sample was selected for individual interviews with male respondents. All men age 15-54 in these households were eligible for individual interview. In the same households, all women age 15-49 and all men age 15-54 were asked to voluntarily provide some drops of blood for HIV testing in the laboratory. Results indicate that 12 percent of adults age 15-49 in Malawi is infected with HIV. HIV prevalence is higher among women than among men (13 and 10 percent, respectively). Prevalence peaks at 19 percent for adults age 30-34, 18 percent for women, and 20 percent for men.

Patterns of HIV Prevalence. Prevalence is higher in urban areas than in rural areas. While 18 percent of urban women are HIV

positive, the corresponding proportion for rural women is 13 percent. For men, the urban-rural difference in HIV prevalence is even greater; urban men are nearly twice as likely to be infected as rural men (16 and 9 percent, respectively). HIV prevalence among women is higher in the Southern Region (20 percent) than in the Northern (10 percent) or Central (7 percent) Regions. The same pattern is observed for men, HIV prevalence is higher in Southern Region (15 percent) than in Central (6 percent) and Northern (5 percent) Regions. In Malawi, circumcised men have a slightly higher HIV infection rate than men who are not circumcised (13 and 10 percent, respectively). Among couples, 83 percent are both HIV negative, and 7 percent are both HIV positive. Ten percent of the couples are discordant, that is, one partner is infected and the other not.

GENDER-RELATED VIOLENCE

Violence since Age 15. Gender-related violence refers to any act of violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women. Domestic violence has negative health consequences on the victims and on the reproductive health of women. In response to the international and regional instruments on women's rights, the Malawi government and its stakeholders started to implement various initiatives aimed at creating awareness on the dangers of gender-based violence. In the 2004 MDHS, women were asked if they had experienced any physical violence since age 15. The data show that 28 percent of women experienced physical violence since age 15 and 15 percent experienced it in the 12 months preceding the survey.

Marital Violence. Seventy-seven percent of ever-married women who experienced physical violence report their husbands as the perpetrators of the violence. The survey further found that 13 percent of ever-married women report to have ever experienced emotional violence, 20 percent experienced physical violence, and 13 percent experienced sexual violence. About one-third of women (30 percent) experienced at least one of the three forms of violence, and 4 percent experience all three forms of violence. The common form of spousal violence is slapping and arm twisting (16 percent) and forced intercourse or marital rape (13 percent). The 2004 MDHS results show that 39 percent of women were physically or sexually violated once or twice in the 12 months preceding the survey, 21 percent three to five times, and 10 percent more than five times. The factor most strongly related to marital violence is husband's alcohol and/or drug use. Violence is more than twice as prevalent among women who say their husband gets drunk very often as among those whose husbands do not drink.

Help-seeking Behaviour among Women who Experienced Violence. Less than half of women who experienced violence actually sought help (42 percent). Of these women, 44 percent sought help from relatives or friends, one in three sought help from their own family, and 11 percent sought help from their in-laws.

MALARIA

Mosquito Nets. The use of insecticide-treated mosquito nets (ITNs) is a primary health intervention proven to reduce malaria transmission. The 2004 MDHS found that 42 percent of households in Malawi own at least one mosquito net, 29 percent of households own at least one ever-treated mosquito net, and 12 percent of households own an ITN. In one in five households the interviewer observed the mosquito nets. Among the observed nets, 21 percent are blue, 74 percent are green, and 5 percent are white. Most nets (71 percent) are rectangular. About one in four of the observed nets had at least one hole. Of the households that have no mosquito nets, 38 percent prefer a blue net and 41 percent prefer a green net. Forty-five percent of households with no mosquito net prefer a

conical net while 43 percent prefer a rectangular net.

One in five children under five years in Malawi slept under a mosquito net the night before the survey. Most of these children (18 percent) slept under an ever-treated net and 15 percent slept under an ITN. There is a small difference in the use of mosquito nets between pregnant women (19 percent) and all women (21 percent).

Intermittent Preventive Treatment during Pregnancy. In Malawi, as a protective measure against various adverse outcomes of pregnancy, it is recommended that pregnant women receive at least two doses of sulfadoxine-pyrimethamine (SP), one in the second trimester and one in the third trimester. The 2004 MDHS data show that 81 percent of pregnant women in Malawi take an antimalarial drug for prevention during pregnancy—almost all take SP/Fansidar (79 percent)—and most women receive the drug during an ANC visit. Less than half (47 percent) of the women receive the recommended two or more doses of SP/ Fansidar.

Prevalence and Management of Malaria in Children. The survey found that 37 percent of children had fever and/or convulsions in the two weeks preceding the survey. Of the children that had fever, 57 percent were given an antimalaria drug and 46 percent were given the medication the same or the following day. Children with fever were given quinine (45 percent), amodiaquine (39 percent), or SP/Fansidar (23 percent). One in five children were given medication (modern pharmaceutical or traditional) that was obtained at home, 39 percent of the children were given medicine that was bought at a pharmacy or shop (without a prescription), and 31 percent were taken to a health centre. Six percent of children with fever were not treated.

MEN'S PARTICIPATION IN HEALTH CARE

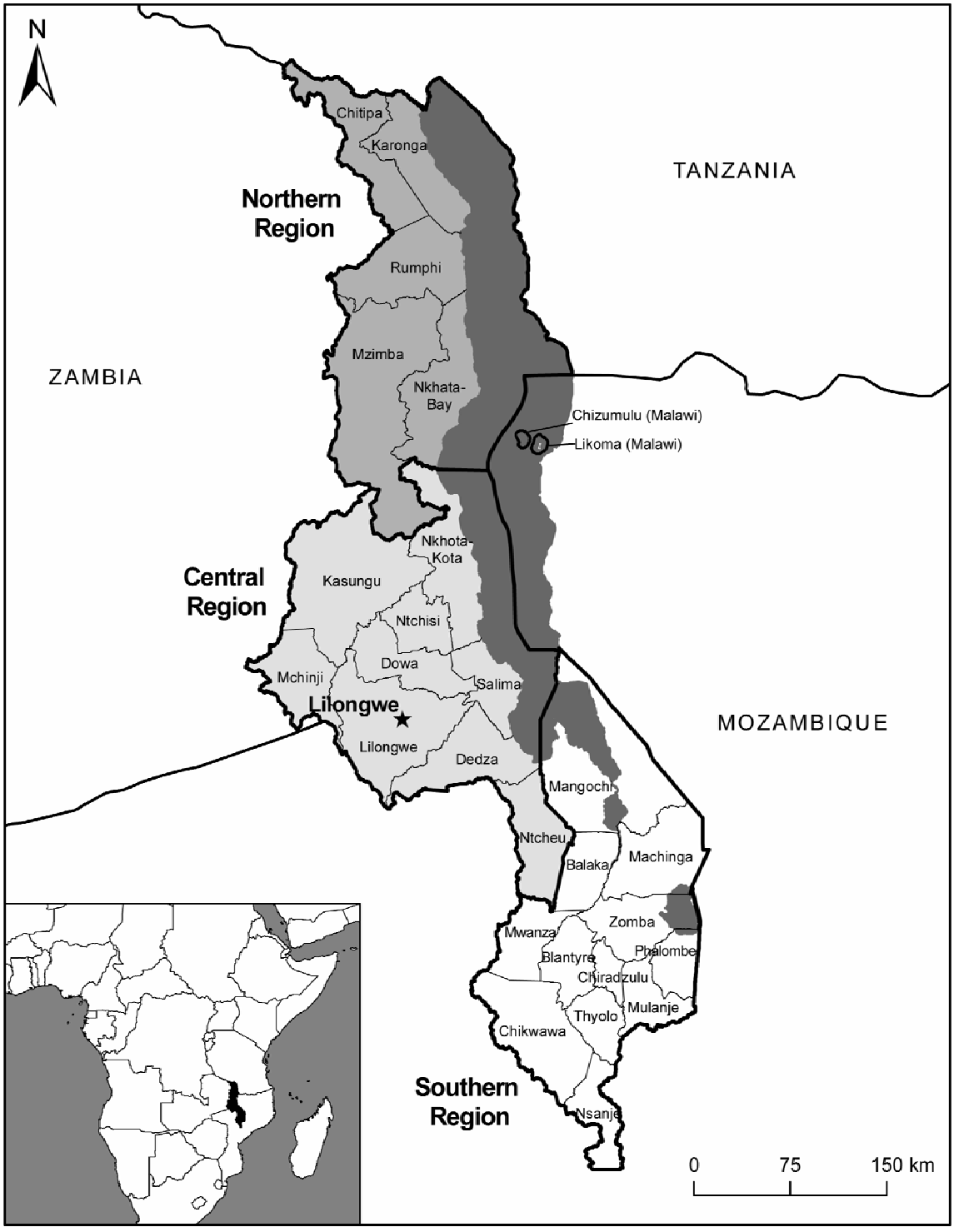
Reproductive Health Care. The 2004 MDHS collected information on men's participation in their wives and children's health care. This information helps family planning and health programme managers in investigating men's role in taking care of the health of their family. When asked about antenatal care, 96 percent of fathers reported that the mother of their last child born in the five years preceding the survey received care from a health professional. This was almost the same as the response given by women (93 percent). For delivery assistance by a health care provider, 74 percent of men reported this response compared with 57 percent of women. Differences in question wording may account for differences in reporting by men and women. It should also be noted that fathers and mothers may not necessarily be reporting on the same child.

Main Provider during Pregnancy, Delivery and after Delivery. The majority of men with a child born in the past five years reported that free services were received for antenatal care for 76 percent of pregnancies, delivery care for 66 percent of births, and postnatal care for 86 percent of births. Fathers reported providing payment for antenatal care for 19 percent of pregnancies, delivery care for 27 percent of births, and postnatal care for 12 percent of births.

Decisionmaker on Child's Health Care. The 2004 MDHS also collected information from fathers on who usually decides about their children's health care. Questions were specifically asked about the health care for their youngest child under five. In 87 percent of cases, fathers reported that they decide about the health care for their children; mothers do so in 64 percent of cases.

Knowledge of Signs of Danger in Pregnancy. The results from the 2004 MDHS show that men's knowledge of danger signs in pregnancy is limited. Two in three men have no knowledge of any danger signs or symptoms that indicate that a pregnancy may be at an elevated risk. The most often cited sign of pregnancy complication is vaginal bleeding, with 11 percent of men reporting this complication.

MALAWI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