SOCIAL POLICY IN SOUTHERN AFRICA: THE CASE OF MALAWI

A Quantitative Report on the Accessibility, Quality and Relevance of Basic Social Services (Education and Health) and Social Protection Programmes in Malawi

By

Wycliffe Chilowa*

And

Stephen Devereux**

*Centre for Social Research University of Malawi P.O. Box 278 Zomba, Malawi **Institute of Development Studies University of Sussex Brighton UK

May, 2001

SOCIAL POLICY IN SOUTHERN AFRICA: THE CASE OF MALAWI

A Quantitative Report on the Accessibility, Quality and Relevance of Basic Social Services (Education and Health) and Social Protection Programmes in Malawi

By

Wycliffe Chilowa*

And

Stephen Devereux**

*Centre for Social Research University of Malawi P.O. Box 278 Zomba, Malawi **Institute of Development Studies University of Sussex Brighton UK

May 2001

Table of Contents

SOCIAL POLICY IN SOUTHERN AFRICA: THE CASE OF MALAWI	1
EXECUTIVE SUMMARY	6
	8
SURVEY METHODOLOGY	8
Sampling	9
South	. 10
Southeast	. 10
Central	. 10
North	. 10
HOUSEHOLDS DEMOGRAPHICS	. 11
Occupation	. 12
DEMAND FOR AND SUPPLY OF HEALTH SERVICES	. 13
The Health Care System in Malawi	. 13
Utilisation of Health Services	. 14
Assessment of Health Services	. 19
Access to health services	. 19
Queuing	. 20
Relevance of health services	. 21
Conclusions and Recommendations on health services	. 21
EDUCATION SERVICES	. 22
Education System in Malawi	. 22
Education Levels of the Sample Populations	. 22
Explanations of the Low Educational Status of the Sample Population	. 24
Access factors	. 25
Ouality	. 28
Relevance	. 29
Fit	30
SAFETY NETS	.31
Agriculture support	32
Programme	35
Agriculture support	37
Exclusion from Safety Net Programmes	37
Programme	38
Participants' Satisfaction with Safety Net Programmes	39
Access	40
Programme	40
Onality	40
Programme	41
Relevance	41
Programme	<u>4</u> 2
Fit	· τ2 Δ2
Programme	· τ2 Δ3
110510111110	. TJ

Overall satisfaction	. 43
Access to Social Protection Programmes	. 44
Annex Tables	. 46

List of Tables

Table 1 Rural communities selected for the survey	. 10
Table 2 Main occupation of individuals surveyed, by location	. 12
Table 3 Main occupation of economically active individuals surveyed, by gender	. 13
Table 4 Utilisation of health services by surveyed households	. 15
Table 5 Frequency of ailment	. 15
Table 6 Frequency of why those who got ill took that first response	. 16
Table 7 Frequency of why those who got ill took that first response, by service provide	17
Table 8 Frequency of why those who got ill took that first response, by service	. 18
Table 9 Accessibility of health services	. 20
Table 10 Quality of health service	. 20
Table 11 Relevance of health services (effectiveness of treatment)	. 21
Table 12 Educational qualifications of sample population	. 23
Table 13 Reasons given for leaving school before completing Form 4, categorized	. 25
Table 14 Distance (km) from home to the nearest schools (% of households)	. 27
Table 15 Frequency of problems with school	. 28
Table 16 Household participation in formal safety net programmes, by year	. 32
Table 17 Household participation in formal safety net programmes, by region	. 34
Table 18 Household participation in selected formal safety net programmes, by district	t
(1998-2000)	. 35
Table 19 Household participation in safety net programme (1998-2000) by sex of	
household head	. 37
Table 20 Household exclusion from formal safety net programmes (1998-2000)	. 38
Table 21 Participants' satisfaction with formal net programmes (1998-2000): Access	. 40
Table 22 Participants' satisfaction with formal safety net programmes (1998-2000):	
Quality	. 41
Table 23 Participants' satisfaction with formal safety net programmes (1998-2000):	
Relevance	. 42
Table 24 Participants' satisfaction with formal safety net programmes (1998-2000): Fa	it
	. 43
Table 25 Participants' overall satisfaction with formal safety net programmes (1998-	
2000)	. 43

EXECUTIVE SUMMARY

- 1. A nation-wide survey was conducted between March and April, 2001 under the IDS-CSR Social Policy Study Programme in Southern Africa, to investigate the mismatches in social service provisioning (health, education and social protection programmes) and the actual needs of the poor Malawians. S gap analysis was therefore undertaken at three namely, coverage gap, effectiveness gap and needs gap.
- 2. A total of 1264 households were randomly sampled from 16 sites nation-wide stratified by region, poverty indices as documented in national studies and by the rural-urban divide.
- 3. The findings show that indeed gaps exist both in the supply and demand of the basic social services (health and education) and social protection programmes. Physical (distance and waiting time), financial (user fees) and quality barriers have been documented as thwarting the supply of and demand for health services amongst most people in Malawi. For primary education services, the current main barriers are quality related (poor management, low teacher professionalism, poor infrastructure) while in the past, distance and financial related barriers were the main ones. However for secondary and nursery education, physical, financial and quality barriers still exist.
- 4. The recommendation here is that the low level of formal educational attainment in the sample, which also refers to the low level of demand for education services, should be improved through massive investments in education at all levels. Similar investments must be made in the health sector if the general welfare of the Malawian rural population is to improve.
- 5. Nursery schools are predominantly in urban areas. Providers should consider extending greatly this education service to rural areas to enable earlier mental development among Malawian children.
- 6. It is high time that government formulated proper mechanism for instituting cost-sharing services in its health facilities.
- 7. It is also recommended that better means of targeting for the social protection programmes (area and household) should be devised and reinforced and regular monitoring should be provided to avert the current situation which has elements of high exclusion of the intended beneficiaries while having inclusion of the non-intended beneficiaries.
- 8. Policy should re-assess the credit schemes to provide for an all-winner framework especially for the rural poor.

ACKNOWLEDGEMENTS

This research report was prepared by a team from the Centre for Social Research (CSR) University of Malawi, and the Institute of Development Studies (IDS), University of Sussex, following a field survey into social policy issues in Maawi, under the DFID-funded Social Policy Research Programme at IDS. Additional funding was provided through DFID Central Africa, which allowed a modest planned survey to be scaled up to the national level. Apart from the authors, the research team included Dr Wiseman Chirwa and Mr Maxton Tsoka (CSR) and Dr Milton Kutengule (National Economic Council NEC) and they provided technical inputs to the survey design, while Dr Andrea Cornall and Dr Henry Lucas (IDS Sussex) offered useful comments on the methology. Dr Todd Benson (IFPRI/NEC) generated the stratified random sampling frame, and Mr Massy Chiocha (CSR) was the data analyst for this project. Mrs Annie Chinkombelo (CSR) provided logistical support.

Fieldwork was undertaken in four regions of Malawi, by the following teams:

South	-	Mackie Kamowa, Veronica Mbulaje, Norah Pemba, Joyce Kunje, Francis Mloza, James Semu and James Chirwa (deseased)
South-East	-	Christopher Manyamba, Tamanda Nambuzi, Annie Banda, Chifera Mapemba, Lazarous Msatida and Naomi Nyambo;
Central	-	James Mwera, Linda Mpando, Matilda Kalungwe, Joseph Kandiesa, Lucius Chipendo and Ausbet Khembo;
North	-	Vincent Gondwe, Esther Saka, Isaac Chirambo, Titus Nyirenda, Noella Nkandawire and Patrick Msukwa.

Mr John M. Kadzandira also provided useful comments on the findings in the report and produced the final report.

INTRODUCTION

The report is a product of a nation-wide survey conducted during March and April, 2001 under the IDS-CSR Social Policy Study Programme in Southern Africa. The overall intention of this programme is to provide information to stakeholders that will inform social policy and lead to more effective social intervention in the country. The main aim of the current study was to investigate mismatches in social service provisioning (health, education and social protection programmes) with the actual needs of the poor Malawians. A range of methods, both qualitative and quantitative, were used.

This report presents findings from the structure questionnaire administered to individual households. The issues that were tackled include demand for and supply of education and health services and the participation of households in formal safety net programmes. In the education ad health sections, respondents were requested to give their views on problems experienced with various services in terms of access, quality, relevance and fit. The section on safety nets sought to ascertain households participation, or lack of it, in the past three years in various programmes. Lastly, respondents' views on unaddressed problems, which could be covered by formal safety nets, were also addressed.

A gap analysis was therefore undertaken at three levels, as follows:

<u>Coverage gap</u> – exploring which communities and categories of people or are excluded from current social programmes;

<u>Effectiveness gap</u> – exploring the variance between the service being provided and the users' needs or expectations;

<u>Needs gap</u> – exploring the needs actually being addressed vis-à-vis those needs that remain unaddressed.

SURVEY METHODOLOGY

This section of the report introduces the methodology that was designed and implemented for the Social Policy in Malawi field survey. A discussion of the survey instruments for the qualitative component of the study are found in another report by Kadzandira and Mvula (2001) "A Qualitative Report on the Accessibility, Relevance and fit of Basic Social Services (Education and Health) and Social Protection Programmes in Malawi"¹.

The principal purpose of the fieldwork was to elicit the experiences and opinion of service users (programme participants or beneficiaries) at the individual, households and community level, about basic social services and safety net programmes in rural and urban Malawi. With this object in mind, a wide range of qualitative and quantitative research methods were designed and used. For this component of the study, a semi-

¹ This reports is available at the Centre for Social Research of the University of Malawi and at the Institute of Development Studies of the Sussex University

structured questionnaire was administered to a total of 1264 households drawn from 16 study sites across the country.

The questionnaire included sections on household demographics, demand for and supply of education and health services, household participation in formal safety net programmes, and respondents' evaluation, health and safety net programmes. The demography section also allowed the number and location of orphans to be identified. The sections on health and education asked respondents to list problems experienced with these services in terms of access, quality, relevance and fit. The section on safety nets explored participation during the past three years in a dozen programmes, including public works projects, agriculture input distribution, feeding programmes and microfinance. The questionnaire concluded by asking respondents if they had any unaddressed problems, which could be covered by formal safety net programmes.

Sampling

Fieldwork was conducted in 16 Enumeration Areas (EAs) nation-wide, stratified both geographically (by region and rural-urban), and by poverty indicators (derived from 1998 Census findings). Sampling took place on four levels: selection of (1) districts, (2) rural communities, (3) urban settlements and (4) respondents within these communities.

Selection of rural survey sites

As a first step, Malawi was divided into four regions – South, Southeast, Centre and North, and it was decided that all four regions would be represented in the survey. The 1998 Malawi Population Census classifies all districts in the country into three categories of educational attainment – high, medium and low – and this indicator was chosen as a proxy for poverty and relative access to basic social services. In the second stage of sampling, four districts were randomly selected from each educational stratum. However, to reflect differences in population distribution across the region, a rule was imposed: three districts would be in the South, three in the Southeast, four in the Centre and two in the North. A list of all EAS in each of the 12 districts was compiled, and all EAs whose catchment areas include the Bomas were purposively screened out, because they have strong urban components. One EA was sampled per district using a computerized random number generator.

Following the procedure described above, the following sites were selected for the study:

Region	District	Traditional	EA
		Authority	Number
South	Phalombe	Mkhumba	098
	Chiradzulu	Mkalo	021
	Nsanje	Tengani	019
Southeast	Balaka	Kalembo	035
	Machinga	Kawinga	045
	Mangochi	Jalasi	034
Central	Dedza	Kachindamoto	035
	Salima	Msosa	002
	Nkhotakota	Kanyenda	017
	Dowa	Kayembe	010
North	Nkhata Bay	Timbiri	005
	Rumphi	Mwankhunikira	007

 Table 1 Rural communities selected for the survey

Selection of urban survey sites

Malawi has four cities, namely Lilongwe (the capital city, in the central region), Blantyre (the commercial centre, in the south), Mzuzu (in the north) and Zomba (in the southeast). Residential areas in these urban centers are categorized into low, medium and high density, with high-density areas – also called Traditional Housing Areas (THAs) – being further subdivided into Planned and Unplanned THAs. Comparatively, Planned THAs have better access roads, access to tap water and most also have government health centers or clinics, a post office and more of the other social services than the Unplanned THAs.

Consultations were carried out with City Council officers in the respective cities to obtain lists of the various THAs and their locations. One Unplanned THA, bordering a planned THA was randomly selected for the student. This was done to capture comparative findings across the two THAs. Fifty percent of the questionnaire were administered in the Planned THA and the rest in the Unplanned THA. Using the procedure described above, the following unplanned THAs were selected: Ntopwa in Blantyre, Chinamwali in Zomba, Ngwenya in Lilongwe and Mchengautuwa in Mzuzu.

The full sampling frame, therefore, was as follows:

Northern Region	-	2 rural EAs and 1 urban THA in Mzuzu
Central Region	-	4 rural EAs and 1 urban THA in Lilongwe
Southern Region	-	3 rural EAs and 1 urban THA in Blantyre
Southeast Region	-	3 rural EAs and 1 urban THA in Zomba

For convenience, district or city names are used throughout this report, instead of the EA names or numbers (for rural survey sites) or THA names (for urban survey sites). A brief description of all 16 survey sites can be found in Appendix 4 of the qualitative survey report (Kadzandira and Mvula 2001). The following codes are also used in this report:

South Rural	South East	Central Rural	North Rural	Urban
	Rural			
S1 = Phalombe	E1 = Balaka	C1 = Dedza	N1 = Nkhata Bay	U1 = Blantyre
S2 = Chiradzulu	E1 = Machinga	C2 = Salima	N2 = Rumphi	U2 = Zomba
S3 = Nsanje	E2 = Mangochi	C3 = Nkhotakota		U3 = Lilongwe
		C4 = Dowa		U4 = Mzuzu

Selection of households

The sample size of the questionnaire survey was set at 75 households per survey site. This produced a total sample size of 1, 200 households (900 rural plus 300 urban), as follows:

- Rural 75 households x 3 EAs x 4 regions = 900 households
- Urban 75 households x THA x 4 regions = 300 households
- Total 900 rural + 300 urban households = 1,200 households

Within each EA or THA, a degree of over-sampling was practiced to ensure that a minimum of 75 valid questionnaires were completed per survey site. The actual number of households surveyed ranged from 77 to 83 in each study area and the valid questionnaires processed in an EA, an equal number of households was sampled. Where there was more than one village in an EA, an equal number of villages]). In each village, a sampling ratio was calculated based on the approximate number of households in a village and the sample size required from it (i.e. sampling ratio = [number of households in a village]/ [sample size allocated to it]). Four Research Assistants (RAs) were deployed to administer questionnaires. Each team started from a central location in the village, and the RAs walked in four directions at right angles to each other, holding interviews at every <u>i'th</u> household (e.g. every fifth household) until the required number of interviews was completed.

HOUSEHOLDS DEMOGRAPHICS

In total, 5,999 household members were recorded in the 1,264 interviewed for the questionnaire survey, giving an average household size of 4.75. This approximates to the

national average of 4.3 reported by the 1998 National Population and Housing Census. There is no significant difference between the proportion of males and females in the sample population. The mean age of the sample population was 20.1 years with 46% being under 15 years old. There were no significant differences in age structure between the urban and rural samples. Of the 1,264 households, 194 (15.4%) were female-headed, below the national average of about 31%.

Different agencies in Malawi favour different definitions of 'orphan.' The broadest definition comes from the Ministry of Gender, Youth and Community Services – a child under 18 years old who has lost one or both parents – while the National AIDS Control Programme (NACP) prefers a narrower definition – a child under 15 yrs who has lost a mother due to AIDS. This survey recorded 3,066 children under 18 years of age, 423 (13.8%) of whom had lost one or both parents to any cause. Of 2,694 children under 15 years of age, 327 (12.1%) had lost one or both parents, and 132 (4.9%) had lost their mothers².

Table 2 presents data on the principal occupation of the $\pm 6,000$ individuals surveyed. The ratio of economically inactive (64%) households members to economically active (36%) is almost 2:1. Over three in five of the economically active population were engaged in formal employment. Not surprisingly, agriculture-based livelihoods were predominant in rural areas, while self-employment or casual work in the informal sector dominated urban livelihoods.

Occupation	Total (%)	Economically	Location			
		active (%)	Urban (%)	Rural (%)		
Economically active:		(36.3%)				
Smallholder farmer	1,66 (19.4%)	(53.5%)	25 (5.2%)	1,141 (67.4%)		
Other agriculture	196 (3.3%)	(9.0%)	4 (0.8%)	192 (11.3%)		
Self-employed/casual	511 (8.6%)	(23.5%)				
work						
Salaried/waged employee	277 (4.6%)	(12.7%)	191(39.4%)	86 (5.1%)		
Unemployed/seeking	29 (0.5%)	(1.3%)	24 (4.9%)	5 (0.3%)		
work						
Economically inactive:	(63.7%)					
Housewife/home-maker	340 (5.7%)		187(11.3%)	153 (3.5%)		
Student/dependent	3,460 (57.7%)		975(59.0%)	2,485 (57.2%)		
Other	20 (0.3%)		20 (0.3%)	15 (0.3%)		
Total	5,999		1,652	4,347		
	(100%)		(100%)	(100%)		

 Table 2 Main occupation of individuals surveyed, by location

² Although national demographic statistics should not be extrapolated from this survey, paternal mortality was significantly higher than maternal mortality in these 1,264 households, at 9.8% and where 15.5% of children under 15 years of age had lost one or both parents, than in rural areas, where the figure was 10.9%

Table 3 disaggregates the occupation of economically active individuals surveyed by sex, and finds that economic activities in Malawi are significantly gendered. About 40% of males and 33% of female in this sample were working or looking for work. Among economically active females, 77% were engaged in agriculture, 17% were self-employed or doing casual work and only 4.4% has salaried or waged employment. Among economically active males, around half were engaged in agriculture but almost half had non-agricultural livelihoods, and one in five had a salaried or waged job. Men were dominant in all employment categories – overwhelmingly so in formal employment – except farming: 70% of women but only 40% of men defined themselves as farmers. These figures confirm two facts: that woman in Malawi are the backbone of crop production in the smallholder sector, and that women are excluded from most of the employment opportunities in the formal (private and public) sectors.

	Sex		% of Occupation		
Occupation	Male (%)	Female (%)	Male	Female	
Smallholder farmer	476 (39.6%)	690 (70.6%)	(40.8%)	(59.2%)	
Other agriculture	127 (10.6%)	69 (7.1%)	(64.8%)	(35.2%)	
Self-employment	333 (27.7%)	166 (17.0%)	(66.7%)	(33.3%)	
Salaried/waged employee	246 (20.5%)	43 (4.4%)	(85.1%)	(14.9%)	
Unemployed/seeking work	20 (1.7%)	9 (0.9%)	(69.0%)	(31.0%)	
Total	1,202 (39.7%)	977 (32.8%)	(55.2%)	(44.8%)	

 Table 3 Main occupation of economically active individuals surveyed, by gender

DEMAND FOR AND SUPPLY OF HEALTH SERVICES

This chapter looks at the demand for and supply of health services in Malawi. Issues of access, quality, relevance and fit of the various health services are discussed.

The Health Care System in Malawi

The overall objective of the health sector, according to the policy framework for the Poverty Alleviation Programme (PAP), is to raise the health status of all Malawians, especially severely affected groups, through improving access to health facilities and related services through Primary Health Care (PHC). The formal health care services in Malawi are structured into six levels namely, health posts, health centers, rural hospitals, district hospitals, central hospitals and special hospitals. These services are delivered by the government³, Christian Health Association of Malawi (CHAM), non-governmental organizations (NGOs), individuals, and large companies. The Ministry of Health and

³ The Ministry of Health and Population, and the Ministry responsible for Local Government

Population is the largest provider of health services running 40% of the families while 19% are CHAM facilities. Local authorities run 8% and the rest are run by the private sector or NGOs. Informal health service providers include traditional birth attendants (TBA), traditional healers and local vendors/shops.

Services at community level include outreach activities conducted through mobile clinics held either in public places or at manned or unmanned health posts. Outreach activities are mainly primary health care type of activities. Most health centers on the other hand offer curative and maternal services. District hospitals are referral centers for health centers and also serve the local town populations, offering both in-patient and out-patient services. Central hospitals act as district hospitals for their own districts as well. They are different from district hospitals in that they provide specialist referral care for their respective regions. Lastly, special hospitals offer very specific services such as mental health services, in-patient care for leprosy and tuberculosis. Services are generally free at all government facilities. All the central hospitals (Lilongwe, Queen Elizabeth, Zomba and Mzuzu Central Hospitals) charge user fees in special wards.

Factors like distance, means of transport, culture, religion, quality of service (perceived and real) and people's social-economic conditions determine the way people in a given area access or do not access various social services that are vital in their lives. These factors will be examined in this section to understand how they have affected people in the 16 study sites in accessing health services.

Utilisation of Health Services

The next section explores the demand amongst sample household members for health services whenever they fall ill. It will look at the most prevalent ailment, the first action taken by respondents after discovering the ailment, why they took that response and whether the response actually helped. Lastly, respondent's views were solicited on what they felt were problems with the health service. About 60% of households had someone who had fallen ill (58% in urban areas and 61% in the rural areas) in the two weeks prior to the study.

Most respondents (68%) in the study indicated that when a member of their family fell ill in the 2 weeks prior to the survey, they first sought assistance from the drug vendor and/or shop (Table 4). Next was the health centre/clinic (57%) followed by CHAM facilities (28%), traditional healer (23%) and private clinic (20%). Private hospital and the Doctor were the least that were visited by household members in the sample. Only 14% of household members visited a district and central hospital, respectively.

Only one respondent visited the Drug Revolving Fund in the entire sample. This illustrates the system is still not yet fully developed.

Health Facility	Used during	Model of Transport				
	past year	Walk	Bicycle	Public		
Drug Revolving Fund	0.1%	0%	100%	0%		
СНАМ	28%	53%	21%	22%		
Health Centre/Clinic	57%	80%	14%	6%		
District Hospital	14%	33%	15%	45%		
Central Hospital	14%	27%	0%	64%		
Private Hospital	3%	44%	15%	32%		
Private Clinic	20%	66%	17%	16%		
Drug Vendor/Shop	68%	97%	2%	0%		
ТВА	6%	87%	10%	0%		
HAS	6%	92%	4%	3%		
Traditional Healer	23%	79%	12%	0%		
Doctor	3%	77%	0%	15%		

Table 4 Utilisation of health services by surveyed households

Table 5 Frequency of ailment

	Total (%)	Location (%)	Gender (%)	
Ailment	[N=1,000]	Urban	Rural	Male	Female
		[n=263]	[n=737]	[n=675]	[n=325]
Fever/Malaria	43.7	49.4	41.7	46.4	38.2
Respiratory Infection	19.9	16.7	21.0	18.8	22.2
Skin Problem	8.8	7.6	9.2	8.6	9.2
Ear, Nose or Throat	7.3	10.3	6.2	7.3	7.4
Diarrhoea	5.7	3.4	6.5	5.5	6.2
Rheumatism/Backache	3.2	2.3	3.5	3.3	3.1
Unspecified long term illness	1.5	1.1	1.6	1.5	1.5
Dental	1.6	1.5	1.6	1.5	1.5
Eye Problem	1.4	0.4	1.8	1.3	1.5

Accident/injury	1.1	1.1	1.1	1.0	1.2
Bilharzia	0.9	0.8	0.9	0.7	1.2
Blood Pressure	0.7	1.5	0.4	0.7	0.6
Tuberculosis	0.1	0.4	-	0.1	-
Cholera	0.1	-	01	0.1	-
STD	0.1	-	0.1	0.1	-
Other	3.9	3.4	4.1	3.0	5.8
Total	100%	100%	100%	100%	100%

The predominant ailment, among those who fell ill in the two weeks previous to the study, was malaria or fever as indicated by about 44% of the respondents (Table 5). The second most prevalent ailment was respiratory infection or pneumonia (20%), followed by skin problems (9%), eye, nose or throat problems (7%) and diarrhoea (6%). A higher proportion of household members had malaria or fever in the urban areas, and these were also more likely to be males. This also held true for ear, nose and throat infections.

On the other hand, proportionally, the following ailments were prevalent in the rural areas: diarrhoea; skin problems and respiratory infections. Respiratory infections were relatively, more prevalent among females in the sample. The predominance of these ailments during the study could be partially explained by the fact the study was conducted towards the end of the rainy season.

As a first response after discovering the ailment, the majority of the respondents (42%) visited a local grocery shop/vendor while 22% had visited a government health centre and 9% had did nothing. About 6% visited a CHAM health facility. Use of home traditional medicine as indicated by about 5% of the respondents was also common among the sample households. Others visited a private health provider and a government district hospital (5% each, respectively). Various reasons were put forward as regards to why people took that first response (Table 6).

Reason	Total (%)	Urban (%)	Rural (%)
Nearest service	256 (25.6%)	33.3	24.5
Effective treatment	191 (19.1%)	12.6	20.3
Cheap or free	155 (15.5%)	10.1	16.9
Government HC too far away	106 (10.6%)	5.6	11.8
Quick treatment	95 (9.5%)	15.6	7.5

 Table 6 Frequency of why those who got ill took that first response

Not a serious problem	78 (7.8%)	10.6	7.2
Drugs available	47 (4.7%)	2.5	5.7
Health provider for institution	9 (0.9%)	1.5	0.9
Religious beliefs	6 (0.6%)	0.5	0.4
Friendly staff	1 (0.1%)	1.0	0.0
Other	56 (5.6%)	8.1	4.9
Total	1,000 (100%)	198	868

The majority of the respondents (26%) took that first response because the facility/service was the nearest service. This was more pronounced in the urban (33.3%) than the rural (25%) areas. About 19% thought they would get effective treatment at the facility while 16% went there because the service was cheap or free. About 11% went to the facility as a result of their preferred government health centre being too far away. This shows that distance (physical access) and quality of service are important factors that influence peoples' decision making about seeking health assistance.

Around 10% (15% in urban areas and 8% in rural areas) went there to get quick treatment while 5% indicated that that was the only facility where drugs were available (Table 8). Only 8% went there first because they thought they did not have a serious problem to warrant going to a higher order facility (11% in urban areas and 7% in rural areas).

A higher proportion of rural households relative to urban households took that first response because they believed they would get effective treatment, because the service was cheap or free, drugs being available and as a result of Government Health Centre being too far away. The majority of respondents (72%) indicated that indeed their first response did help.

Table 7 and Table 8 below give frequencies of why those who got ill took that first response by service provider and criteria, respectively.

	Provider (%)							
Reason	Private/CHAM [n=528]	Governmen t [n=291]	Religious/ Traditional [n=76]	Total [n=895]				
Not a serious problem	5.5	0.3	2.6	3.6				
Quick treatment	12.9	7.9	5.3	10.6				
Nearest service	29.5	27.8	17.1	27.9				

Effective treatment	19.5	23.0	23.7	21.0
Cheap and free	8.0	32.6	21.1	17.1
Drugs available	7.2	1.7	2.6	5.0
Friendly staff	-	0.3	2.6	0.1
Health provider for institution	0.2	2.4	-	-
Government HC too far away	12.7	1.0	5.3	9.6
Religious beliefs	-	-	5.3	0.4
Other	4.5	2.7	7.9	4.2
Total	100%	100%	100%	100%

 Table 8 Frequency of why those who got ill took that first response, by service

	Provider (%)							
Criteria	Private/CHAM	Government	Religious/	Total				
Access 1. Time	12.9	7.9	5.3	10.6				
2. Distance	42.2	28.8	22.4	37.5				
3. Cost	8.0	32.6	21.1	17.1				
Quality/relevance	26.7	25.0	28.9	26.1				
Fit (culture)	0.0	0.0	5.3	0.4				
Other	10.0	5.4	10.5	7.8				
Total	100%	100%	100%	100%				

Those who visited a private provider gave the following reasons for this choice: quick treatment, nearest service, availability of drugs and Government Health Centre being too far away. These are access and the quality reasons. This implies that Government needs to improve both access to its facilities as well as quality of its services. The common reason some respondents used the Government facility was that it was cheap and free. Traditional healer were preferred on the basis that their treatment is perceived to be more effective.

When the reasons were collapsed by criteria of access, quality, relevance and fit (Table 8 above), it became very clear that the private provider was considered more accessible in terms of distance and time, but not cost. In terms of cost it was the Government provided facility that was more accessible because they are free. As regards quality and relevance

of service, most respondents preferred the traditional facility. In terms of fit, culturally traditional facilities and/or religious based facilities were found to be more fitting.

Assessment of Health Services

As part of an evaluation of the health services, respondents were requested to enumerate problems they considered existed with the health services.

Overall, 46% indicated that they had no problems or were satisfied with the service they had accessed in the two weeks prior to the survey. This was more pronounced in the urban (59%) than in the rural areas (42%). Around 12% mentioned that long waiting time was the problem while a similar proportion mentioned that the treatment was unsuccessful or unsatisfactory. This was particularly in relation to the government health facilities where there are usually no drugs and people are given aspirin for any ailment. About 9% mentioned lack of drugs as a problem and 6% indicated that the drugs were becoming too expensive. The need for stocking government health services with adequate and proper drugs cannot be overemphasized. Theft of drugs from the Central Medical Stores all the way to the health establishment should be stamped out.

Access to health services

As regards distance to a health service, household members travel on average, between one and 20 km. The furthest away was the district hospital followed by Drug Revolving Fund facility, the Private Hospital, CHAM facilities and Traditional Healers (Table 9). The other facilities were within manageable distances of 8 Km or less. All the health facilities, except district and central hospitals, were predominantly accessed by walking. This finding is however not very surprising as the study was conducted in rural EAs far from the district headquarters where such facilities are located.

On average, it took households members between one and two hours to reach the health facility. In terms of queuing time, members waited longer (at least 2 hours) at Government health facilities (District and Central hospitals and Health Centre) that the other facilities (Table 9).

Average spending per visit was more pronounced at the private hospitals where members paid at least K1, 661 per visit while at CHAM facilities it was K341 followed by private clinics (K275) and central hospitals (K205). The private doctor charges were on averages were on average K156 per visit whereas the traditional healer charged about K151 per visit. The discussion about average user fees brings out two important points. First, the fees are high considered that the majority of Malawians (60%) live in poverty and therefore cannot afford to access these health services. Secondly (on the contrary), is the issue of cost sharing. It would appear that with a properly designed and targeted cost-sharing programme, health services in government facilities could be run on a cost-sharing basis. This approach however, would require further investigation.

	Average	Average tin	ne costs (hr)	Average
Health facility	distance (km)	Travel	Queuing	spending per visit (MK)
	17	1.7	2	
Drug Revolving Fund	1/	1.5	2	25
CHAM Facility	13	2	1	341
Health Centre/Clinic	6	1.4	2	8
District Hospital	20	2	2	53
Central Hospital	11	1	2	205
Private Hospital	13	2	1	1,661
Private Clinic	8	1	1	275
Drug Vendor/Shop	1	0.36	0.015	49
TBA	4	1	0.5	68
HAS	3	0.7	0.6	3
Traditional Healer	8	1.6	0.7	151
Doctor	7	1	0.5	156

Table 9 Accessibility of health services

Quality of health services

Assessing quality of service from the quantitative survey, it was clear that the quality of the service offered by Government health facilities has some problems, or in some instance, was very poor. All the other facilities seemed to offer very good quality services (Table 10).

Table 10 Quality of health service

Health facility	Good (%)	Adequate	Poor (%)	Ν
		(%)		
Drug Revolving Fund	100	0	0	0.1
CHAM Facility	63	29	8	28
Health Centre/Clinic	26	51	24	57
District Hospital	36	48	15	14
Central Hospital	35	45	20	14
Private Hospital	85	15	0	3
Private Clinic	83	15	2	20
Drug Vendor/Shop	71	28	1	68
TBA	92	6	3	6
HAS	65	30	5	6.3
Traditional Healer	64	32	4	23
Doctor	74	24	3	3

Relevance of health services

In terms of effectiveness of treatment or service in the health establishment, the data suggests that it is only in the government health centers/clinics and District hospitals where this has been called into question (Table 11). It seems all the other facilities offer very effective treatments or services. These findings seem to reinforce the common understanding that Government facilities lack drugs. The behaviour of the health workers has also been called into question.

Health facility	Good (%)	Adequate (%)	Poor (%)	Ν
Drug Revolving Fund	100	0	0	0.1
CHAM Facility	74	17	9	28
Health Centre/Clinic	35	32	33	57
District Hospital	48	33	20	14
Central Hospital	64	20	16	14
Private Hospital	85	12	3	3
Private Clinic	83	12	6	20
Drug Vendor/Shop	58	36	6	68
TBA	93	7	0	6
HAS	61	31	8	6.3
Traditional Healer	63	22	15	23
Doctor	74	24	3	3

 Table 11 Relevance of health services (effectiveness of treatment)

For the supply of health services to be improved, there is a need therefore for Government health facilities to improve their services in terms of making sure that drugs of the right type for a particular ailment are readily available. The behaviour of staff also needs to be improved. This calls for massive refresher courses and sensitization campaigns for Government health staff.

Conclusions and Recommendations on health services

Access to Health Services

The data has shown that gaps exist both in the supply and demand of health services. It is obvious from these findings that in terms of time and distance access, the private health facilities are preferable than the rest. Government facilities score highly on cost access whereas traditional/religious facilities are preferred in terms of effectiveness and relevance. The recommendation here is that service providers should make a concerted effort to reduce these barriers if the gaps are to be reduced and supply and demand for health services is to be improved and satisfied.

Quality and Relevance of Health Services

The findings have revealed that drug and staff shortages, poor management, nonobservance of work schedules and bad behaviour of health staff prevent some people from seeking assistance from the formal health facilities. These have made some people to seek assistance from the informal sector. For the supply of health services to improve, government should improve its services by making sure that drugs, of the right type for common illness in the respective areas, are readily and adequately available at all health facilities.

EDUCATION SERVICES

Education System in Malawi

Formal educational services in Malawi are provided at four levels – pre-primary, primary, secondary TERTIARY. The main providers are the government, NGOs, the religious community, and the private sector. Primary education runs for eight years, with Standards 1-4 being regarded as 'junior primary', while Standards 5-8 are 'senior primary'. Secondary school runs for four years, from Form 1 to Form 4. Entry into secondary education and university depends upon satisfactory performance in national examinations in Standard 8 and Form 4 respectively. Pre-school education in Malawi is loosely structured and regarded as informal, although its importance in early childhood development is recognized by the education policy. Services offered for pre-school children (2-5 years) fall within the broad categories of nurseries, day care centers, crèches, kindergartens and play groups. These pre-primary services are almost entirely provided by the private sector and are therefore, not free.

The recommended age for starting primary education in Malawi is 6 years, although not many children actually start at that age, particularly in the rural areas. This is particularly because of long distances to the nearest schools and various other socio-cultural reasons. In 1995, for instance, only about 51% of 6- year old children had entered primary education (MSIS 1995). The current education policy provides for free primary education in all government schools. Secondary school students pay tuition fees, which currently stand at over K2,000 (£18+) annually, while those provided with boarding facilities are asked to pay over K6,000 (£55+) annually.

Education Levels of the Sample Populations

Table 12 summarises the educational status of the sample population⁴. About 26% of the sample household members aged 10 years and above had no formal education, while a further 37% had only completed four years of schooling. The definition of functional literacy adopted in Malawi states that one must complete Standard 4 to be considered literate. By this definition, approximately 56% of the sample population was literate, meaning that 44% of the members of those households were probably unable to read or write.

⁴ A detailed breakdown year by year is annexed as Table A.1

Interestingly, there were no significant differences between the rural and urban individuals sampled, in terms of their levels of educational attainment. The explanation for this initially counter-intuitive finding, is that the poorest (squatter and unplanned traditional housing) areas within Malawi's four main cities were purposively selected for the urban survey, hence many socio-economic characteristics of these areas' residents mirror those of the rural sample.

Highest Educational	Total (%)	Location	(%)	Gender (%)		
Attainment		Rural	Urban	Male	Female	
No education	1,417 (25.7%)	25.2	27.2	20.8	30.6	
Junior Primary (1-4years)	2,057 (37.3%)	37.5	36.4	36.2	38.4	
Senior Primary (5-8 years)	1,390 (25.2%)	25.1	25.8	28.0	22.4	
Secondary (9-12 years)	585 (10.6%)	11.0	9.4	13.3	7.8	
Tertiary	66 (1.2%)	1.1 1.1		1.8	0.6	
Total	5,515 (100)	100%	100%	100%	100%	

 Table 12 Educational qualifications of sample population

Note: Junior Primary = Standards 1-4; Senior Primary = Standards 5-8; Secondary = Forms 1-4; Tertiary = Post-secondary course, Vocational or Technical College, University Diploma/Degree

Conversely, sharp gender disparities emerge clearly from Table 12. Almost one in three females (31%) of the sample population indicated that they had no education, against one in five males (21%). Although comparable numbers of males and females enter school, the data suggests that females dropped out of school earlier and their attrition rates are persistently higher than males at every level as evidenced in the numbers reaching higher classes. In this sample, 43% of males and just only 31% of females continued their education to at least senior primary level. Almost twice as many males (13.3%) as females (7.8%) and thrice as many males (1.8%) as females (0.6%) had benefited from secondary and tertiary education respectively.

Significantly, given evidence from many countries on the importance of maternal education in influencing the nutritional status (and the other indicators of well-being) of children, there were large differences in literacy rates between male and female households heads in our sample. Only 16% of male household heads had no education at all, while the figure for female household heads was 42%. Furthermore, 69% of female household heads were illiterate compared to 41% of male household heads.

Explanations of the Low Educational Status of the Sample Population

People who had no education or left school before reaching Form 4 were requested to give reasons why they dropped out or never attended school. The explanations given in the Annex to this report (see Table A.2) can be clustered into the four categories (plus twp extra categories) developed for this analysis of social policy in Malawi (Table 13). By far the most frequent responses related to financial constraints. These included higher school fees, unaffordable materials and school uniform, or needing to work to support the family. These factors forced more than half of those individuals (55%) out of school before completing Form 4, or prevented their attending school at all. This finding is consistent with evidence from across the world that access to education is regressive in the sense that children from wealthier families are more likely to go to school and to continue further in education than children from poorer families. The Government of Malawi's efforts to redress this inequality of access by reducing the direct costs of education - fees, uniforms - have already had a positive impact (see below). However remains the case that poorer families face higher indirect costs - specifically, the 'opportunity cost' of sending children to school instead of using their labour power for domestic chores, farming or earning income.

The perception of education as 'irrelevant' (which accounted for 22% of explanations given) is related to this last point. Several respondents – or their parents – did not appreciate the value of acquiring an education. They were either "lazy" or " not interested in school" "school seen as of less important" or "that their parents or guardians advised or forced them to stop attending school". Again, this factor is correlated with wealth in Malawi, as in most countries. Although poor families everywhere struggle to find the means to educate their children, the perceived returns from education are higher for the middle classes, whose children are more likely to enter highly paid professions because of class stratification in labour markets. The poor tend to have more modest (and empirically realistic) ambitions, regarding basic literacy as adequate to pursue a livelihood in semi-skilled employment or the informal sector.

Reason Given	Total (%)	Location	(%)	Sex (%)		
	[n=2,664]	Rural	Urban	Male	Female	
Access factors						
Financial constraints	54.5%	54.0	56.0	59.6	50.2	
Physical inaccessibility	3.7%	3.7	3.7	3.4	4.0	
Socio-cultural barries	2.4%	2.4	2.3	2.8	2.0	
Quality issues (negative)	1.4%	1.5	1.7	1.7	1.4	
Relevance (negative)	15.8%	16.2	14.7	15.6	15.9	
Fit (negative)	0.3%	0.4	0.0	0.2	0.3	
Personal circumstances	13.4%	18.5	19.7	13.3	23.3	
Other	3.2	3.7	1.6	3.4	3.0	
Total	100%	100%	100%	100%	100%	

 Table 13 Reasons given for leaving school before completing Form 4, categorized

Proportionately, the various explanations given do not vary much rural people and those from the urban unplanned THAs. However, when compared across the genders, it is striking that more males (60%) indicated that finance-related barriers (especially school fees) stopped their schooling than females (50%). The literature suggests that parents everywhere are more likely to invest in educating their sons than their daughters, since the returns from male education are generally perceived as higher. (IN Malawi, where formal employment in all sectors and most positions of power are heavily monopolized by men, this perception has a sound basis in reality.) Where household resources for educating children are limited, one would therefore expect daughters to have their education rationed before sons. The reversal of education rationing by gender in our sample probably reflects the success of the 'positive discrimination' policies adopted to promote girls' education in Malawi, such as offering free secondary education to girls (but not to boys).

On the other hand, girls were much more likely than boys to leave early because of 'personal circumstances' (23% of responses against 13%). The main factor here are falling pregnant and getting married, both of which affected girls more (in the case of pregnancy, exclusively) than boys. This finding is not surprising because in the past, girls who became pregnant while in school were automatically expelled, while it was rather easier for the boy responsible to continue his schooling (or, in the case of teacher who were responsible for the pregnancy, to continue teaching). The official reversal of the policy of expelling pregnant schoolgirls has not yet had much impact.

Current Access to Education Facilities

In the questionnaire survey, respondents were asked if any member of their household had attended any educational facility in the 12 months prior to the survey. Almost all households (96%) answered in the affirmative. Among children currently in school, 86% of the schools were run by government, 7% were private, 6% were run by Christian missions, while the community, NGOs and Islamic mission together accounted for only 1% of the schools.

Respondents were also asked to estimate the distance to the nearest educational institutions, in either kilometres or walking time. In some cases, the research team's vehicle was sent to verify the distance from the centre of the village. Table 14 shows the proportions of households living at various distances from the nearest nursery, junior primary, full primary and community day secondary schools in the 16 sites. Nursery schools were found only in 7 of the 16 sites (3 rural and 4 urban). With the exception of the Balaka EA, nursery schools were within a distance of 1 km (mean = 0.7 km) from most households in the other six EAs where such schools were found (all 4 urban unplanned THAs, plus Nkhata Bay and Rumphi in the rural north and Mangochi in Southeast).

Junior or full primary schools were within 0-3 kilometres of all households, and almost all rural households, in the densely settled rural south. The average distance to the nearest junior or full primary school was 2.6 km, ranging from 0.05 km to 10 km. Most children attending primary school (98%) reached it by walking, and the time taken to walk to school averaged 28 minutes. However, for several rural EAs in the southeast, central and northern Malawi, high numbers of households lived a considerable distance from the nearest educational facility. More than half the respondents from Machinga, Machochi and Salima EAs lived more than 3 km from their nearest primary school, and many of these lived more than 5 km away. In Machinga, 38% and 46% of interviewees lived more than 5 km from their 'local' junior primary and full primary schools, respectively.

Survey Site	Nursery	r (%)	Juni Sch	ior ool (%	Pri	mary	Full (%)	Prim	ary So	chool	Seco	ondary	s Sc	chool
	<1km	1-3	<1	1-3	3-5	>5	<1	1-3	3-5	>5	<1	1-3	3-5	>5
South				•		•						•		
Phalombe								38	9	-	33	33	-	33
							53		_					
Chiradzulu							21	64	4	-	-	38	63	-
Nonio							31	0	1					
Insalije							87	9	4	-	-	-	-	-
South-East							07							
Balaka	33	67	-	88	13			77	5	-	100	-	-	-
							19							
Machinga			-	41	22	38	-	46	8	46	-	-	-	-
Mangochi							-	44	25	31	-	-	100	-
Central										-				
Dedza			19	68	13	-	-	50	48	2	-	-	-	100
Salima				100			-	34	50	16	-	50	-	50
Nkhotakota			-	100	-	-	20	62	8	-	-	33	-	6/
Down							30	64	0	7		25	25	50
Dowa							20	04	9	/	-	23	23	50
North							20							
NkhataBay	100	-						63	19	7	10	50	20	20
-							12							
Rumphi	100	-	-	100	-	-		53	16	2	-	30	30	40
							29							
Urban	70	21	00	20				4.4	2			00	20	
Blantyre	/9	21	80	20	-	-	54	44	Z	-	-	80	20	-
Zomba	92	8	_	100	_	_	54	75	8	2	_	14	86	_
Zomoa	12	0	_	100	_	_	15	15	0	2		17	00	_
Lilongwe	68	32	100	-	-	-		67	-	-	7	79	7	7
E C							13							
Mzuzu	100	-	50	50	-	-		16	-	2	13	53	27	7
							82							
Total	82	18	18	58	12	12	32	51	13	4	7	46	22	25

 Table 14 Distance (km) from home to the nearest schools (% of households)
 Image: school is a school is a

Secondary schools were relatively very far from the sample households in most EAs (>5 km) where people indicated that they have access to them, while in two of the sixteen (Machinga and Nsanje) they were described as not available at all.

It is clear from the above discussion that only full primary schools are very accessible to most Malawians in terms of distance and financial considerations. This finding is to be expected especially with the introduction of free primary education. University was termed physically and financially inaccessible to almost all respondents (about 94%), as was vocational training (94%). Over half of the respondents indicated that they have no

physical access to a nursery school (53%) and three-quarters had no access to adult literacy classes (76%) in their area. Secondary schools were at distances of over 5 km on average in rural areas, and were financially accessible, although with some difficulties.

Eligibility criteria that restrict access to higher-level education services, for example, the need to graduate from primary to secondary school and from secondary school to University, were reported by 33% of respondents. According to some, this requirement is exacerbated by limited places at higher levels, so that the student has to perform extremely well in the national examinations to proceed. The University of Malawi has its entrance exams, which also limits access.

Quality

Complaints about the quality of education services provided at the schools that were near to the sample households was described as another barrier to the demand for education services. Various problems were identified through the household interviews and interviews with teachers as affecting the quality of education in the various communities that were visited (Table 15)⁵. Performance of pupils in most schools (primary and secondary) was reported to be declining over recent years. Not many pupils graduate to secondary school from primary schools and very few manage to secure university places even after finishing Form 4. The various explanations given for this state of affairs can be summarized in terms of the analytical categories developed for this study (table 15).

Category	Problem	Total (%)	Urban (%)	Rural (%)	Reported in Qualitative Surveys
Quality	Insufficient teachers/infrastructure	27.6	27.8	27.6	All 16 sites
	Insuffitient teaching materials	20.5	18.5	21.0	All 16 sites
	Poor quality of teaching	10.1	6.3	11.3	11 of 15 sites
	Poor sanitation at schools	8.0	10.0	7.4	All sites
	Poor management	5.1	3.6	5.6	6/16 sites
	Poor exam results	3.5	1.7	4.0	All 16 sites
	Teachers negligence/drunkards				13 of 16 sites
	Pupils being over-punished				12 of 16 sites
	Pupils being exploited at school				15 of 16 sites
Access:					

 Table 15 Frequency of problems with school

⁵ These vies are reported in Kadzandira and Mvula (2001)

Physical	Long distance to school	10.1	11.7	9.7	5 of 16 sites
					(secondary)
Financial	School fees/materials too	4.9	5.4	4.7	16 of 16 sites
	expensive				(secondary)
None	No problems	10.2	15.1	8.6	-
Total		100%			

Findings that were discussed in (Table 13) above indicated that over 54% of the household members never reached Form 4 either because they left school early or had never attended school at all and this was because of financial barriers like fees uniforms and school materials. However, as Table 15 shows, there appears to be a shift from the financial constraints to quality constraints in terms of education in Malawi. Most (about 75%) of the respondents indicated that the quality of education in the schools close to them was poor. Common quality factors that were enumerated included insufficient teachers/ infrastructure and materials, poor quality of teaching and inadequate sanitation. Only about 10% of the respondents cited long distance to school as being a barrier to accessing education.

The low number of respondents indicating finance as a barrier to education services is likely to be due to the free primary school education system and the fact that in some schools pupils are provided with notebooks and pens at the beginning of each term. Further, the current Education Policy also lifted the ban on the compulsory wearing of uniforms in primary schools. The 4.9% who reported financial constraints could be parents/guardians with children that were attending secondary and nursery schools.

The findings further revealed that schools in rural areas were more likely to experience poor management problems, poor quality of teaching, poor exam results and insufficient teaching materials compared to schools in the urban areas (Table 15). On the other had, urban areas were likely to have long distances to school and sanitation problems. It is clear from the table above that the majority of the problems indicated are education quality problems, followed by physical access and sanitation problems.

Relevance

As discussed above, 'relevance' relates to people's appreciation of lack of appreciation for the value of education to one's life. Some of the respondents in both rural and urban areas thought that tertiary education (University of vocational training) held little relevance for them (Table A.6). Perhaps this was because, in many areas, tertiary education is not known.

Education schedules may overlap with people's normal livelihood systems and may complete for children's time. For example, children may be required to assist parents with agricultural activities like weeding at the same time that they are supposed to be in school. Such conflicts of interest would imply that the education system is not compatible with local calendars. In this study, participants were asked to state whether the scheduling of activities at local schools overlap with the demands on the children in other activities. Few respondents to the household interviews answered in affirmative (Table A.6).

Conclusion and Recommendations relating to the Demand and Supply of Educational Services

Access to educational services

The results of the study would suggest that primary education is both physically and financially accessible in most areas of Malawi in comparison with nursery and secondary education. Where nursery education is available (mainly in towns) it is virtually unaffordable to most residents because of high fees and requirements for materials. A similar observation was made in relation to secondary education. University and other tertiary education is generally not available because institutions offering such education are few and where available, eligibility criteria and finance constraints exclude most people. Adult literacy was unavailable in almost all areas where the study was carried out.

It is therefore recommended that nursery and secondary education must be brought closer to the people in most parts of the country and increase the intake of students into the other higher institutions.

Quality of education services

The data has shown that insufficient infrastructure and teachers (many of who are untrained), and poor management are affecting the delivery and quality of education in Malawian schools. The consequence of this is an increase in the number of poor people becoming dissatisfied with the educational services. There are also a number of controversial issues surrounding the behaviour of teachers including their (lack of) professionalism, the dubious nature of their relationships with pupils, and their attitudes to discipline and punishment that require sensitive but urgent intervention by policy. Regular supervision is also needed in the schools. It also recommended that the government should consider revising the rumination packages for teachers to attract more people into the teaching profession.

Relevance of education.

The data has shown that nowadays people place some value in education (especially at the primary and secondary levels) despite the many shortfalls within the education system itself.

Fit

Fitness of educational services to people's livelihoods

Education schedules and lesson content would appear to be compatible to people's livelihoods, although cases of school schedules clashing with agricultural and cultural activities have been recorded.

SAFETY NETS

In recent years there has been a great deal of activity in Government and among the donor agencies regarding the issue of providing adequate social protection for Malawi's rising numbers of poor and vulnerable citizens. Key developments have included:

- free distribution of agricultural inputs in most years since the 1994 drought (at first called 'Supplementary Inputs Project', later 'Starter Packs' and now 'Targeted Inputs Project');
- the drafting of a concept paper Safety Nets in Malawi: How much? For how many? by the World Bank in October 1998;
- the drafting by the Government of Malawi of a National Safety Net Strategy in September 2000, which was ratified by Cabinet in December 2000.
- the preparation of a Draft Paper on the Design of the Safety Nets Programme in Malawi during early 2001, as an input to Malawi's Poverty Reduction Strategy Paper (PRSP).

Although the national safety net <u>programme</u> is not yet operational (as of mid-2001), a wide variety of safety net <u>projects</u> has been provided to vulnerable groups in Malawi for several years. (One of the objectives of the National Safety Net Strategy, in fact, is to coordinate and rationalize these diverse and ad hoc interventions, delivered by various governmental and NGOs, into a comprehensive programme under a single coordinating authority.) Questions were therefore asked in our survey about household participation during the past three years in a dozen separate safety net projects, including:

- <u>food transfers</u> (under-five therapeutic feeding, free food distribution, flood relief,
- <u>employment programmes</u> (food-for-work, cash-for-work, inputs-for-work),
- <u>agricultural support</u> ('Starter Packs', other free input programmes, inputs credit),
- support to <u>vulnerable groups</u> (orphan care, cash credit targeted to the poor).

Participants⁶ were then asked to assess these programmes in terms of the four criteria used elsewhere in this study (access, quality, relevance, fit).

⁶ In this report the term 'participant' is generally (but not always) preferred to 'beneficiaries', mainly because of the pejorative connotations of the latter term, particularly where benefits are provided as an

Respondents were also asked if any member of their household had been denied access to these safety net programmes during the past three years, and if so, to explain why they were excluded. Finally, respondents were asked to identify problems faced by their household or community that could be addressed by safety nets, and to suggest appropriate interventions.

Participation in Safety Net Programmes

Table 16 lists the percentage of households in the survey that participated in various safety net programmes in Malawi in any of the three years 1998 to 2000. Note that the figures for 'participated' indicate the proportion of households that participated in one or more of these three years; it does not mean the household received benefits in all three years (the following three columns give participation rates for each individual year).

Programme	Participated n=1264 (%)	1998 (%)	1999 (%)	2000 (%)
Food transfers				
Under-five feeding	59 (4.7%)	1.4	2.1	2.5
Free food distribution	41 (3.2%)	0.8	1.0	2.2
Food relief	3 (0.2%)	0.1	0.2	0.2
Agriculture support		1		
Starter Packs	775 (61.3%)	36.6	44.0	38.3
Inputs credit	116 (9.2%)	2.2	4.8	5.1
Other free inputs	16 (1.3%)	0.4	0.7	1.1
Employment creation				
Food for work	15 (1.2%)	0.2	0.2	0.7
Cash for work (PWP)	49 (3.9%)	0.9	1.7	1.8
Inputs for work	4 (0.3%)	0.2	0.1	0.2
Vulnerable groups				1
Orphan care	13 (1.8%)	0.1	0.2	0.9
Cash credit/loan	45 (3.6%)	0.6	0.8	2.7
$n = 1.2(4.1, \dots, 1, 1.1)$				

 Table 16 Household participation in formal safety net programmes, by year

n=1,264 households

^{&#}x27;entitlement' rather than a 'favour'. It is arguably more accurate to describe to describe people employed on public works as participants, and recipients of free food or income transferred as beneficiaries

Immediately striking is the fact that three out of five households surveyed (775 out of 1,264 households, or 61%) received the Starter Pack in one or more of these three years. In terms of numbers of beneficiaries, this initiative has had by far the greatest reach of any safety net programme since the phasing out of untargeted support such as fertilizer and food price subsidies. On the other hand, the unreliable and ad hoc nature of targeted transfer is apparent from the figures for Starter Pack participation for each individual year. Coverage is always less than half (the range is 36% to 44%), which suggests that farmers can nor rely on receiving a Starter Pack from one year to the next. Nor is the programme well targeted on the same group of beneficiaries; instead, there is a high degree of rotation from year to year. Among the beneficiaries, only 23% (12% of the full sample) had received a Starter Pack in all of the last three years, while one in four beneficiaries (26%) received it in two of the three years and half (51%, or 28% of the full sample) received it only once. Other programmes were less regular and reliable than this. Of the 45 recipients of cash credit, 40 (89%) received a single loan, and only 2 had borrowed in all three years.

Table 17 disaggregates participation in safety net programmes by region. The sample covered northern, central, south-west and south-east Malawi, and included one urban centre and three rural communities in each region. In Table 17 the urban centers are extracted into a district category, and the south-west and south-east are also combined into one category.

The distinctively rural character of several safety net programmes is immediately apparent by considering interventions that were targeted at farmers, such as the Starter Pack, inputs credit, inputs-for-work, and flood relief. Paticipation rates in the Starter Pack Programme rose from 61% of the sample in Table 16, the national average to 77% of rural households evenly spread across the north (76%), central (76%) and southern region (79%) (Table 17). Conversely, only 14% of urban households received one or more Starter Pack between 1998 and 2000. Only one urban household out of 300 sampled urban households had received inputs credit, and none at all had participated in inputs-for-work projects or received flood relief assistance.

This rural bias was reversed in only a few cases, and never to such an extreme extent. More urban households than rural households had taken a cash loan (9% versus 2% respectively), benefited from the under-five feeding programme (6% versus 4%), or received support under the orphan care programme (2% versus 0.7%).

Programme	Urban (%)[n=317]	All Rural (%)[n=946]	Rural South(%)	Rural Centre (%)	Rural North(%)
Under-five feeding	6.3	4.1	6.3	1.6	2.6
Free food distribution	1.3	3.9	1.1	9.8	0.6
Flood relief	0.0	0.3	0.2	0.3	0.6
Starter Packs	13.0	77.3	79.0	75.6	75.5
Inputs credit	0.3	12.2	5.3	23.2	11.0
Other free inputs	0.6	1.5	2.9	0.0	0.0
Food for work	0.6	1.4	2.7	0.0	0.0
Cash for work (PWP)	2.8	4.2	7.1	0.3	3.2
Inputs for work	0.0	0.4	0.6	0.3	0.0
Orphan care	1.9	0.7	0.6	1.0	0.6
Cash credit/loan	8.5	1.9	1.1	3.5	1.3

 Table 17 Household participation in formal safety net programmes, by region

N=1,263 households

Within the rural areas, there was little evidence of systematic bias in favour of, or discrimination against, one region or another (table 17). Overall, safety net programmes appear to be concentrated in areas of highest population density, with the south generally receiving more benefits than the centre, and the north benefiting the least from safety net transfer. The south enjoys higher coverage than the central and northern regions in terms of under-five feeding, Starter Packs and other free inputs and public works programmes of various kinds. However, the central region enjoys the highest coverage in terms of free food distribution, inputs credit, orphan care and access to cash loans. The northern region is marginally disadvantaged in most safety net programmes, but does have a slightly higher participation rate than the centre or south in terms of flood relief.

The surprisingly low participation across all households sampled in employment programmes (food, cash, or inputs-for-work) does not conceal a marked concentration of these activities in certain parts of the country. Although participation rates were uniformly higher for all three programmes in the south, peaking at &% for cash-for-work, the difference was not especially pronounced. It was significant, though, that not a single household in the central and northern regions participated in food-for-work, which seemed to occur exclusively in the south.

In order to investigate the possible concentration of safety net programmes in some parts of Malawi, a further level of analysis was undertaken, of participation at the District level. This disaggregation produced evidence of sub-regional concentration for certain programmes, though not all. Table 18 presents the results of this analysis. It is immediately apparent that, while certain programmes were operational fairly uniformly across all districts (e.g. under-five feeding, which was recorded in 15 of 16 districts surveyed), most were concentrated in certain districts (e.g. food-for-work, which was recorded in just 4 districts). Cash credit programmes displayed an urban bias: they were operational in all 4 towns but in only 7 of the 12 rural communities. Agricultural support was concentrated in the rural areas, and the range was rather wide. For example, Starter Packs varied from 54% in Nkhotakota to 94% in Phalombe, and for inputs credit, from zero coverage in Balaka and Nsanje to 60% in Dedza. There was no obvious explanation for this scattered and variable coverage (i.e. the selection of some districts and apparent exclusion of others, and the range of participation rates across communities).

Programme	Rural South			Rural South-East			Rural Central		
	S1	S2	S3	E1	E2	E3	C1	C2	C3
Under-five feeding	9%	4%	3%	1%	17%	1%	4%	5%	0%
Free food distribution	0%	1%	35%	1%	0%	1%	0%	3%	3%
Flood relief	1%	0%	0%	0%	0%	0%	0%	0%	1%
Starter Packs	75%	86%	89%	60%	74%	94%	80%	87%	80%
Inputs credit	0%	18%	60%	4%	0%	6%	26%	4%	6%
Other free inputs	3%	0%	0%	2%	1%	5%	0%	7%	0%
Food for work	3%	0%	0%	4%	0%	0%	0%	11%	0%
Cash for work (PWP)	20%	1%	0%	1%	7%	3%	1%	11%	0%
Inputs for work	0%	0%	0%	2%	0%	0%	0%	1%	1%
Orphan care	1%	3%	0%	0%	0%	0%	3%	0%	0%
Cash credit/loan	4%	3%	0%	0%	0%	0%	10%	0%	3%

Table 18 Household participation in selected formal safety net programmes, by district(1998-2000)

S1 = Balaka, S2 = Chiradzulu, S3 = Dedza; E1 = Mangochi, E2 = Nsanje, E3 = Phalombe; C1 =Dowa, C2 = Machinga, C3 = Salima; N1 = Nkhata Bay, N2 = Knhotakota, N3 = Rumphi, U1 = Blantyre, U2 = Lilongwe, U3 = Mzuzu, U4 = Zomba

Programme	Rural North			Urban			
	N1	N2	N3	U1	U2	U3	U4
Under-five feeding	1%	0%	4%	4%	5%	1%	15%
Free food distribution	0%	1%	1%	1%	1%	0%	3%
Flood relief	0%	0%	1%	0%	0%	0%	0%

Table 18 (continued)

Starter Packs	82%	54%	69%	8%	10%	1%	36%
Inputs credit	4%	1%	18%	0%	1%	0%	0%
Other free inputs	0%	0%	0%	0%	0%	0%	3%
Food for work	0%	0%	0%	0%	0%	0%	3%
Cash for work (PWP)	6%	0%	0%	0%	0%	1%	10%
Inputs for work	0%	0%	0%	0%	0%	0%	0%
Orphan care	0%	1%	1%	3%	5%	0%	0%
Cash credit/loan	1%	1%	1%	6%	14%	8%	6%

One reason for the low levels of participation in many programmes is that targeting criteria may have excluded the majority of households from eligibility for programme benefits. For example, the only households officially entitled to receive support under the Orphan Care programme are those actually caring for one or more orphans. A complicating factor is that, as stated previously, different agencies use different definitions of what constitutes an orphan. The broadest definition comes from the Ministry of Gender, Youth and Community Services – a child under 18 years old who has lost one or both parents- while the National AIDS Control Programme (NACP) prefers a narrower definition – a child under 15 who has lost a mother due to AIDS. This survey recorded a total of 3,066 children under 18, 423 (13.8%) of whom had lost one or both parents to any cause. Of 2,694 children under 15, 327 (12.1%) had lost one or both parents, and 132 (4.9%) had lost their mothers⁷.

If we take the broadest and assume only one orphan per household, the maximum number or surveyed households that could be eligible for Orphan Care support is 423 (33.5%). This figure falls to just 132 surveyed households (10.4%) if the narrower NACP definition is used. The point is that a participation rate of just 1.8% for Orphan Care is a misleading proxy for coverage of the eligible population, which in fact 33% under the generous definition of orphanhood and 10% the NACP definition – not very high in either case, but better than 1.8%

Table 19 disaggregates participation in safety net programmes by sex of household head⁸. There is no statistically significant evidence of discrimination against, or in favour of either male – or female-headed households on most of these programmes. Interestingly, however, female-headed households enjoyed significantly higher in terms of Starter

⁷ Although national demographic statistics should not be extrapolated from this survey, parasternal mortality is significantly higher than maternal mortality in these 1,264 households, at 9.85 and 4.8 % for children under 15 respectively. There are more orphans in urban areas, where 15.5% of children under 15 have lost one or both parents, than in rural areas, where the figure is 10.9%.

⁸ Since over 80% of households surveyed are male-headed, it is inevitable to read too much into direct comparative data between these two categories. On the other hand, 194 female-headed households constitutes a big sample to draw meaningful conclusions.

Packs, while male-headed households were more likely to participate in employment programmes (only 4 out of 194 female-headed households had done any food – or cashfor-work).

Programme	Full Sample	Male-Headed	Female-Headed
	[N=1,262]	(n=1,068]	[n=194]
Food transfers			
Under-five feeding	59 (4.7%)	53 (5.0%)	6 (3.1%)
Free food distribution	41 (3.2%)	37 (3.5%)	4 (2.1%)
Food relief	3 (0.2%)	3 (0.3%)	0 (0.0%)
Agriculture support			
Starter Packs	775 (61.3%)	621 (58.1%)	153 (78.9%)
Inputs credit	116 (9.2%)	95 (8.9%)	21 (10.8%)
Other free inputs	16 (1.3%)	11 (1.0%)	5 (2.6%)
Employment creation			
Food for work	15 (1.2%)	14 (1.3%)	1 (0.5%)
Cash for work (PWP)	49 (3.9%)	46 (4.3%)	3 (1.5%)
Inputs for work	4 (0.3%)	4 (0.4%)	0 (0.0%)
Vulnerable groups			
Orphan care	13 (1.0%)	10 (0.9%)	3 (1.5%)
Cash credit/loan	45 (3.6%)	37 (3.5%)	8 (4.1%)

Table 19 Household participation in safety net programme (1998-2000) by sex ofhousehold head

Exclusion from Safety Net Programmes

Respondents were also if they or any member of their household had been denied access to any safety net programmes during the past few years. They were then asked if they knew why they had been excluded from the programme. Their open-ended responses were clustered into five categories, as follows:

'Nepotism' = "Chiefs or registration clerks favoured their kinsmen, close aides, the rich and other fellow local leaders"; "Opposition favourites and Jehovah's Witnesses were not allowed to benefit";

'Criteria'= "Eligibility criteria excluded us" (e.g. only households with elderly, orphaned or disabled members were entitled to benefit);

'Registration' = "Our names were missed by the clerks or deleted during distribution time"; "Our qualification certificates mysteriously went missing during distribution time" We were not available when people were being registered";

'Repayment' =	"For fear of failing to rep	bay" "Lack of deposit";
- F ··· J		······································

'Distance' = "Registration and distribution centers were too far for us to reach".

Programme	Excluded	Nepotism & Politics (10%)	Eligible Criteria (%)	Regist ration (%)	Repay ment (%)	Distanc e (%)
Under-five feeding	10 (0.8%)	10	80	0	0	10
Free food distribution	9 (0.7%)	11	78	0	0	11
Flood relief	7	0	29	14	0	57
Starter Packs	588(46.5%)	16	37	43	0	5
Inputs credit	23 (1.8%)	22	39	26	9	4
Other free inputs	9 (0.7%)	11	33	22	0	33
Food for work	7 (0.6%)	29	43	29	0	0
Cash for work (PWP)	9 (0.7%)	11	22	44	0	22
Inputs for work	6 (0.5%)	33	17	17	0	33
Orphan care	14 (1.1%)	64	14	0	0	21
Cash credit/loan	79 (6.3%)	28	9	6	33	23

 Table 20 Household exclusion from formal safety net programmes (1998-2000)

n=1,264 households

The figures for exclusion rates are uniformly low – mostly less than 1% - with the notable exception of the Starter Pack, where almost half the sample complained that they had been excluded at least once since 1998⁹. Apart from cash credit, which 6% of respondents

⁹ The apparent contradictions between Table 3, where 46% of respondents complained of exclusion, and Table 1, where 61% of respondents said they had received Starter Packs, is explained by the fact that the question applied to three years(i.e. three repeated rounds) of the programme. Clearly, some respondents benefited in one or two years and felt they were excluded in the other years(s)

said had been denied to them, exclusion rates did not exceed 2% for any other programme. There were no significant differences in reported exclusion rates by location (urban/rural), region (north/centre/south) or sex of household head (male/female).

These figures are rather difficult to interpret, since respondents would only have mentioned cases where they felt aggrieved that they had not received benefits that they had applied for, or believed they were entitled to receive. The generally low coverage of public works programmes, for instance, would not registered here as an individual complaining about being refused employment, unless they had applied to a specific project and been turned away.

The point is that there are two forms of exclusion, which might be labelled 'passive' and 'active'. <u>Passive exclusion</u> results from 'undercoverage' of the target population by a safety net programme, while <u>active exclusion</u> occurs when an eligible individual is denied benefits to which they are entitled. With the exception of the Starter Pack initiative, exclusion from safety net benefits in Malawi is more often a combination of both forms.

Participants' Satisfaction with Safety Net Programmes

An attempt was made in the questionnaire to elicit approval ratings from respondents about safety net programmes in which they were participants. The methodology was necessarily crude: respondents were asked to evaluate the programme in terms of four criteria (access, quality, relevance, and fit), by scoring each criterion on a three-point scale (good, adequate, poor)¹⁰. Moreover, the wide disparity in participation rates between programmes produced such divergent numbers of responses (over 1,500 in the case of Starter Packs, just three in the case of flood relief) that comparisons are extremely difficult to draw with any confidence.

There is an obvious incentive for beneficiaries to report favourably on programmes from which they hope to benefit in the future, and their awareness that the results might be reported to programme implementers might reasonably be expected to bias their responses. For these reasons, the results of this exercise should be treated as indicative rather than statistically robust, and should be used mainly to reflect relative rankings between programmes and across criteria, rather than absolute judgments about each one.

¹⁰ During the pilot testing, alternative methods and scrolling systems were tried, including a four-point and five-point scale, but the three-point scale proved to be easiest to explain and most robust

Access

The results reported in Table 21 suggest that food transfers were perceived as very accessible by programme participants, while employment and agricultural input programmes were slightly less favourably rated. By individual programme, under-five feeding and orphan care achieved the highest 'good access' ratings (80%) each), while food-for-work scored the highest 'poor access' rating (13%), though (coincidentally) these were each based on just 15 respondents. The two programmes with the highest number of responses, Starter Packs and cash credit, performed relatively badly on this indicator, with 57% and 52% respectively rating access as 'good'. This is consistent with the findings reported above, that the Starter Pack and cash credit ranked first and second in terms of respondents being excluded from participation or benefits.

	Programme	Good (%)	Adequate (%)	Poor (%)	N
Food	Under-five feeding	80	13	7	15
	Free food distribution	63	33	0	51
	Flood relief	67	33	0	3
Agriculture	Starter Packs	57	39	5	1,504
	Inputs credit	64	30	6	154
	Other free inputs	43	54	3	28
Employment	Food for work	60	27	13	15
	Cash for work (PWP)	64	32	4	56
	Inputs for work	25	75	0	4
Vulnerable	Orphan care	80	13	7	15
Groups	Cash credit/loan	52	46	2	52

Table 21 Participants	' satisfaction	with formal n	<i>iet programmes</i>	(1998-2000): Access
-----------------------	----------------	---------------	-----------------------	---------------------

Note: '<u>Good</u>' = Very accessible; '<u>Adequate</u>' = Accessible with some difficulty; '<u>Poor</u>' = Very inaccessible

Quality

The quality of safety net programmes and the benefits they provide was also assessed very favourably in most cases, with the orphan care programme receiving 100% approval from all 15 beneficiary households. Among the other safety net programmes, inputs credit and under-five feeding scored over 80% approval, however all the three forms of employment programme scored worst, at around 50%, along with cash credit

programmes. Agricultural input programmes were generally highly rated in terms of quality – over 70% for Starter Packs and other free inputs, 84% for inputs credit.

Category	Programme	Good	Adequate	Poor	Ν
Food	Under-five feeding	82	14	4	76
	Free food distribution	61	33	6	51
	Flood relief	67	33	0	3
Agriculture	Starter Packs	73	22	5	1,503
	Inputs credit	84	14	2	155
	Other free inputs	71	29	0	28
Employment	Food for work	53	46	0	15
	Cash for work (PWP)	56	40	4	57
	Inputs for work	50	50	0	4
Vulnerable	Orphan care	100	0	0	15
Groups	Cash credit/loan	54	44	2	52

Table 22 Participants' satisfaction with formal safety net programmes (1998-2000):Quality

Note: <u>'Good</u>' = Very good quality; <u>'Adequate</u>' = Good quality with some problems; <u>'Poor</u>' = Very poor quality

Relevance

In the context of safety nets, which are typically designed to meet identified needs, it might be expected that these programmes would be very highly rated in terms of their relevance. It is not surprising, then, that flood relief and under-five therapeutic feeding were both rated as 'very relevant' by over 90% of beneficiaries. The relatively disappointing evaluation of free input distribution, both Starter Packs (63%) and other programmes (64%), on this criterion might be due to problems of late delivery, while in some parts of Malawi the standard package of fertilizer and maize seed is covered inappropriate to local farming conditions and food preferences.

Category	Programme	Good	Adequate	Poor	N
Food	Under-five feeding	93	4	3	76
	Free food distribution	78	16	6	51
	Flood relief	100	0	0	3
Agriculture	Starter Packs	63	28	8	1503
	Inputs credit	76	21	3	155
	Other free inputs	64	18	18	28
Employment	Food for work	80	7	13	15
	Cash for work (PWP)	75	16	9	57
	Inputs for work	75	0	25	4
Vulnerable	Orphan care	67	33	0	15
Groups	Cash credit/loan	59	25	17	53

 Table 23 Participants' satisfaction with formal safety net programmes (1998-2000):

 Relevance

Note: 'Good' = Very relevant; 'Adequate' = Relevant to some extent; 'Poor' = Not very relevant

Fit

The 'fit' of a safety net programme refers to its compatibility with participants' livelihood systems. The scores recorded for 'good fit' for Starter Packs and cash-for-work (around 45%) are among the lowest for any of the four criteria considered in this section of the report. The disappointing assessment of the Starter Pack programme in terms of 'fit' might be due to problem of late delivery. Also, in some parts of Malawi the standard package of fertilizer and maize seed was considered inappropriate to local farming conditions and food preferences. The poor performance of cash-for-work on this criterion could indicate dissatisfaction with the projects undertaken, or that the timing of employment on cash-for-work projects conflicted with labour requirements on farm.

Category	Programme	Good (%)	Adequate (%)	Poor (%)	Ν
Food	Under-five feeding	78	19	3	77
	Free food distribution	90	8	2	50
	Flood relief	67	0	33	3
Agriculture	Starter Packs	46	27	27	1501
	Inputs credit	79	19	2	155
	Other free inputs	61	25	14	28
Employment	Food for work	60	13	27	15
	Cash for work (PWP)	44	37	19	57
	Inputs for work	75	25	0	4
Vulnerable	Orphan care	87	7	7	15
Groups	Cash credit/loan	67	23	10	52

 Table 24 Participants' satisfaction with formal safety net programmes (1998-2000): Fit

Note: '<u>Good</u>' = Very good fit; '<u>Adequate</u>' = Average fit; '<u>Poor</u>' = Not fitting at all

Overall satisfaction

Table 25 collates the overall scores for participants' satisfaction with each safety net programme in terms of the four criteria; access, quality, relevance and fit and ranks the programmes from highest to lowest overall score for 'good'. Interestingly, the two programmes targeted at children, orphan care and under-five feeding emerge as the two most popular safety net initiatives, ahead of inputs credit and (not surprisingly) two free food distribution programmes.

Rank	Programme	Good (%)	Adequate	Poor (%)	Ν
			(%)		
1	Orphan care	84	13	3	15
2	Under-five feeding	83	13	4	77
3	Inputs credit	76	21	3	155
4	Flood relief	75	17	8	3
5	Free food distribution	73	23	4	51
6	Food for work	63	23	13	15
7	Other free inputs	60	32	8	28

 Table 25 Participants' overall satisfaction with formal safety net programmes (1998-2000)

8	Cash for work (PWP)	60	31	9	57
9	Starter Packs	60	29	11	1501
10	Cash credit/loan	58	35	8	52
11	Inputs for work	56	38	6	4

Note: Where scores are tied for 'good', the scores for 'adequate' is used.

The three employment programmes (food, cash and inputs–for-work) were all placed in the lower half of the list, along with both free inputs programmes which surprisingly, were much less positively evaluated than free food distributions. Overall, participants were least satisfied with cash credit and inputs-for-work programmes. That being said, the level of dissatisfaction registered with all safety net programmes was very low. There was no evidence from this survey that any safety net programme was failing to provide real and positive benefits to all but a negligible minority of participants.

Conclusion and Recommendations on Social Protection Programmes

Access to Social Protection Programmes

Our findings indicate that social protection programmes are not available to most poor people in most areas. The coverage for such programmes as Starter Pack does not seem to be skewed towards any region nor gender of household heads. Agricultural related protection programmes like credit schemes, food for work and free input programmes are predominant in rural areas while the employment related programmes are predominant in urban centers

Quality and Relevance of the delivery of the Social Protection Programmes

Complaints registered with free input programmes concern late delivery, biased registration, distribution and irrelevance of some inputs to people's agricultural systems.

It is recommend that better means of targeting (area and household) should be devised and reinforced and regular monitoring be provided to avert the current situation which has elements of high exclusion of the intended beneficiaries while having high inclusion of the non-intended beneficiaries. Policy should re-asses into the credit schemes to provide for an all-winner framework especially for the rural poor.

OVERALL CONCLUSIONS AND RECOMMENDATIONS

1. The findings show that indeed gaps exist both in the supply and demand of the basic social services (health and education) and social protection programmes. Physical (distance and waiting time), financial (user fees) and quality barriers

have been documented as thwarting the supply of and demand for health services amongst most people in Malawi. For primary education services, the current barriers are quality related (poor management, low teacher professionalism, poor infrastructure) while in the past, people had distance and financial related barriers. However for secondary and nursery education, physical, financial and quality barriers exist.

- 2. The recommendation here is that the low level of formal educational attainment in the sample, which also refers to the low level of demand for education services, should be improved through massive investments in education at all levels. Similar investments must be made in the health sector if the general welfare of the Malawian rural population is to improve. Issues of access (communication networks) must be addressed carefully by policy.
- 3. Nursery schools are predominantly in urban areas. Providers should consider extending greatly this education service to rural areas to enable earlier mental development among Malawian children.
- 4. It is high time that government formulate proper mechanisms for instituting cost-sharing services in its health facilities.
- 5. It is recommended that better means of targeting for the social protection programmes (area and household) should be devised and reinforced and regular monitoring be provided to avert the current situation which has elements of high exclusion of the intended beneficiaries while having high inclusion of the non-beneficiaries.
- 6. Policy should re-assess the credit schemes to provide for an all-winner framework especially for the rural poor

Annex Tables

Highest Class	Total	Location (%)		Gender (%)		
Completed	[n=5,515]	Urban	Rural	Male	Female	
		[n=1,368]	[n=4,129]	[n=2,773]	[n=2,742]	
		27.2	25.2	20.8	30.6	
Std 1	12.0	10.1	12.6	11.4	12.5	
Std 2	9.6	10.5	9.3	8.7	10.6	
Std 3	8.9	8.4	9.0	9.1	8.7	
Std 4	6.8	7.4	6.6	7.0	6.6	
Std 5	6.2	7.1	5.9	6.6	5.8	
Std 6	5.9	6.6	5.7	6.5	5.4	
Std 7	4.7	4.2	4.9	4.9	4.4	
Std 8	8.4	7.9	8.6	10.0	6.8	
Form 1	1.9	1.4	2.1	2.3	1.5	
Form 2	3.1	2.5	3.3	3.5	2.7	
Form 3	1.5	1.7	1.4	2.1	0.9	
Form 4	4.1	3.8	4.2	5.4	2.7	
Post-secondary course	0.4	0.5	0.4	0.7	0.3	
Vocational or Technical	0.5	0.5	0.4	0.7	0.2	
University Diploma	0.2	0.2	0.2	0.4	0.1	
University Degree	0.1	0.1	0.1	0.3	0.0	
Total	100%	100%	100%	100%	100%	

 Table A 1 Educational attainment of household members surveyed

Reasons Given	Total (%)	Location (%)		Sex (%)	
		Urban	Rural	Male	Female
No school fees	1,213 (45.5%)	46.0	45.4	50.5	41.3
Not interested in school	273 (10.2%)	10.2	10.3	9.8	10.6
Got married	198 (7.4%)	5.5	8.1	3.4	10.9
Laziness	161 (6.0%)	7.2	5.7	6.1	6.0
School seen as of less important	148 (5.6%)	4.5	5.9	5.8	5.3
Could not afford school materials	111 (4.2%)	3.4	4.4	4.7	3.7
No school uniform/clothing	106 (4.0%)	5.7	3.4	3.3	4.6
School too far from home	98 (3.2%)	3.7	3.7	3.4	4.0
Became pregnant	84 (3.2%)	4.9	2.6	0.0	5.8
Found work, so left school	55 (2.1%)	2.1	2.1	3.8	0.6
Parents told me to stop	39 (1.5%)	1.0	1.6	1.6	1.4
Too old to continue	24 (0.9%)	1.3	0.8	1.1	0.6
Had dependants to support	21 (0.8%)	0.9	0.8	1.1	0.6
Failed promotion test	14 (0.5%)	0.3	0.6	0.5	0.6
School-culture/belief conflict	8 (0.3%)	0.0	0.4	0.2	0.3
Failed government examinations	9 (0.3%)	0.6	0.3	0.4	0.3
Dismissed/expelled	9 (0.3%)	0.4	0.3	0.5	0.2
Poor administration and teaching	5 (0.2%)	0.1	0.2	0.3	0.1
Poor school infrastructure	3 (0.1%)	0.3	0.1	0.0	0.2
Other	85 (3.2%)	1.6	3.7	3.4	3.0

Table A 2 Reasons why household members left school before completing Form 4

 Table A 3 Physical access to education services

Service	Attenda	Distance	Mode of Transport	Time	One way
	nce	(km)		(minutes)	fare (MK)
Nursery School	5.5%	0.7	Walking = 93%	10.5	K26
Junior Primary	8.3	2.6	Walking = 98%	33.7	K10
Full Primary	53.2%	2.0	Walking = 99%	28	K58
Community	9.3%	5.8	Walking = 84%	52	K64
Secondary			Public transport =9.4%		
			Bicycle = 6%		
Vocational	0.7%	23	Public transport =44.4%	34	K51
Training			Walking $= 44.4\%$		
			Bicycle = 11.1%		
Adult Literacy	2.0%	1.5	Walking = 100%	23	-
Classes			_		
Boarding	1.3%	32	Public transport = 56%	288	K207
Secondary			Walking = 19%		
_			Bicycle = 12.5%		
			Institutional = 12.5%		
University	0.1%	320	Public transport = 100%	300	K280

Service	Access Barriers (%)					
	Physical	Financial	Social	Eligibility		
Nursery School	53	33	0	8		
Junior Primary	54	2	0	29		
Full Primary	4	2	1	4		
Community Secondary	41	29	1	15		
Vocational Training	94	40	13	4		
Adult Literacy Classes	76	3	1	2		
Boarding Secondary	68	49	4	3		
University	94	59	4	33		
Other post-secondary	95	40	5	15		

Table A 4 Respondents' assessment of access barriers to education services

 Table A 5 Respondents' assessment of quality of education services

Service	Quality Constraints (%)		
	Teachers	Materials	Infrastructure
Nursery School	3	7	16
Junior Primary	5	21	31
Full Primary	9	18	23
Community Secondary	5	11	14
Vocational Training	0	4	14
Adult Literacy Classes	4	5	9
Boarding Secondary	2	2	2
University	3	0	0
Other post-secondary	5	25	10

 Table A 6 Respondents' assessment of relevance and fit of education services

Service	Low Relevance	Fitness into (%) local:		
	(failure to meet	Culture/beliefs	Agricultural	
	needs) (%)		calendar	
Nursery School	1	0	0	
Junior Primary	8	22	3	

Full Primary	2	9	2
Community Secondary	3	1	1
Vocational Training	11	4	4
Adult Literacy Classes	2	0	5
Boarding Secondary	2	1	1
University	10	0	4
Other post-secondary	10	0	0