5. GENDER, HEALTH AND NUTRITION

Insufficient food supply remains, together with AIDS, the main health problem of Malawi. Increased incomes (in cash and kind) will thus have a large impact on the health situation. We have already examined the problems in terms of introducing improved technologies and have shown that improving food security – at both national and household level – is more than a technology issue. There are other major challenges including gender imbalance, poor health resulting from the HIV/AIDS pandemic, and malnutrition. Removing gender disparities is essential to impacting on these complex problems.

5.1. GENDER ISSUES

5.1.1. Role of Women in Agriculture

Women comprise about 70 % of the full-time farmers responsible for the daily food supplies. They spend as much time on farm work as they do on domestic activities – and they work as much as men on the farm. Women contribute labour to both cash and food crops and there is no differentiation between men and women's operations. They sow, weed, apply fertiliser and pesticides, harvest, and process the crops.

Women's contribution to nutrition and a balanced diet is considerable. They are the major growers of legumes and vegetables for the home (FAO, 2000). In Malawi, people survive on leaves from bean and pumpkin plants and different types of vegetables that provide useful nutrients during the 'hungry season' (three months before harvest – March/April). Women care for the all-important small livestock - poultry, goats, pigs, and rabbits. These are often the only animals owned by poor families. In dairy units, they are responsible for cleaning, watering and feeding, and in some cases, they milk the animals.

Although most households are still headed by a man, 26 % of rural households are headed by women[14] (GoM, 2000a). But female household heads are disproportionately poor; 64 % of rural female-headed households and two-thirds of individuals in rural female-headed households are poor. Poverty is deeper and more severe in female-headed households, suggesting that the ultra poor are more likely to be living in female-headed households.

5.1.2. Access to Agricultural Resources for Women

The important role of women in agricultural production implies that the success of agricultural production to improve food security will depend to a large extent on the assistance and training that women receive. Yet, studies consistently show that the women's access to productive resources such as land, capital, and knowledge is consistently less than that of men. This differential access has a negative impact on agricultural productivity.

Land

Ownership of, and access to, land is important in providing a sustainable livelihood in rural areas. When the landholding size is small, the levels of food insecurity and poverty are higher. The poor have access to land, but holdings are small and fragmented. In the customary land ten-

[14] These include those households headed by a single woman (divorced, separated, widowed, or never married); with women married to husbands who are periodically away in wage employment distant from home and mostly within Malawi; and with women married to husbands with more than one wife.

ure, ownership of land is communal and the chief has the responsibility for distributing land to the people within his or her jurisdiction. These people only have rights to cultivate the land but cannot sell it or give it to other people outside the family group. The State President is the trustee of all customary land but traditional customs regulate the distribution and inheritance of this land. These traditional customs follow the family system (matrilineal or patrilineal system of inheritance and succession) that dictates the inheritance rights (land use, property rights and ownership).

The two family systems differ in terms of the line of inheritance rights followed, which has gender implications. In the matrilineal system, the inheritance rights are through the female line. A woman might inherit land from her mother or grandmother. Women in the matrilineal societies (common in the central and southern regions of Malawi) have influence on major decisions such as the selection of chiefs and use of land, although the man still remains the head of household. When she marries, her husband comes to live with her, and together they till the land. In the case of divorce, the husband leaves the village and the woman and her children continue to cultivate the land. If the wife dies, the husband leaves the village leaving the children behind. The husband obtains the right to cultivate the land through his maternal line. Basically, the opposite is true in the patrilineal system. The man inherits land from his father or grandfather. When he marries, he stays in his village. In the case of divorce, his wife loses custody and her right to cultivate this land and returns to her own village.

However, these descriptions oversimplify the complexities of the two systems. For example, both systems recognise the man as the head of household and therefore the main decision maker. The culture in both systems expects the men to make all the major decisions in a household with or without consultation with their wives. Furthermore, the brothers and uncles in the matrilineal system assume a greater responsibility over the women in their family or clan regardless of their marital status. This implies that the decision and control over land and inheritance in both systems is usually in the hands of the male members. As Sigman (1992) found out, the impact of these two systems on women's agricultural productivity does not seem to be very different. The important factor is the woman's marital status. Female household heads make almost all decisions in their household. While women in male-headed households may make decisions alone, it is more common either for husbands make the decisions alone or for husbands and wives to make decisions together. There is more security for the female partner in the matrilineal system because the woman is cultivating her land, in her own village, and amongst her own people (Hirschman and Vaughan, 1984; Sigman, 1992). In addition, she will support from her own relatives, which is important in view of the high child dependency ratio.

The Ministry of Lands, Physical Planning and Surveys recently commissioned detailed land utilisation studies and special reports, which revealed that the major problems in land were insecure land tenure, improper land use, and poor access to land[15]. These studies informed the development of a land policy in Malawi and later the current land reform programme that is under implementation on a pilot basis. One of the major activities of the land reform programme is to register and title all customary land as secure rights to land are the basis for a sustainable livelihood among smallholder farmers. The gender challenge coming up in this process is: in whose name shall the land title be, considering the complexities of the matrilineal and patrilineal systems of marriage? The experience so far is that it is not easy to title land in the name of a man in the matrilineal societies and in the name of a woman in the patrilineal societies. With the increasing

[15] Some of the studies include the land use study, tracer study, socio-economic study of land tenure, and estate, public and customary land utilisation and interaction studies conducted between 1996 and 1998.

number of deaths largely due to the HIV/AIDS pandemic, it is increasingly difficult for land to devolve to surviving spouse and to children whether male or female. The challenge is to ensure equitable distribution of land for both men and women in both systems of marriages as the land policy stipulates.

Knowledge

Agricultural extension programmes inform farmers about new technologies and opportunities (including market access and other needs) that can help them attain better returns from their agricultural activities. Studies consistently show that women, compared to men, have much poorer access to extension services such as demonstrations, meetings, training and research activities (NSO, 1982; Culler *et al.,* 1990; and Sigman, 1992). Of the 105,000 members in NASFAM in 2004, 36 % were female. Most women have to ask permission from their spouses to participate in such activities. Chibwana (1998) showed that the choice for married women to participate in the extension programme activities really depends on their spouses, suggesting that participation in extension activities is a major family decision and the extension staff should treat it as such.

However, the choice of technologies promoted affects the level of participation between men and women. For example, officials from NASFAM and Care International reported that more women participate in the production of groundnuts and beans than in tobacco. Extension staff in Bembeke EPA also reported a predominance of women when promoting sweet potatoes and indigenous vegetables unlike promoting vegetable crops grown primarily for cash during the late 1990s (Chibwana, 1998). The EPA experienced an increase in sweet potato production largely due to adoption of the new varieties mostly by the women.

CARE International in its attempt to assist farmers to move away from credit focuses on a savings based approach. When the first groups were formed, both men and women turned up. However, most men dropped out when they discovered that CARE was not offering credit. Women therefore dominate the savings schemes[16]. They save about MK5-20 per week. The money paid in is immediately cycled into approved small projects so there is no need for savings books or stamps or to keep significant amounts of cash. The scheme requires that all loans be repaid by August so that the members can use the money to purchase inputs for the next growing season and buy food to cater for the 'hungry season'.

Access to credit and inputs

The most important extension messages in Malawi concern the use of better varieties and seed of maize, and the use of fertiliser. Most farmers are aware of these messages, but, as noted earlier, the key constraint to adoption is the lack of cash or credit to access these inputs. Although it is difficult for most smallholders to access credit, the participation and benefit of women in credit programmes is much less than their role in agriculture warrants. This situation continues to persist despite deliberate efforts to increase the participation of women in credit operations run by the government or organisations such as Concern Universal and NASFAM. Most of the credit is offered to facilitate the production of cash crops such as tobacco and paprika, which is typically the domain of men.

Gender mainstreaming is central to most agricultural programmes, projects, and services, but gender disparities persist. This is largely because implementation does not adequately address the major constraints to enhancing the important role of women in agriculture. Much greater attention needs to be paid to how implementation actually affects gender needs, how gender roles

---

[16] Which repeats the experience in other countries in the region such as Zimbabwe.

are changed and enhanced, and where the key intervention points exist to modify important gender relationships. This requires understanding who makes what decisions in a community or household and who controls what assets. Close monitoring is therefore important and as part of this, collection of data by gender is a prerequisite.

5.2. HIV/AIDS

Malawi has one of the highest HIV infection rates in the southern Africa region. The National Aids Commission (NAC, 2001) estimates a national adult prevalence rate (15-49 years) of 15 % with 25 % in the urban areas and 13 % in the rural areas (translating to about 740,000 adults living with HIV/AIDS). The estimated number of annual AIDS related deaths is at 80,000, which contributes to the increase in the number of orphans (children who have lost their mother or both parents to disease) in Malawi.

About three quarters of all AIDS cases are found among adults between the ages of 20 and 40. As this is the most economically productive segment of the population, deaths in this age group are an important economic burden. Deaths in this age group also have significant family consequences since most people in this age group are raising young children (NAC, 2004).

Although the total number of reported AIDS cases according to sex is about equal, the distribution by age group and sex is quite different. For females, these are concentrated in the younger age groups. There are four times as many females as males reported to have AIDS in the group aged 15-19, while there are about one third more females than males in the group 20-29. This pattern then reverses; where more males than females are reported to have AIDS in all of the groups aged 35 or more. Some of the differences may be due to the pattern of transmission from older men to younger women, but young women are also more vulnerable to HIV infection physiologically (NAC, 2004).

The outcomes of the epidemic include:

- Over 840,000 children under the age of 18 are orphans, with 45 % of these due to AIDS.
- 70,000 children (aged less than 15) are infected with HIV. There were 25,840 new infections in 2003, 20,590 new AIDS cases and 20,410 AIDS deaths in 2003.
- The death rate for adults has tripled since 1990.
- The number of tuberculosis cases is three times higher than it would be without AIDS.
- 170,000 people are in need of anti-retroviral therapy.
- About 500,000 pregnant women need good antenatal care including HIV counselling and testing. About 80,000 mothers need anti-retroviral therapy to prevent vertical transmission of the virus (NAC, 2004).

The annual number of AIDS deaths is projected to increase to 96,000 in 2010. The number of adult deaths will be 260 % higher than a without AIDS scenario in 2010. The number of new tuberculosis cases is projected to be 180 % higher than a without AIDS scenario while the number of people needing antiretroviral therapy will increase to 190,000 in 2010.

The epidemic has affected all sectors of Malawi society. About 170,000 adults living with AIDS are estimated to be in need of treatment – but less than 3% have begun receiving treatment (GoM, WHO, and NAC, 2004). In addition, HIV/AIDS related conditions account for more than

50 % of all hospital admissions. Over 70 % of all tuberculosis patients also have HIV infection (NAC, 2004).

Malawi's health services simply do not have the resources of medical personnel and funding to cope with the opportunistic infections associated with the disease. As a result, the Ministry of Health encourages people to use home-based care. This strategy has increased the load on women who bear much of the responsibility for taking care of the sick and orphans, and participating in funeral ceremonies – which impacts strongly on the time available for productive (typically, agricultural) activities.

5.2.1. HIV/AIDS and Gender

While the prevalence of HIV/AIDS is showing signs of decline in Malawi, women account for an increasing proportion of the infected (WHO, GoM, and NAC, 2004). Oxfam (2004) stated that more than 80 % of infections in sub-Saharan Africa are through heterosexual intercourse and in most cases within the context of a marriage relationship. However, most HIV prevention strategies focus on advocating abstinence from sex and faithfulness (Marcus, 1993). Yet, many women are unable to negotiate the timing and conditions under which sex occurs, particularly the use of condoms, as women are expected to be submissive. Attempts to argue in such matters only invite violence and even divorce. The powerlessness of women and girls makes them particularly vulnerable to HIV infection, which increases in times of food crisis and poverty. Oxfam (2004) illustrates this point well in the following quote:

> *'The cultural and social circumstances of women are a big disadvantage to their ability to negotiate safer sex. It is culturally allowed and expected that men will be more mobile than women, they can have more than one partner, and that women's key strength to survive in marriage is submission and endurance. There are still a number of very private cultural practices that force girls to engage in early sex with older men, force widows to marry their in-laws, force women to engage in cleansing rituals that involve sex. Women's poor economic status has made them more dependent on their husband/partner even when there is a high risk of being infected. Economic hardship has forced young girls to get into early marriages often times with older men, therefore exposing them to HIV/AIDS infections.' p.9.*

Apart from the above socio-cultural factors, medical specialists suggest that women are physically more vulnerable to HIV infection and other sexually transmitted diseases (STD) than men (Panos and UNAIDS, 2000). In addition, women get sexually mature and active at an earlier age than men.

In addition to being more at risk of HIV infection, women are also disproportionately affected by HIV. The task of caring for people with AIDS and AIDS orphans falls more on women than on men. Upon death of a husband, many women (regardless of their HIV status) often return to their maternal homes, particularly when very ill. Property grabbing after the death of a husband is also common throughout the country. This leaves the women and children with nothing, thereby increasing their vulnerability to the disease through high risk coping strategies and exploitation. Girls tend to be the first to be withdrawn from school as AIDS exacerbates poverty at the household and community level. Poverty also limits people's access to reproductive health services, prevention and treatment. Cuts in social expenditure also leads to increased pressure on women and girls to take on the role of social safety net through caring for sick relatives as other wage earners become sick and die.

5.2.2. Impact of HIV/AIDS

Since the national response started 15 years ago, the impact of HIV/AIDS remains devastating. The impact of HIV/AIDS in terms of illness and death has affected individuals, families, communities and indeed the whole nation. It has reduced the productive work force among professionals and the ordinary farming communities. Trained staff is lost at a faster rate than the rate of training replacements, creating a high vacancy rate. Officers consulted in this study reported that many trained and highly skilled young men and women are dying while others are terminally ill due to AIDS. Many more people are involved in taking care of the sick or busy attending funeral ceremonies. A study of the impact of the disease on human resources in the Malawi public sector singles out the Ministry of Agriculture as one of the most hit among government ministries, which is losing 29 officers per month. Agricultural officials estimate that the ratio of extension worker to farm families has doubled and in some cases tripled in recent years from the recommended 1:750. This loss has reduced the ability of the MoA to generate and disseminate technologies.

As a result, the role of NGOs and international research organisations has expanded. For example, international research organizations such as ICRISAT and ICRAF are forced to go beyond research into development, disseminating their technologies to farmers in collaboration with NGOs. On the other hand, NGOs such as NASFAM, CARE International and Concern Universal, who largely depend on the public extension system to mobilise farmers and disseminate technologies, find themselves employing their own grassroots extension workers to do the job.

The pandemic has increased the vulnerability of women, the elderly, orphans and the sick, as they cannot access productive resources such as labour, fertiliser and seed. This has resulted in an increase of households being headed by children and old people. Elderly people are taking care of small children (grand children) while children are taking care of other children. The challenge is for service providers to develop new strategies for reaching the children and the elderly whose needs might be different from their conventional clients. Often these new clients are left with nothing, are helpless and require safety nets. Consequently, most NGOs and government are implementing both relief and development activities.

The HIV/AIDS pandemic has significantly increased the vulnerability of households to acute food insecurity, which increases sustainability of household members to HIV infection. As noted above, the food crisis in Malawi is perennial and households are pushed into destitution when this is coupled with adult illness and death. These households experience marked reduction in agricultural production in terms of area planted as well as yields. In addition, they opt for crops that are less labour demanding. Their ability to generate income is therefore severely reduced, which forces them to engage in coping strategies much earlier than their counterparts. Children drop out of school to help their mothers in taking care of the sick or their relatives and to engage in casual labour to earn a living. Girls may be forced into early marriages. Household members engage in casual labour in exchange for food while their gardens remain with weeds. Their immediate survival becomes a priority. For example, some families have no option but to sell their own garden together with the crop just to survive during the hungry season. Others have to engage in sex in exchange for food and other basic commodities – which fuels the AIDS pandemic. Up to 60 % of Malawian girls have accepted money or gifts in exchange for sex (Panos and UNADIS, 2000). As Khaila (2002) found out in a study in Lilongwe district, promiscuity (*chiwerewere*) is common in the Malawian society and this increases in times of food insecurity. The challenge is to slow down the spread of HIV/AIDS in a society where multiple partners are common.

5.2.3. Response by Government and Civil Society Organisations

The government, civil society, faith-based organizations, community groups and private sector have made extensive efforts to raise awareness of the pandemic and to encourage people to change their behaviour. However, the sector's response is sporadic and not coordinated. In the Ministry of Agriculture, for example, efforts to respond to HIV/AIDS at the community level began in 1998 by implementing strategies in specific locations[17]. The preliminary activities have led to the development of a policy and strategies for responding to the disease in the agricultural sector.

Many civil society organisations and faith-based organisations are also responding to the disease by integrating HIV/AIDS issues within their programmes. These include CARE International, NASFAM, Concern Universal, Action Aid, CADECOM, and WFP. Available reports show that there are very high awareness levels among the people but limited behavioural change.

A strategy to develop agriculture as we have outlined will require agriculture to be more market integrated. But we know that a higher degree of market integration also exposes people to more contacts that may spread HIV. On the other hand, the gathering of people in market places may be used as a possibility for spreading information about how to reduce infection risk (e.g. ”street theatre” in the markets) and cheap condoms.

5.3. NUTRITION AND OTHER PUBLIC HEALTH ISSUES

Food insecurity and malnutrition is widespread in Malawi as indicated by the high infant and child mortality rates (Table 6). In 2000, infant and under-five mortality rates were estimated to be 104 and 189 deaths per 100,000 live births, respectively. The maternal mortality rate in 2000 was 1,120 deaths per 100,000 live births. In terms of malnutrition, the Malawi Demographic and Health Surveys (GoM, 2000a) show in Table 7 that the proportion of children who are underweight is more than 12 times the level expected in a healthy well-nourished population. In addition, wasting affects 6 % of the children, this is three times the level expected in a healthy population. The proportion of children (49 % in 2000) who were found stunted is almost 25 times the level expected in a healthy well-nourished population. In addition, the poor consume only 66 % of the recommended daily calorie requirements, implying that malnutrition affects the adults too.

Table 6. Demographic indicators from 2000 Malawi Demographic and Health Service.

Indicator	*Malawi*	*Urban*	*Rural*
Total fertility rate (children per woman)	6.3	4.5	6.7
Infant mortality (infant deaths per 1,000 births)	104	83	117
Child mortality (child deaths per 1,000 births)	95	71	106
Under 5 mortality rate (< 5 deaths per 1,000 births)	189	148	210

Table 7. Demographic indicators for children under-five years

Indicator	*1992*	*2000*
Underweight (too thin for age)	27%	25%
Wasting (too short for height)	5%	6%
Stunting (too short for age)	49%	49%

[17] These include the following: 'A preliminary study for integrating HIV/AIDS activities in the agricultural sector', and the 'Formation of an organisational and operational structure to develop implement the rural community and workplace programmes'.

The majority of rural households face chronic food insecurity due to inadequate home production and low incomes. Lack of household food security has been a major problem since the 1980s. Maize, the main staple food crop contributes about 65 % of energy intake in the national diet. Figure 16 indicates that the production of maize has been erratic for the past decade due to a number of factors including drought, inadequate inputs and volatile prices. This has led to an increased rate of chronic household food shortages and malnutrition. The food deficit months have increased from 3 to 6 at household level. At national level, the food deficit increased from 300,000 ton in 2001/02 to 482,000 ton in 2004/05 (excluding potatoes). The poor health indicators mean that the health care budget has to increase to take care of the sick and malnourished. The productivity of labour force is significantly reduced and in the long-term, the mental and physical development of the people is reduced. The need to increase food and nutritional security in Malawi is therefore critical. A food and nutrition security policy aimed at reversing this trend has been formulated and its implementation is urgent.

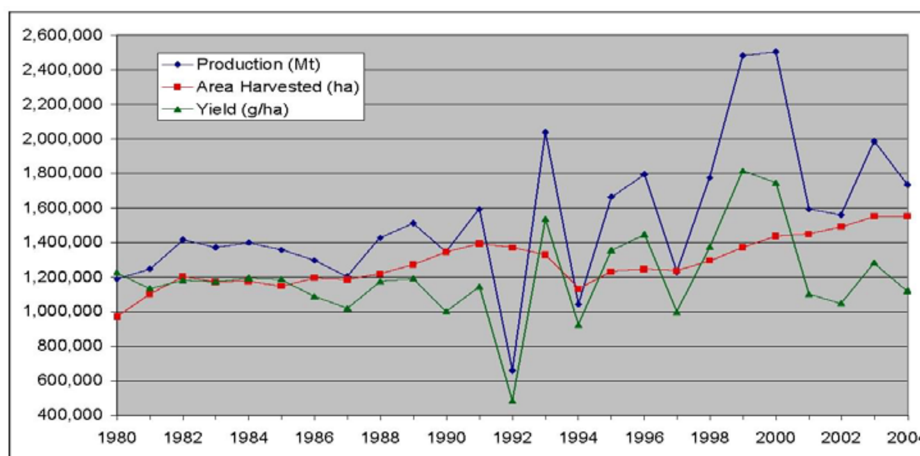

Figure 16. Total maize production, area harvested and yield in Malawi 1980-2004 (FAO web-site, country profiles)

Given the presence of the HIV/AIDS pandemic and other infectious diseases common in developing countries such as malaria, diarrhoea, TB, internal parasites and schistosomiasis, the health situation becomes complex, as most of these diseases closely relate to an individual's nutritional status. Malnourished individuals, especially children and pregnant women are more susceptible to infection (GoM, 2000b). Well-nourished individuals respond better to immunisation, treatment and rehabilitation. People with poor health are less able to fend for themselves as well as care for others. Since agricultural production in Malawi is labour intensive, productivity of people with poor health is minimal, thereby perpetuating food insecurity and malnutrition and therefore poverty.