

THE ROLE OF COMMUNITY BASED ORGANIZATIONS IN ENHANCING
FOOD SECURITY OF HIV AFFECTED HOUSEHOLDS: THE CASE OF
SELECTED COMMUNITIES IN ZOMBA DISTRICT, MALAWI

Master of Arts in Development Studies Thesis

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DECLARATION

I declare that this is my original work and that it has not been presented for a degree at this or any other university. Where work of others has been utilized, acknowledgement has been duly given. I am solely responsible for all errors herein.

Name

Signature

Date

CERTIFICATE OF APPROVAL

We declare that this is from the student's own work and effort. Where she has used other sources of information, it has been acknowledged. This thesis is submitted with our approval.

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DEDICATION

This thesis is dedicated to my husband, John and our children, Chiyambi and Chimwemwe for their tolerance, patience and support during the study period. I also dedicate this thesis to all those afflicted with and affected by HIV and AIDS.

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ABSTRACT

Malawi has one of the highest HIV prevalence rates in Southern Africa and the world, with the prevalence rate of between 12-14%. It is among countries with the highest prevalence in Southern Africa with other countries like Mozambique having the prevalence of 16.1%, South Africa 18.8% and Zimbabwe 20.1% as of 2005 (UNAIDS, 2006). Since 1990s, the Government of Malawi (GoM) has put in place programs aimed at reducing the spread of the pandemic, treating those infected and helping the affected individuals, families and communities to regain their potential. The civil society which includes the Community Based Organisations (CBOs) has also joined government in this endeavor. The study was aimed at exploring the roles the CBOs are playing in enhancing the food security of the HIV and AIDS affected households.

This research used both quantitative and qualitative methods of data collection for purposes of triangulation. The quantitative data was collected by the use of questionnaires and these were analyzed using the Statistical Package for Social Science (SPSS) Version 12.0. These were administered in 81 households that were chosen randomly. The qualitative data was obtained using key informant interviews (KII) and focus group discussions (FGDs).

The results show that the CBOs in Zomba are running a number of activities in order to help the affected households. However, the households that are benefiting from the

CBOs activities are still facing food problems. On average food from own production lasts for about 5 months. Comparing the CBOs though, it was also found that the CBOs that had funding from government and other organisations (external help) had a lot of beneficiaries. These CBOs also had higher asset-livestock portfolio. Thus the households in these CBOs had at least something that could be sold and use the money for food as compared to those that had no external help. The study also found that there was higher proportion of households that eat three meals a day as well as that consume fruits from the households belonging to CBOs that received external support. Male-headed households also had higher ownership of both livestock and assets. Thus it is concluded that the households from the CBOs that received external support are better off than those from the CBOs that did not receive external support. It is therefore important that the government and donor agencies should strengthen the activities that are done by the CBOs in Zomba by making funds available to them. However, proper monitoring mechanisms be put in place to make sure that the intended beneficiaries are reached. The CBOs should also be encouraged to do income generating activities (IGAs).

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
AU	Asset Unit
CALI	Composite Asset-Livestock Index
CAPA	Children Alliance and Partners Association
CBO	Community Based Organisation
CADECOM	Catholic Development Commission
DAC	District AIDS Coordinator
DADO	District Agricultural Development Officer
DAPP	Development Aid from People to People
EU	European Union
FAO	Food and Agriculture Organization
FGDs	Focus Group Discussions
FHH	Female Headed Households
GoM	Government of Malawi
HBC	Home Based Care
HIV	Human Immune Deficiency Virus
IGA	Income Generating Activity
IRT	Independent Review Team
KI	Key Informant
KII	Key Informant Interview
LU	Livestock Unit
MACRO	Malawi AIDS Counseling and Resource Organisation
MASAF	Malawi Social Action Fund
MDHS	Malawi Demographic and Health Survey
MHH	Male Headed Households
MDS	Master of Arts (Development Studies)
MPS	Master of Arts (Political Science)
MTP	Medium Term Plan
NAC	National AIDS Commission
NACP	National AIDS Control Programme

NAF	National HIV and AIDS Action Framework
NGO	Non Governmental Organisations
NSF	National HIV and AIDS Strategic Framework
NSO	National Statistical Office
OSA	Orphan Support Africa
OVC	Orphans and other Vulnerable Children
PMTCT	Prevention of Mother To Child Transmission
PLWHA	People Living with HIV and AIDS
SLA	Sustainable Livelihood Analysis
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
WFP	World Food Programme
WHO	World Health Organisations

CHAPTER ONE

1.0 BACKGROUND TO THE STUDY

1.1 Introduction

Food is one of the basic needs for the survival of human beings together with breathing, water, sex, homeostasis and excretion as suggested by the renowned Psychologist Abraham Maslow in his paper entitled 'Theory of Human Motivation' (Maslow, 1943)¹. However, many countries in sub-Saharan Africa (including Malawi) are struggling to fulfill this very basic requirement of every human being for reasons ranging from environmental and climatic stress to policy shortfalls, disease, poverty and resource distribution inequalities (Panagides, Graciano, Atekyereza, Gerberg and Chopra, 2007). The emergency of HIV and AIDS in the 1980/90s and the consequent rise in the prevalence and spread seems to have exacerbated the situation with many households trapped in vicious cycles of poverty, hunger, disease and food insecurity (Khaila, Kadzandira and Mvula, 1999). Malawi is one of the countries in the world which has not been spared by the HIV and AIDS pandemic. At 12-14%, the HIV prevalence is considered as one the highest in the world surpassing only a few countries in Southern Africa such as Mozambique 16.1%, South Africa 18.8% and Zimbabwe 20.1% as of 2005 (Arrehag, De Vylder, Durevall and Sjoblom, 2006, UNAIDS, 2006).

As a landlocked country, Malawi depends heavily on agriculture as its major source of livelihood for most of its population and the situation has remained the same since the colonial era (Arrehag et al, 2006). As such, any stress on the agricultural sector in Malawi has far-reaching consequences on the overall economy, food security and people's

¹ http://en.wikipedia.org/wiki/Maslow's_hierarchy_of_needs

general welfare. The impact of AIDS on agriculture, food security and on people's livelihoods has generally been researched on. Many researchers have spotlighted the role of HIV and AIDS in weakening the population and predisposing them to what is being referred to as the 'new variant famine' (De Waal, 2003; Deveruex, 2002; Shah, Orsborne, Mbilizi and Vilili, 2001). People affected by HIV and AIDS are seen to contribute less to food production or income required to purchase food than normally they would because of declined activity (Palamuleni, Kambewa and Kadzandira, J., 2003). This is because the sickness and death of the working adults affect the total labor available in a farm household as well as the division of labor between adults and children and also between men and women. According to the gender system prevailing in Malawi, women are the traditional caregivers and whenever a member of the family is sick (from AIDS or other illnesses) they spend a lot of time taking care of him/her and this reduces the supply of the agricultural labor hence resulting into increased food insecurity. This is a very tricky situation in Malawi where it is estimated that almost 80% of household food production is done by women (Arrehag et al, 2006).

Furthermore, it is seen in most instances as having formed an entwined fabric of net-traps where poor people are finding it hard to escape (Khaila et al, 1999; Kadzandira, 2003; Kadzandira, Mvula and Chilimampungu, 2005). This is because the combination of a decline in food production, the sale of food reserves and liquidation of assets, mobilization of savings, the decrease of household income and overall increase in expenditures are often found impacting on each other thereby creating a cycle of destitution and suffering among the poor people.

As a country, Malawi has since 1990s put in place a program aimed at reducing the further spread of the pandemic, treating those infected and helping the affected individuals, families and communities to regain their potential. The civil society in Malawi has also joined government in this endeavor by mobilizing additional resources (financial, material and psychosocial) for the implementation of various interventions some of which are on enhancing household food security. The aim of this study was to explore the role that CBOs are playing in enhancing the food security situation of households affected by HIV and AIDS. The study was conducted in selected rural communities of Zomba district in Southern Malawi.

1.2. Statement of the Problem

In 2001, the UN general assembly special session on HIV and AIDS adopted the declaration of commitment on HIV and AIDS. This declaration commits member states and the global community to take strong and immediate action to address the HIV crisis. This is also a follow up to the Millennium Development Goals which were adopted in 2000 which called for the expanded efforts to halt and reverse the spread of HIV and AIDS by 2015. There are also regional and national commitments to confront the epidemic as seen in other documents like the Abuja Declaration and Framework for Action on HIV and AIDS, Tuberculosis and other related infectious diseases that were adopted at the Africa Summit on HIV and AIDS, Tuberculosis and other related infectious diseases (GoM, 2005). From these, countries have developed national targets and programmes depending on the situation of the problem in the countries.

The government of Malawi together with development partners has been implementing several programmes aimed at mitigating the effects of HIV and AIDS on the affected households and communities and also treating those infected by the virus. The civil society has also helped the government to scale-up the response to many parts of the country through home based care services. In addition to these efforts, there have also been traditional safety nets in the form of the extended family systems through which communities come up with actions for caring of the sick and orphans. However, these traditional safety nets have been under strain because of the same disease (and poverty) such that households that would have assisted are themselves often found experiencing the same stress. Thus the epidemic has weakened the traditional coping mechanisms to the extent that the needs of orphans and the sick are now becoming beyond the extended family's capacity (Ngwira, Bota and Leovisohn, 2001). This led (in some communities) to the formation of community groups to meet the expanding needs in their communities. In some cases these organic groups were funded and with time some funding agencies agitated for their formation. In the end, the groups have become a mechanism for mobilizing resources to meet the needs of those infected and affected by HIV and AIDS (Singleton, Kadzandira, Mwapasa, Wamai and Ngwira, 2005).

With these community based groups (CBOs), a range of strategies are being used to assist the affected households in preparing, responding, adjusting and surviving the impacts of the epidemic as well as other threats to their livelihoods. Most of these strategies are traditionally based, and coupled with extended family support and in some instances, they constitute the only form of assistance provided to AIDS affected households (Panos

Africa, 2007; Palamuleni et al, 2003; Leovinson and Gillespie, 2003). Some question the sustainability of these initiatives as members of the very CBOs are succumbing to the epidemic (Palamuleni et al 2003). In addition, CBOs frequently lack funds and critical resources to fully implement their projects (Singleton et al, 2005) rendering their impact minimal to some extent.

Again, there is generally a cloud over what exactly CBOs are doing in the area of impact mitigation particularly the extent affected households are supported in meeting their food requirements (Singleton et al, 2005). Some studies looked at the relationship between HIV and AIDS and food security but few have provided details on the processes that are actually followed. Few have also dwelt on the sustainability of the CBO interventions. Answers are needed for questions like: ‘What roles are CBOs playing in relation to food security of the affected households?’ and ‘Are there differences between CBOs receiving external support and those relying on local resources in building the capacity of their communities and households?’ This study was therefore conducted to answer these questions so as to inform policy and programme design.

1.3 Objectives of the Study

1.3.1 Main Objective

The main objective of the study was to explore the roles of CBOs in enhancing food security of households affected by HIV and AIDS and how external support enhances their ability to help HIV/AIDS affected households.

1.3.2 Specific Objectives

The specific objectives of the study were:

1. To assess the food security situation of households affected by HIV and AIDS benefiting from CBOs.
2. To explore food security coping mechanisms of HIV and AIDS affected households benefiting from CBOs.
3. To identify and characterize different food security initiatives by the community based organizations aimed at enhancing food security of affected households.

1.4 Study Hypothesis

The major hypothesis was that food security status of households supported by CBOs that do not receive support from external sources is not different from that of households whose CBOs receive support. It was assumed that:

1. Food security situation of households affected by HIV and AIDS benefiting from CBOs has not improved.
2. HIV and AIDS affected households benefiting from CBOs have no food security coping mechanisms.
3. CBOs do not run food security initiatives aimed at affected households.

1.5 Justification and Significance of the Study

In a country such as Malawi where resources (human, material and financial) are limited, it is important that the little resources that are available are put to best use. Research-based evidence guides better policy making and leads to better understanding of the

complexities through which systems operate. In Malawi, CBOs are increasingly being seen as a vehicle for scaling-up the response on HIV and AIDS especially with regard to treatment, care and support, community awareness and impact mitigation. However, there is paucity of information regarding how the CBOs are working in enhancing household food security. Review missions of the 2005-07 financial years of the national response to HIV and AIDS all pointed out the need to conduct a thorough assessment of community based interventions (especially those concerning impact mitigation) so as to ascertain the nature, magnitude and relevance of these interventions in enhancing people's resilience mechanisms (i.e. how households respond and regain their strength for a better livelihood).

There are some indications on the role of CBOs in supporting the welfare of vulnerable households, but there is still a gap of knowledge as regards how these CBOs are contributing to the food security of the infected and affected households. It is envisaged that findings from this study would contribute to the knowledge of these issues and will help policy debates with regard to the relationship between HIV and AIDS and food security in the country.

1.6 Organisation of the Thesis

This thesis has five chapters. This first chapter (Chapter 1) provides the background to the study also covering HIV and AIDS situation in Malawi and the responses, problem statement, study justification, objectives and hypothesis. Chapter 2 presents the review of literature in which both the conceptual and theoretical frameworks are discussed

including the threats to achieving food security in Malawi and the rise of CBOs. Chapter 3 discusses the study's methodology while Chapter 4 presents and discusses findings. Conclusions and Recommendations are provided in Chapter 5.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on issues relevant to this study. It first looks at the theoretical framework for analyzing the relationship between food security and HIV and AIDS. It then discusses literature on the situation of HIV and AIDS in Malawi, the national response to the pandemic, and how food security is conceptualized. Subsequently, the threats to achieving food security in Malawi, the impact of HIV and AIDS on household food security are reviewed and finally, the rise of CBOs in development is also reviewed.

2.2 Theoretical Framework

The study uses the sustainable livelihood framework. The livelihoods approach is based on the premise that the asset status of the poor is fundamental to understanding the options open to them, the strategies they adopt to attain livelihoods, the outcomes they aspire to achieve and the vulnerability context under which they operate (Carney, 1998). A livelihood is defined as a combination of resources used and the activities undertaken by an individual or household in order to live and it is sustainable if it can cope with and recover from stress and shocks, maintain and enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation (Ellis, 2000).

In this approach, households are seen to possess five sets of capital assets essential to their livelihood strategies: human capital, natural capital, financial capital, social capital, and physical capital. The human capital refers to the amount of labour available to the household. This also includes education that people have, skills they possess and how healthy they are (Carney, 1998). The financial capital is the amount of money which the household has access to. This could be in form of savings and credits in the form of loans. This could also be extended to include money substitute like livestock. The natural capital comprises the land, water and the biological resources that are utilized by people to generate means of survival. This capital is not static and is enhanced when it is brought under human control that increases its productivity. The physical capital comprises the capital that is created by economic production processes. On the other hand the social capital attempts to capture community and wider social claims on which individuals and households can draw by virtue of their belonging to social groups of varying degrees of inclusiveness in the society at large (Ellis, 2000).

Utilizing these assets, households adjust to their physical, social, economic and political environments through a set of livelihood strategies designed to strengthen their wellbeing (Stokes, 2002). Additionally, the institutional structures and processes influence access, control and use of assets. On the other hand, depending on the assets that people have, structures and processes that impact on them, tradition, and the vulnerability context under which they operate, people choose livelihood strategies that will best provide them with livelihood outcomes. Livelihood strategies are composed of activities that generate the means of household survival (Ellis, 2000).

The sustainable livelihood approach is important in the analysis of HIV and AIDS because it is people centered. It emphasizes on the effects not only of the infected/afflicted but also the affected especially within the household. It also seeks to identify the various factors which hinder or provide opportunities to people in order to improve their situation and how these factors relate to each other, including links to macro policies.

The sustainable livelihood framework has been applied by looking at the assets of the people (human, physical, financial, social and natural capital) in the study area, how they are utilized and how the CBOs are helping the infected and affected households through the livelihood platform in order for the households to be food secure. According to Tollens (1998), the entitlement that an individual can make to food depends on the possession of physical, human and social resources. The CBOs play a role in mitigating the social and economic impacts of HIV and AIDS. Using the livelihood framework, they form part of the institutional structures that are available in the communities as well as the part of the capitals (social). Through the activities done by these CBOs, the household can be able to have strategies as well as improving on the assets for them to achieve their outcome, in this case food security. Thus, the activities of the CBOs should be seen to embrace the five capitals that are available to the rural people as well as enhance the sustainability of these assets.

2.3 The Situation of HIV and AIDS in Malawi

The first case of HIV was diagnosed in 1985 (NAC, 2003) and since then, the prevalence has been growing. It is currently estimated that 12-14% of Malawians aged 15-49 years are living with HIV and AIDS in Malawi (NSO, 2004; NAC, 2006) and the prevalence is higher among women compared to men, 13% versus 10%, respectively (NSO, 2007). Across the urban-rural divide, latest statistics on HIV prevalence indicate higher prevalence in urban areas (17%) than rural areas (10%) but the worrying trend is that the prevalence in rural areas is gradually rising instead of falling as is the case in the urban areas (NAC, 2007). With over 80% of the Malawi population residing and working in rural areas (NSO, 2008) where almost 90% of the country's food is produced, the rising prevalence places a heavy burden on the country's economy as a whole. A number of studies conducted in the last decade have reported the consequences that HIV and AIDS is placing on individual households and communities (Arrehag et al, 2006; Palamuleni et al, 2003; Shah et al, 2001).

Results of the 2004 Malawi Demographic and Health Survey (MDHS) also indicated that at regional level, HIV prevalence is highest in the southern region at 17.6% compared to the northern and central regions where prevalence is estimated at 8.1% and 6.5%, respectively (NSO, 2004). In 2005, the southern region also had the highest prevalence rate of 18% while the northern and the central regions had the rates of 8% and 10% as estimated from the national sentinel surveillance system (NAC, 2006). It has been further estimated that 100,000 new HIV infections occur annually and that almost half of these new infections occur among young people aged 15-24 (NAC, 2005). In 2005, there were

930,000 people (including children aged less than 15 years) infected with HIV and this figure rose to approximately 1.3 million people in 2007 (GoM and NAC, 2007).

The HIV and AIDS epidemic has also negatively impacted on life expectancy. In 2007 it was estimated at 39 years from an earlier projected life expectancy of 54 years (Munthali and Maleta, 2008). The number of orphans has also increased due to the HIV and AIDS epidemic to more than 1 million and half of these are due to HIV and AIDS and related factors (GoM, 2005; Munthali and Maleta, 2008). In the mid 1980s, there were approximately 22,000 deaths annually in Malawi, these figures rose to approximately 37,000 in 1998 and to 70,081 in 2003, 71511 in 2005 before starting to decline in 2007 to 61,332 and it is estimated to decline further to less than 30,000 in 2010 if the scale-up of the ART programme continues at the pace experienced between 2004 and 2007 (GoM and NAC, 2007).

2.4 The National Response to the HIV/AIDS

Since 1990s the Government of Malawi together with development partners have been implementing several programmes aimed at reducing the further spread of the epidemic, treating those infected and helping households and communities that have been affected. The major policy shifts were witnessed in the mid-1990s following the change in political dispensation from one party state of government to multiparty system when there was a clear political commitment and openness about the need to deal with HIV and AIDS. A number of policy instruments were developed as a result of this including the Medium Term Plans (MTP I and II) which were used for the period 1989-1999 although in the

period before 1994, political interest was less significant. During the period 1989-1994, the response emphasized on blood screening, HIV and AIDS awareness campaigns, public awareness and the setting up of an epidemiological HIV surveillance system while the period 1995-1999 largely focused on addressing the critical shortage of human resource within the health sector, the mobilization of resources for the national response and the setting up programs for the care and treatment of PLWHAs. Furthermore, the National AIDS Control Program (NACP) was established within the Ministry of Health in 1988 and was later replaced by the National AIDS Commission (NAC) in 2001 so as to enhance the multi-sectoral nature of the response because it was initially seen as a health-sector response when NACP was in the Ministry of Health (GoM and NAC, 2005)

The National HIV and AIDS strategic framework (NSF) was also adopted and used in the period 2000-2004. This was multi-sectoral in nature and promoted the participation of PLWHAs, a community-based approach and had a strong emphasis on the youth (GoM and NAC, 2007). Of late the National HIV and AIDS Action Framework (NAF) 2005-2009 and the HIV and AIDS policy and several implementation guidelines have also been developed since 2003. Additionally, the OVC Policy and the ARV Equity Policy were also developed during the period 2000-2004. NAC and other stakeholders, with support from donors, have also come up with different policies and guidelines including those on the Prevention of Mother to Child Transmission (PMTCT) of HIV and treatment of opportunistic infections. These further provide guidance in the delivery of HIV and AIDS services in Malawi.

2.5 Food security: The concept and its applications in the study

Food security as a concept originated in the mid-1970s, in the discussions of international food problems at a time of global food crisis and it was defined during the 1974 food summit as ‘availability at all times of adequate world food supplies of basic foodstuffs to sustain a steady expansion of food consumption and to offset fluctuations in production and prices’ (Clay, 2002). The focus was on the volume and stability of food supplies. In 1983, the definition was expanded to include securing access by vulnerable people to available supplies, implying that attention should be on the balance between the demand and supply side of the food security equation. Thus it was defined as ensuring that all people at all times have both physical and economic access to basic food that they need (FAO, 2003).

The World Bank in 1986 redefined food security as access by all people at all times to enough food for an active and healthy life its essential elements being; (i) availability of food; and (ii) the ability to acquire it (Mataya, 2000; FAO, 2003) while in 1994, the definition was broadened to incorporate food safety and also nutritional balance, reflecting concerns about food composition and minor nutrient requirements for an active and healthy life. Food preferences, socially or culturally determined, now became a consideration. The World Food Summit of 1996 defined it as a situation when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life (Clay, 2002).

The State of Food Insecurity Report for 2001 on the other hand defined food security as a situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life (Clay, 2002). This definition emphasizes on consumption, the demand side and the issues of access by vulnerable people to food.

The study takes food security as defined by the World Bank in 1986 as “access by all people at all times to enough food for an active and healthy life” because it has been widely used. This definition uses the conceptual framework that includes three components of food security namely: availability, accessibility and utilization of the food. Considering the fact that food availability is a function of domestic food production, imports and donations, this study focuses on domestic agricultural production of the selected households and access to food by the affected households through purchasing. It will focus on the household food security since this is the level of social organisation that most of programme interventions implemented by CBOs aim to enhance.

2.6 Threats to achieving food security in Malawi

Malawi aspires to have adequate safe food for all members of the households at all times of the year by the year 2020 (GoM, 2000). This is consistent with the definition of food security in which emphasis is laid on access to food by all people at all times to lead to an active and healthy life (FAO, 2003; World Bank, 1986). This is expected to be achieved through own production and using cash to buy food from the market. . However, Tsoka (2005) revealed that Malawian households have been historically food insecure as

manifested in the depleted food stocks, reduced number and poor quality of meals eaten by the households. NSO (2007) also observed that 81 % of the household in Malawi that grew food crops in 2004/2005 season had run out of food by December 2005.

There are three kinds of food insecurity: seasonal, chronic and transitory (Palamuleni et al, 2003). Seasonal food insecurity is a decline in access to food and this is in line with the changes in the season. Chronic food insecurity on one hand is a continuously inadequacy in dietary requirements caused by the inability to acquire food, and affects households that persistently lack the ability either to buy enough food or to produce their own. Transitory food insecurity on the other hand is a temporary decline in a household's access to enough food, and results from instability in food prices, food production or household incomes (Palamuleni et al, 2003; Benson, 2004). All these are however still experienced by the households in Malawi in one way or the other.

There are a number of reasons that explain the food security situation. However, the dimensions and causes of food insecurity may differ from place to place. But in general the major constraints to improved food security are low productivity, poor market, road infrastructure as well as the rising population pressure. Agriculture in Malawi is mostly rain-fed. This makes domestic food availability and the economy as a whole highly vulnerable to climatic variation.

Poor weather conditions coupled with high population growth and low maize productivity are believed to be major contributory factors to deteriorating food security in

Malawi (GoM, 2004). The population pressure has made the mean land holding size of the small farms to decrease from 1.53ha per household in 1968 to 0.8ha per household in 2000 (GoM 2001) making the majority of the rural household to be unable to feed themselves from own production for the entire year. Thus, for the households on holdings that are too small to generate enough food or cash crop income to attain food security, an alternative source of cash or food could be sought and the CBOs in the areas could be one of the alternative sources since they could be running a number of activities so as to help the households

In Malawi, levels of maize production have been used as a measure of food security considering that it is the main staple food of majority of the people. However, the dependence on maize using the current production techniques appears to compromise food security in Malawi. Mataya (2000) also reported that an average farmer obtains approximately one eighth of the potential yield of maize which is the Malawi's staple food and occupies more than 60% of the total cultivatable land. While this is the situation, Cromwell and Kyegombe, (2005) explained that end of fertilizer subsidy in the early 1990's coupled with devaluation limited the use of fertilizer there by reducing the maize productivity. With this situation it has also been estimated that the small farm maize yields are currently about one third of the potential.

Additionally, most access roads to rural Malawi areas where maize is produced are seasonal. This makes it difficult to transport inputs and produce to major consuming areas. Hence the activities of the private traders are limited to areas with adequate

infrastructure and close to urban areas (Mataya, 2000). The lack of transport and proper roads make it difficult to get inputs into the rural areas and bringing output to the market. Sutter and Saaks (2002) identified inaccessible farm inputs, particularly fertilizer, but also improved seeds, erratic rains, high dependency ratios, limited income sources, and access to poor arable land as the principle sources of food insecurity. Farm inputs like fertilizers are important in helping the households to improve the productivity of the available land thereby increasing the productivity of the crops. On the other hand, the high dependency ratio means a lot of people to be fed. Hence, the need for more food. The households in the rural areas find it difficult to purchase fertilizers because of the lack of transport and proper roads is making it difficult to access inputs. The CBOs may be able to play an important role in implementing programmes that will increase the access to the households in the areas for instance through the maintenance of the infrastructures like roads.

In explaining the 2001/02 famine situation, De Waal and Tumushabe, (2003), HIV and AIDS were said to be the major factor as to why many households faced food shortages with a few of them been able to recover. That is, Malawi being an agricultural based economy, the HIV and AIDS is causing loss of productivity since agriculture demands healthy labour and timely land and crop husbandry hence food insecurity. This is due to the fact that HIV infects the sexually active who are in turn the most productive. The most important productive resource that rural people have is the family labour. Those infected and ill are less productive and taking care of them means lost production and reduced savings at household. The untimely deaths mean reduced child and parents

support and loss of the productive population. Thus, the affected households sometimes would not afford to purchase inputs because most of its finances are on the care and support of the sick. The CBOs would be able to provide the households with the necessary needs for them to be food secure.

2.7 Impact of HIV and AIDS on Household Food Security

Many scholars and rural development practitioners have highlighted the various impacts that the HIV and AIDS epidemic is making on household food security and general livelihoods. These effects are experienced in the human capital; financial capital; social capital; physical and natural capital. These capitals form part of the livelihood platform.

FAO (2004) revealed that HIV and AIDS related adult morbidity and mortality is increasingly becoming one of the principal factors undermining sustainable development and poverty alleviation in the region. A good number of rural farming households in the region are increasingly becoming poorer and more vulnerable to the consequences of food insecurity and other socio-economic shocks as a result of increasing HIV and AIDS related adult morbidity and mortality.

Furthermore, the human and financial capital are affected by HIV and AIDS due to loss of household labor, increased household expenses, loss of productive assets, skills, loss of agricultural (especially crop) productivity, liquidation of valuable assets leading to impoverishment of the households, and to intensification of malnutrition (Palamuleni et al, 2003). Additionally, Ngwira et al (2001) revealed that the affected households

experience a reduction in agricultural production due to the decrease in both the area planted and yeilds. This is because of the loss of potential able bodied adult labour, loss of the quality of labour, time diverted from agricultural activities for care giving and /or attending to funerals as well as the decrease in financial capital to hire labour when needed.

However, as argued by De Waal and Whiteside (2003) the HIV and AIDS affected households may escape complete demise in the face of a food security shock through various coping strategies, but cannot escape the longer term downward trend in food security. Thus, while the HIV and AIDS is affecting the households, the households are also seen to develop different strategies in order for them to survive. These livelihood strategies are composed of activities that generate the means of household survival. But these strategies also depend on the household assets, structures and processes that impact on them as well as the vulnerability context under which they operate (Ellis, 2000) such as belonging to a CBO. Similarly, the World Bank identifies three main coping strategies households use as response to the impact of HIV and AIDS which include: altering household composition (for example, by sending one or more children to live with relatives, or inviting a relative to join the household in exchange for assistance with farming, household and childrearing tasks); drawing down savings or selling assets (durable goods, livestock, etc.); and utilizing assistance from other households and from informal rural institutions (Topouzis, 1999).

FAO and UNAIDS (1999) showed that the adverse effects of HIV and AIDS on both agricultural production and food security were more pronounced among rural women than men. This study also revealed that widows with dependent children became entrenched in poverty as a result of the socio-economic pressures related to HIV and AIDS. Widows lost access to land, labor, inputs, and credit, and support services. HIV and AIDS stigmatization compounded their situation further, as assistance from the extended family and the community, their main safety net, was severed. As the ability to produce and accumulate food and income decreases, the household enters into a downward spiral of increasing dependency ratios, poorer nutrition and health, increasing expenditure of resources (time and money) on health problems, more food shortages, decreasing household viability, and increasing reliance on support from extended family and the wider community. This reflects how the pandemic is affecting the three key household capitals namely human, social and financial.

Haddad et al, (2001) and Brown, Webb and Haddad (1994) posited that the effects of HIV and AIDS on food security occur through the effects of the pandemic on two key farm production factors which concomitantly affect household food security which are quantity and quality of family labor supplied and household income. HIV and AIDS results in reduced household labor quality/productivity and quantity due to chronic illnesses and deaths which leads to poor crop yields due to untimely implementation of agronomic practices like planting, reduced area under cultivation; and shift from labor-intensive nutritious crops (e.g. groundnuts, vegetable gardening) to less labor-intensive crops. As regards the livelihood approach, this is illustrating how the human capital is

affected by the epidemic which will in turn lead to loss of financial capital as well as the natural capital.

Furthermore, Haddad and Gillespie (2001) also found that HIV and AIDS affect food security through decline in disposable household income, which is affecting the financial asset in the livelihood framework. In the absence of functioning medical care systems in most African countries, medical costs and caring for the sick family members are usually borne entirely by the nuclear family members or by the extended family members. This illustrates the importance of social capital. During periods of illness, household financial resources may be diverted to cover medical expenses. Such resources may otherwise be used to purchase agricultural inputs (e.g. new seeds, planting materials, fertilizer, and pesticides). Given the possibility that more than one family member is affected by HIV and AIDS the entire pool of assets and savings of the family could be completely wiped out such that the surviving family members inherit nothing but poverty. In cases where some family assets are left, these could either be sold immediately after the death of the family member or confiscated from the immediate family members by greedy relatives.

Kirstan and Karim (2002) also indicated that the burden of ill-health and death as a result of AIDS impacts on livelihoods, depleting human capital, disrupting social support networks, institutions and both formal and informal organisations, thereby limiting or undermining livelihood opportunities, productivity and social support mechanisms. The breakdown of community institutions and social relations also weakens group-based microfinance initiatives, thereby reducing access to credit. Rural development and

livelihood opportunities are therefore critical to improving wellbeing and lengthening lives of people living with HIV or AIDS (PLWHAS) and their families.

In their study in Malawi, Palamuleni et al (2003) found that HIV and AIDS affects household food security through its effects on human capital, financial capital and social capital. They result in the direct loss of labour and skills of the one who is chronically sick and may eventually die as well as the labour and skills of the caretakers and neighbours. Furthermore, due to the illnesses and care that is provided, farming and other productive activities are withdrawn. The longitudinal nature of the HIV and AIDS related illnesses and the associated demands that are made (those of supplementary food and treatment), a lot of resources and valuable assets are depleted, savings are drawn down and households enter into unprepared loans. The study also revealed that HIV and AIDS is greatly inducing demographic changes in Malawi by increasing the number of orphans, orphan led households, elderly led households and single parent households. Since the epidemic is taking away the productive young people, the shells of social support are gradually shrinking, paving way for deprivation and destitution. Thus the social security networks which are an important social capital are eroded. This is because as the prevalence of HIV and AIDS rises, the burden, that is of caring for the sick and for orphans which are customarily spread within communities, overwhelm the ability or willingness of other household to take in further dependants or further dividing their economic entitlements.

Panos (2007) found that when the main bread winner faces prolonged AIDS related illnesses, the household's opportunity to earn a living is reduced, and some people living with HIV and AIDS sell their household assets to raise money to support themselves and their families. This means that they use up assets that they have accumulated for future use as a source of livelihood. Thus, HIV and AIDS adversely affect household food security by undermining both the availability (through reduced production) and access (through reduced income) components of food security.

2.8 The Rise of Community Based Organisations in development

The growth of civil society institutions can be reflected back in the 1980s during the growth of neo-liberal economic policies in Africa that were influenced by the international financial institutions (Manji and Naidoo, 2004). These macro economic reform packages which were influenced by the World Bank and International Monetary Fund were adopted in many developing countries including Malawi. The policies on privatization, decentralization and economic liberalization made the private sector increasingly assume a leading role in rural development (i.e. in the provision of health and agricultural extension services as well as water schemes) and as such, should also feature prominently in the response to HIV/AIDS.

In Malawi, the NSF emphasized the need for active participation by stakeholders (GoM and NAC, 2007) and the citizenry are the primary stakeholders. Thus, organizations owned and serving the citizenry, CBOs are therefore encouraged. The local Government Act (cap22:01) of laws of Malawi define the CBO as a membership based organization

formed by a particular community residing in a Group Village Headman's area of jurisdiction sharing common goals and objectives in order to address development issues relating to that community and includes, where appropriate, a faith based organization (IPRSE, 2007). They are non profit making organisations that are based in and staffed by the communities they serve. Thus, they are the means by which community members mobilize themselves to address some of the pressing issues affecting their communities. They perform vital functions for communities including the mobilization of labour, conflict resolution, infrastructure development, cultural activities, and management of relations with outsiders as well as emergency relief. These roles reflect the human capital i.e. the mobilization of labour, issues of physical capital (infrastructure development) as well as the social capital (conflict resolution).

Narayan contends that historically, indigenous groups have developed community organisation as solutions for confronting economic, social, and political challenges. Through the CBOs, social capital becomes their capital (Narayan, 2000). According to the sustainable livelihood framework, social capital means the social resources upon which people draw in seeking for their livelihood outcomes for instance networks and connectedness that increase peoples trust and ability to cooperate or memberships in more formalized groups (Kullmair and Gamper, 2002). Similarly, Putnam (2000) also refers social capital to connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them. Thus, social capital often represents a place of refuge in mitigating the effects of shocks or lacks in their capitals through the informal networks. Putnam, (2000) reveals that the interaction enables people to build

communities, to commit themselves to each other, and to knit the social fabric. A sense of belonging and the concrete experience of social networks can bring great benefits to people.

Further more, Narayan (2000) also revealed that the poor people invest heavily and place much trust in their own CBOs. They do so for their survival and security. This further supports the increased presence of CBOs in various localities nowadays which could as well be ascribed as one of the coping strategies against the impact of HIV and AIDS on household's livelihood.

In both rural and urban areas in Malawi, care and support organisations for HIV and AIDS and PLWHAs exist ranging from those which provide counseling service to those offering medical care, home based care, food provision and other supplies (Panos Africa, 2007; Palamuleni et al, 2003).

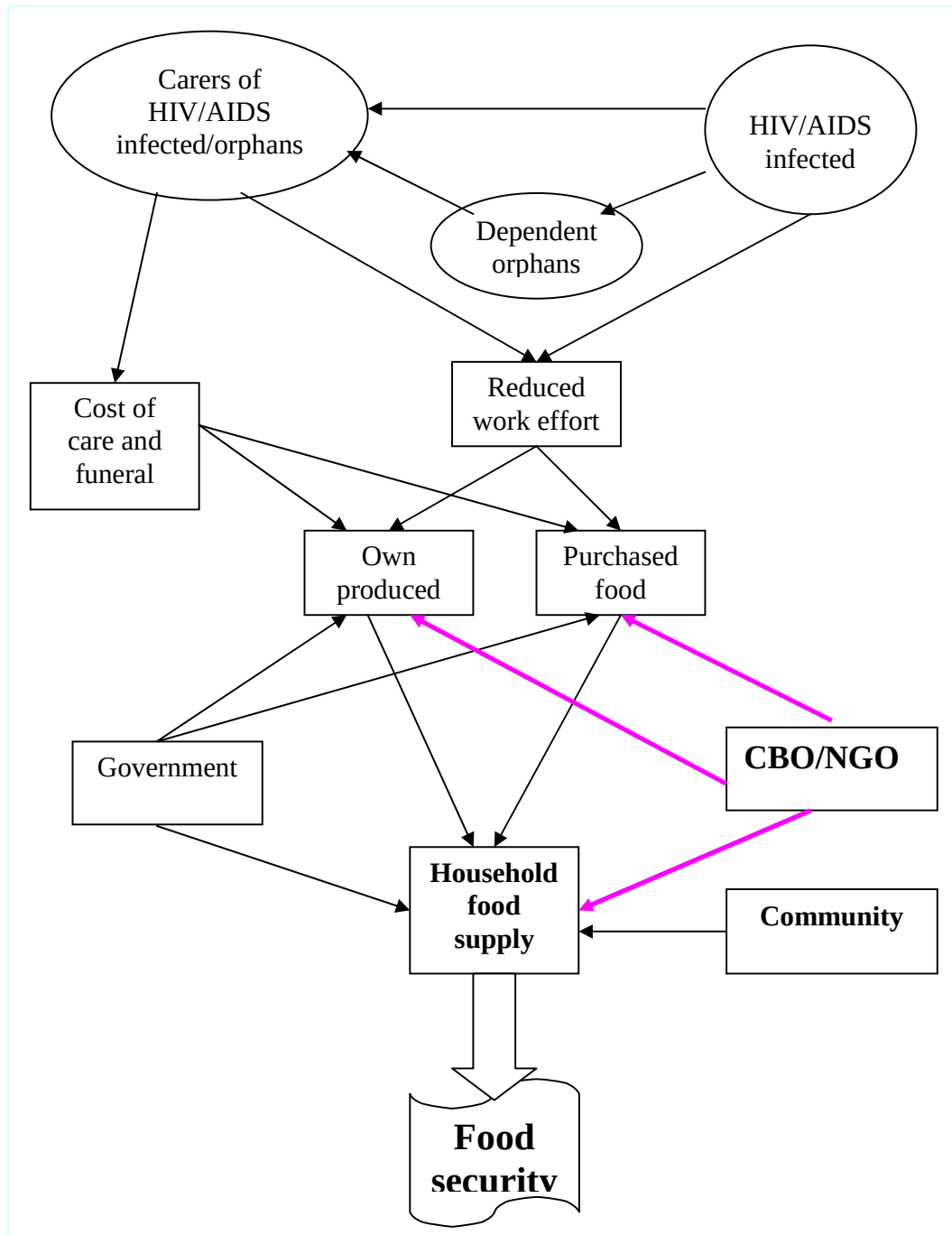
2.9 Schematic presentation of the literature

Figure 1 provides the schematic presentation of the HIV and AIDS, food security and CBO link. The presence of the problem of HIV and AIDS in the households means reduced work effort both in farms and off farm activities and also high costs of care and funerals. This influences the household access to food. The households access to food through own production and the purchases of food is also a function of the different things like the capitals (human, financial, physical, natural and social capital). Sen's entitlement approach highlights that a person's ability to command food depends on ownership endowments (of labour, land) and exchange entitlement mapping (Sen, 1981).

Thus, the access to food may be gained through production of food, purchase of food with cash income and receipt of transfers of food as well as cash.

Because of the problems being faced by the HIV and AIDS affected households, the government and its development partners are also running different programmes in order to help the households have access to food. For instance targeted nutrition programmes in which pregnant women and breast feeding mothers receive food items such as likuni phala. This is also used in supplementary feeding programmes for malnourished children. There are also nutritional support programmes which provide PLWHA and malnourished individuals are given plumpy nuts (Panos, 2007). These programmes are coming in either as formal or informal safety nets. Relatives and friends are major donors of informal safety nets. Additionally, the CBOs are also working in different areas to help those affected by HIV and AIDS. It is therefore the aim of this study to look at how the households benefiting from the CBOs are fairing and identify the activities that the CBOs in Zomba are carrying out in order to enhance the food security of the affected households.

Figure 1: HIV and AIDS, food security and CBO link



2.10 Chapter Summary

The chapter discussed the concept of food security and how it will be applied in the study. The literature on the theoretical framework used in the study, threats to food security in Malawi, the impact of HIV and AIDS on household food security and the rise of CBOs in development have also been reviewed.

CHAPTER THREE

3.0 METHODOLOGY

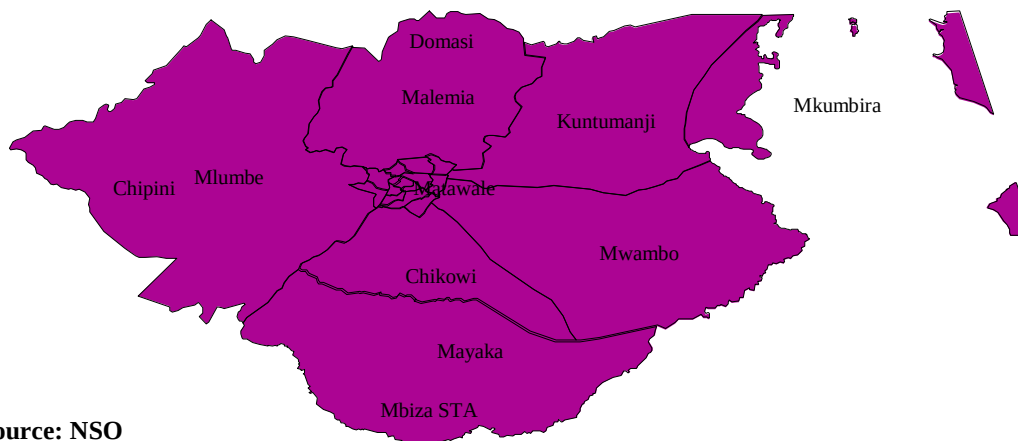
3.1 Introduction

This chapter details the methods and procedures that were used for collecting and analyzing the data. The chapter first gives the study setting (population characteristics for Zomba district in which the study was undertaken) followed by a discussion on the study design and study methods. The issues related to design and methodology are discussed and include sample and sampling procedures that were used, data collection methods, data analysis, ethical considerations that were made and limitations of the study.

3.2 Study setting

The study was conducted in the area of Traditional Authority (TA) Mwambo in Zomba district where 30 villages in six group villages were covered. Annex 1 gives a summary of the number of households that were visited in the area of each group village headman. Figure 2 is a map of Zomba showing the areas under the various TAs.

Figure 2: Map of Zomba showing the area of T/A Mwambo and other T/As



Source: NSO

3.3 Population characteristics for Zomba district

According to the preliminary results of the 2008 Population and Housing Census, there are 670,533 people in Zomba district, 87% of whom are residing in rural areas while 13% are in urban areas of the district. The households in urban areas had, on average, more members than rural ones ((4.6 persons and 4.1 persons, respectively). At TA level, TA Mwambo (where the study was conducted) has 116, 083 people and ranks third after TA Mbiza (137,761) and TA Mlumbe (133,502). Details are presented in Table 1.

Table 1: Population and housing statistics for Zomba district as by the 2008 census

	Total Population	% of district population	Number of households
Rural	583, 167	86.9	142, 394
Urban	87, 366	13.1	19, 041
Total	670, 533	100.0	161, 435
Traditional Authorities *			
Kuntumanji	72, 889	10.9	16,566
Mwambo	116, 083	17.3	26,383
Mkumbira	4, 858	0.7	1,104
Chikowi	57, 389	8.6	13,043
Mbiza	137,761	20.5	31,309
Mlumbe	133, 502	19.9	30,341
Malemia	60, 685	9.0	13,792

Source: NSO (2008)

*** Number of households calculated using population and district household size**

Health indicators for Zomba district as extrapolated from the 2004 MDHS show that the infant mortality rate was estimated at 84 per 100,000 live births against 76 at national level, under-five mortality rate was estimated at 144 deaths per 100,000 live births

against a national estimate of 133 deaths per 100,000 live births in 2004. HIV/AIDS prevalence was estimated at 17.8% which was among the highest among all the districts in the country. HIV prevalence among female residents of Zomba district is more than twice that of males, 24.6% and 10.5% respectively (NSO, 2004).

3.4 Study Design

The study was cross-sectional and utilized both quantitative and qualitative research methods. The quantitative research method that was used was a survey of households affected by HIV and AIDS where a structured questionnaire was administered. The selection of the HIV affected households is discussed below. The qualitative methods included focus group discussions (FGDs) and key informant interviews (KIIs). Data collection for the study was conducted from May to July 2008.

3.5 Sampling for the household survey

A list of community based organisations (CBOs) in TA Mwambo was obtained from the District AIDS Coordinator at the Zomba District Assembly. Six CBOs were randomly selected from the list after re-classifying them into two groups as either former recipients of government/NAC support and non-recipients. The six CBOs were: Namikhate, Lomoni and Mawa ndi anthu (recipients) and Children Alliance and Partners Association (CAPA), Makoka and Sitima (non recipients). The non recipient CBOs were selected purposively from the list of CBOs because the District AIDS Coordinator (DAC) had problems to provide the actual location of some of the CBOs.

Each CBO provided a list of its beneficiaries and these lists were used as sampling frames. Sample size was decided on the basis of what was feasible within the time period of the study and it was assumed that 120 households were good enough to make statistical inferences. However by the end of the study 81 households were visited because other people did not consent to be interviewed and no replacements were made. Other CBOs also had few beneficiaries.

The sampling of households was done randomly as well as purposively based on the number of beneficiaries the selected CBOs had. Each CBO had a register in which a list of its beneficiaries was maintained. Based on the number of the beneficiaries in the CBOs, a sampling interval was identified to achieve the required sample from that CBO for the survey. Where it was not possible to do random sampling, because of the number of beneficiaries, firstly purposive identification of FGD participants was done with the help of the CBOs coordinators and volunteers in order to choose persons that are active and able to speak openly on HIV and AIDS related issues. After this, then the rest were visited for the administration of the household questionnaire.

The sampling intervals were two for both Lomoni CBO and Mawa ndi Anthu CBO. That is, one out of two households was selected for questionnaire interviews. The numbers one to two were drawn randomly to determine the start point of the sampling in the interval. In addition, no replacement list was drawn. At Namikhate, all the beneficiaries were taken for the household survey. In this CBO, the beneficiaries were less than the number

which was to be sampled such that all the beneficiaries formed part of the household interviews as a result no FGD with the infected persons was conducted.

Sampling for the households in the CBOs that had never received any funding was basically purposive by first selecting from the list of beneficiaries, focus group discussion members first and then the rest were taken for the household survey. This was the case because these CBOs had few beneficiaries relative to the required sample size. Foregoing FGDs would have increased the number of households available for the interviews but the FGDs were prioritized because there was need to get people's perceptions as well.

During the execution of the study, it became apparent that identifying households affected by HIV and AIDS but not benefiting from any CBO was difficult because of the stigma that is associated with the epidemic. Households that belong to a CBO have otherwise declared their status and they are as such easy to identify. Van Lettow M., Thompson S., Masina H. and Mulemga M (undated) observed that registration with CBO may be a marker for a person's acceptance of his/her HIV status. Hence, those households that are known and benefiting from the CBOs were used in the study.

3.6 Selection of respondents for the FGDs and KIIs

Focus group discussions were conducted in all the six CBOs – one with HIV and AIDS infected/afflicted persons and the other with other ordinary members of the community (CBO's catchment area). The members of the FGDs were sampled purposively with the help of the CBO coordinators and volunteers. In addition, key informants (KIs) were also

purposively selected. The purposive sampling helped identify key informants who had technical information, experiences and insights which were of central importance to the study (Gay and Airasian, 2003). Key Informant interviews (KIIs) were conducted with coordinators of CBOs, traditional leaders, the District AIDS Coordinator (DAC). Table 2 shows the CBOs that were involved in the study, number of household interviews, KII and FGDs that were done. Appendix 5 provides the discussion/interview guides for the FGDs and KIIs.

Table 2: CBOs visited, number of household, number of KIIs and FGDs done

Name of CBO	Number of sessions		
	Household interviews	KIIs	FGDs
Namikhate	19	2	1
Lomoni	20	2	2
Mawa ndi Anthu	13	2	2
CAPA	18	2	2
Makoka	13	2	2
Sitima	0	1	0

3.7 Process of Data collection

The researcher administered the questionnaires, facilitated the FGDs and conducted KIIs. A research assistant was used to take notes during the FGDs in addition to recording the discussions on tape so as to ensure that most of the information was collected. The researcher also took brief notes during the FGDs.

3.8 Data Analysis

Data from the household questionnaires was entered, cleaned and analyzed using SPSS, a data management statistical package. Descriptive and other relevant statistics were derived on the basis of which findings and conclusions were made. The qualitative data was analyzed using content analysis. The quantitative data was triangulated with content analyzed qualitative data from FGD and KII reports, which were typed in Microsoft Word.

Additionally, different types and numbers of livestock and household assets that different households own are compared using a common factor for conversion into same units. These conversional factors have been provided by FAO on www.fao.org/es/ess.

3.9 Ethical considerations of the study

Before the commencement of the study, permission was sought from the District Assembly so as to conduct the study in the area. After the approval, the office of the DAC was also visited in order to get clearance on visiting the CBOs dealing with HIV and AIDS issues.

Whilst in the area of study, one of the chiefs surrounding the catchment area of the CBOs was also visited for approval to go in the villages for the study. At household level, consent from the household member was also obtained. Confidentiality and privacy of responses were also observed. The respondents were assured that nothing in the report will be traced back to specific individuals or communities.

3.10 Limitation of the Study

A number of factors may have affected the reliability and validity of the data obtained in this study. A major limitation of the study was the difficulty to identify households affected by HIV and AIDS but not benefiting from any CBO (either at time of the study or before). Stigma associated with HIV and AIDS made it difficult to identify such households compared with households that are supported by CBOs because these have declared their status and are generally willing to participate in studies. Thus only those that are known by the CBOs were used.

It was discovered that some of the CBOs on the list from the Social Welfare Office in Zomba no longer operate and the Office of the DAC has not yet updated the CBO list. This affected sampling. In order to deal with the situation, convenience sampling was applied so as to replace the CBOs that are no longer operating.

In some instances some of the beneficiaries were not receptive and this might have an effect on the data collected. The study was done soon after harvest when a lot of households were still having food from own production. This will also have an influence on information sought in line with consumption.

CHAPTER FOUR

4.0 FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter provides and discusses the findings of the research. It starts by describing the demographic and socio-economic characteristics of the sampled households. Subsequently, the household food security issues, coping strategies, household experiences with long term illnesses and deaths of members and the activities done by NGOs and CBOs will be discussed.

4.2 Demographic and Socio-economic characteristics of the households

This section will look at the demographic and socio-economic characteristics of the households that were interviewed mainly focusing on age and sex composition of the household members, parental status of children aged 18 or below and schooling status, sex distribution and marital status of the heads of households, education levels of the heads of households, main sources of livelihood, ownership of assets and livestock as well as the main source of income, household expenditure and savings, household land resources and use.

4.2.1 Age and sex composition of household members

The total population for the 81 households was 361 persons giving an average household size of 4.5 persons per household. This is slightly higher than the average household size in Malawi (4.4) but the same as the average household size of the southern region (NSO, 2008). The ages ranged between <1 to 98 years. Children aged 14 years or less

constituted 47% of the members (53% of the male members and 42% of the female members) whereas 7% of all the household members were aged 60 years or more. Details of the age and sex composition of the household members are presented in Table 3. This means that almost half of the population in the study area is comprised of children. Hence, there is almost equal distribution of children and adults. The household members constituted 54% females and 46% males.

Table 3: Age and sex composition of household members by percentage

	Sex of Household Members		Total (N=361)
	Male (n=166)	Female (n=195)	
<5 years	13.3	13.3	13.3
5-14 years	39.8	28.7	33.8
15-24 years	21.1	17.9	19.4
25-60 years	19.3	32.3	26.3
>60 years	6.6	7.7	7.2

Source: Calculated from the household questionnaire data

4.2.2 Parental status of children aged 18 or below and schooling status

Nearly half (49%) of the 218 children in the sampled households aged 18 years or less were orphans, (24% had lost one parent, while 25% had lost both) whereas the other half were not orphans. Table 4 indicates the schooling status of the children aged 18 or below. Seventy eight percent of the orphans are attending school compared to 82% among non-orphans of the same age group. Hence a lot of the orphans are unable to go to school as compared to the non orphans.

Table 4: Schooling status among orphans and non-orphans

	Non orphans (n=74)	Orphans (n=82)	Total (N=156)
Yes	82.4	78.0	80.1
No	8.1	17.1	12.8
Not Applicable (N/A)	9.5	4.9	7.1

Source: Calculated from the household questionnaire data

As education is an aspect of the human capital in the livelihood framework (Ellis, 2000), by not attending school, this will have a long term effect on food security of the households of these children since they will not have the chance to get formal employment which would help them access food through purchasing. On the other hand, the adoption of new technologies in agricultural production will also be affected.

4.2.3 Sex distribution, marital status and educational levels of the household heads

Sex and marital status of the household heads are important factors for determining the welfare of the household as they affect the labour resources and have implications on the overall household food security of the households. Women comprise the largest single segment of the poorest in most countries including Malawi (Kabbaj, 2003). Because they are also traditionally care-takers and are the ones doing most of the agricultural work², their reduced time to go to the fields because they are taking care of the sick means reduced work in the fields and hence reduced production. In the sample, two-thirds of the households were female headed households (Table 5). This is a mirror image of the situation in the general population (NSO, 2008). This reflects the fact that more HIV positive women disclose their status and join CBOs than HIV positive men as studies in

²Women account for some 60% of total agricultural output and about 70% of staple food production in Africa (Kabbaj, 2003).

Malawi have shown (Singleton et al, 2005, Singleton et al, 2006, Singleton et al, 2007). With regard to marital status, the majority of the male heads of households were married (78%) compared to the female heads where 43% were widowed, 35% were divorced or separated and only 15% were married.

Table 5: Marital status of household heads in percentage

	Sex of household heads		
	Male (n=27)	Female (n=54)	Total (N=81)
Single	3.7	7.4	6.2
Married	77.8	14.8	35.8
Separated/Divorced	3.7	35.2	24.7
Widowed	14.8	42.6	33.3

Source: Calculated from the household questionnaire data

Similarly, education is also an important aspect of the human capital in the livelihood framework (Ellis, 2000). Among the heads of the households, 29.6% had no formal education (39% of female heads and 17% of male heads), 64.2% had primary while 5.0 % had secondary and 1.2% had tertiary education.

4.2.4 Sources of Livelihoods

Table 6 shows the main sources of livelihood for the people in the area under study. Generally, farming is the main source of livelihood for 86% of the sample while 6% depends on micro businesses, 3% on farm *ganyu*, 4% off-farm *ganyu*, and 1% on remittances.

Table 6: Sources of livelihood

Sourceof livelihood	Frequency	Percent
Farming	70	86
Business (petty)	5	6
Ganyu (on-farm)	2	3
Ganyu (off-farm)	3	4
Remittances	1	1

Source: Calculated from the household questionnaire data

4.2.5 Ownership of Assets and Livestock

Assets (livestock, equipment or otherwise) that households posses assist in times of household distress such as food insecurity, chronic illness or other shocks through liquidation (selling) or pawning them with money or services. They are also used as proxy indicators of household wealth status in economic household studies. In the survey, the respondents were asked to state what assets and livestock their households possessed. Additionally, the households were also asked if these assets were sold because of HIV related expenses in the last 1 year.

Appendix 2 presents the overall ownership of the various assets and livestock. Generally, both livestock and asset ownership were found negligible. Only 3% of the households owned cattle while goat ownership was at 13% and chickens were owned by 43% of the households. While the household questionnaire did not inquire why the ownership was as low as it were, information gathered during FGDs and KIIs also confirm to this. It was revealed that livestock (mainly cattle) ownership was very low and this was largely attributed to the lack of land to graze the animals, labour and financial requirements as well as deteriorating security status (thefts). Livestock theft was reported to be on the

increase such that the risk attached to owning livestock outweighs the gains of doing so. Hence, low livestock ownership. The commonest assets that were captured are household utensils. Cooking pots are owned by (98%) of households, buckets (98%) and plates/bowls (96%). Hoes (for farming) were reported in 93% of the households. These results reveal that there is low ownership of livestock. This also explains further that the households in the area have low financial assets which could be used to purchase food and other needs.

4.2.6 Computation of livestock and asset indices

In order to compare different types and numbers of livestock that different households own, a common 'factor' for conversion into same units and this is called livestock unit or LU (www.fao.org/es/ess) was used. A livestock unit is generally a standardized 'animal units' obtained by multiplying total number of animals with a conversion factor that takes into account "feed requirements" for the animal. One cow in sub-Saharan Africa is assigned a LU of 0.5, 0.1 for sheep and/or goats, 0.2 for pigs, 0.5 for donkeys and 0.01 for poultry. Total household livestock unit is therefore an addition of various livestock units that it gets from each livestock owned.

Similarly, to compare numbers and different types of assets that households owned, the same exercise was adopted and asset units (AU) were thus derived. This section presents the findings on the livestock and asset ownership portfolio. Table 7 presents values for the various assets and livestock.

Table 7: Conversion factors for livestock and assets

Livestock	Coefficient	Livestock	Coefficient
Cattle	0.5	Poultry	0.01
Goat/sheep	0.1	Rabbit	0.02
Pig	0.2		
Asset	Coefficient	Asset	Coefficient
Hoe, axe	0.01	Treadle pump	0.6
Utensils	0.01	TV	0.5
Tilly lamp/ torch	0.03	Telephone	0.5
Bed	0.10	Sewing machine	0.6
Watch	0.08	Bicycle	0.6
Mobile phone	0.50	Motorbike	0.8
Sofa	0.40	Tractor	1.0
Radio	0.40	Plough	0.6
Mattress	0.10	Cart	0.6
Cane	0.01	Bee hive	0.07
Sickle	0.01		

Source: www.fao.org/es/ess

Table 8 shows livestock and asset ownership by sex of the household head and CBO type. As stated above, livestock ownership was generally very low. Up to half of the female headed households had no livestock at all (0 LU) while up to half of the male headed households owned a maximum of 0.02 LU. Up to three quarters of the female headed households owned 0.05 LU or less (0.1 LU among male headed households).

With regard to assets, up to a quarter of the female headed households possessed 0.1 asset units (AU) or less and 0.72 AU or less among male headed households. Generally, both livestock and asset ownership was higher among male headed households compared with female households.

Table 8: Livestock and asset ownership status by sex of head and CBO type

		Percentiles						
Sex of head		5	10	25	50	75	90	95
Livestock ownership	Female	0.00	0.00	0.00	0.00	0.05	0.27	0.46
	Male	0.00	0.00	0.00	0.02	0.10	0.45	0.83
Asset ownership	Female	0.03	0.06	0.10	0.17	0.58	1.29	1.91
	Male	0.15	0.25	0.72	0.89	1.68	3.03	3.85
CBO receives external support?								
Livestock ownership	No	0.00	0.00	0.00	0.01	0.09	0.40	0.43
	Yes	0.00	0.00	0.00	0.01	0.09	0.34	0.73
Asset ownership	No	0.02	0.06	0.09	0.17	0.75	0.98	1.69
	Yes	0.04	0.09	0.15	0.59	1.34	2.34	3.07

Source: Calculated from the household questionnaire data using conversion factors for livestock and assets

Comparing households whose CBOs receive external support and those whose CBOs do not receive any support, the findings were generally similar for livestock ownership in the sense that there were not much differences in the ownership at almost every percentile. However, households whose CBOs receive external support had more assets units at every percentile compared to their counterparts. This indicates that the households from the CBOs that received external support were better off as compared to their counterparts in terms of asset ownership while they are not different as regards livestock ownership.

4.2.7 Composite Asset-Livestock Index (CALI)

LU and AU for each household were added up to derive a composite asset-livestock index (CALI) for each household. This gives the overall ownership of livestock and assets. Table 9 provides the overall ownership of assets and livestock. The findings on this showed that male headed households had more than three times CALI than female headed households at every percentile. Similarly, households from CBOs with external

support had more than two times CALI at every percentile than their counterparts. These findings imply higher asset-livestock portfolio among male headed households than female headed households and among households whose CBO had external support than their counterparts.

Table 9: Overall ownership status of assets and livestock (as assessed using a composite asset-livestock index-CALI)

		Percentiles						
Sex of head		5	10	25	50	75	90	95
Asset based index	Female	0.0275	0.055	0.1175	0.255	0.70	1.410	1.985
	Male	0.1500	0.256	0.8000	1.170	2.02	3.286	4.244
CBO receives external support?								
Asset based index	No	0.02	0.06	0.11	0.27	0.765	1.38	1.765
	Yes	0.043	0.093	0.17	0.7	1.3825	2.375	4.2215

Source: Calculated from the household questionnaire data

4.2.8 Sales of livestock and assets for HIV-related expenses

Table 10 shows the proportion of LU, AU and CALI that were sold because of HIV related expenses by the households in the last 1 year. Female headed households on average sold 35.6% of their livestock units while male headed households sold 40% because of HIV-related illnesses. On asset units, male headed households on average sold 13.8% of their AU compared to 17.5% among female headed households. Generally, the average sales of LU, AU and CALI were not significantly different ($p>0.05$) between male and female headed households. However, the sales of livestock are more than two times the sales of assets in both FHH and MHH. For example, FHH on average sold 35.6% of LU compared to 13.8% of AU. In MHH, 40% of LU was sold compared to 17.5% of AU.

Table 10: Sales of livestock and assets for HIV-related expenses (% of LU, AU and CALI sold for HIV and AIDS)

Sex of head of household		% LU sold	% AU sold	% CALI sold
Female	N	31	54	54
	Mean	35.55	13.84	18.05
Male	N	18	27	27
	Mean	39.98	17.45	20.15
Total	N	49	81	81
	Mean	37.18	15.04	18.75
	p-value	0.706	0.585	0.75
Does CBO receive external support?		% LU sold	% AU sold	% CALI sold
No	N	20	29	29
	Mean	46.81	25.90	32.36
Yes	N	29	52	52
	Mean	30.54	8.99	11.16
Total	N	49	81	81
	Mean	37.18	15.04	18.75
	p-value	0.153	0.08	0.01

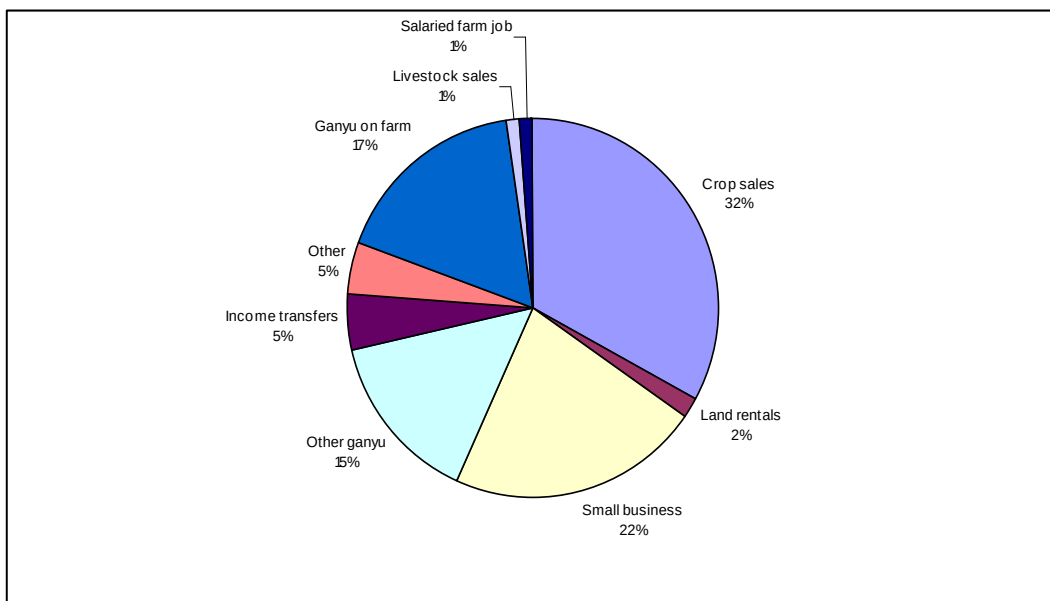
Source: Calculated from the household questionnaire data

The findings presented in Table 10 above also shows that the sales of LU were higher in the households from the CBOs that did not receive external support (46.8% versus 30.5% of their LU). But these sales were not statistically significant ($p > 0.05$). However, sales of AU were also statistically higher among households whose CBOs do not receive external support (25.9% of their AU) compared to households whose CBOs receive external support (9% of their AU) and these were also not significant. As was the case in the FHH and MHH where the sales of livestock are more than two times the sales of assets, the sales of LU are also more than two times higher than sales of AU in the CBOs that received external support. These assets and livestock were sold at lower prices than would have sold in normal circumstances.

4.2.9 Income sources

Respondents were asked to state all their sources of income (multiple responses were allowed). These were then consolidated and tallied against each household. Figure 3 shows the major sources of income of the households in the study. A third of the households depend on crop sales as their main source of income (32%), followed by running of small businesses (22%) and ganyu (on-farm 17%; off-farm 15%). This further explains the fact that agriculture is the main source of income and livelihood in the area. On average, households get K1,775.90 per month from their main sources but the average accumulates to K3,303.80 per month when all major sources of income are considered.

Figure 3: Main source of income



Source: Calculated from the household questionnaire data

4.2.10 Expenditure

The households were also asked to estimate how they spend their money on various households needs. Table 11 below shows the mean monthly expenditure of the

households. The larger part of the households expenses (56%) are on food, taking an average of K1,798.5 per month followed by health, education, transport and land with averages of K457.5, K396.9, K394.4, and K179.5 respectively. These expenditures on food are higher in the MHH than the FHH and also in CBOs that had no external funding. The greater expenses on food further explain that food is the ultimate goal of every human being as Tollens E. (undated) also observed.

4.2.11 Savings

As regards savings, only 7% of the households (n=9) reported that had a savings account of some sort. However six of the nine households (67%) reported that the account has been affected because of the disease in the house. Similar findings were also reported by Palamuleni et al (2003) that households with cash savings end up using all these savings in times of shock such as illness.

Table 11: Household Monthly Expenditures

Sex of Heads of households				
Item		Expenditure in FHH (MK)	Expenditure in MHH (MK)	Expenditure (MK)
Food	Mean	1607.0	2181.4	1798.5
	Median	1100.0	1200.0	
Education	Mean	374.4	430.0	396.9
	Median	200.0	300.0	
Land	Mean	0	179.5	179.5
	Median	0	179.5	
Transport	Mean	344.8	463.3	394.4
	Median	250.0	300.0	
Health	Mean	310.3	715.0	457.5
	Median	200.0	200.0	
CBO receives external support?				
Item		Yes	No	Expenditure (MK)
Food	Mean	1619.2	2120.0	1798.5
	Median	1125.0	1200.0	
Education	Mean	448.5	313.1	396.9
	Median	275.0	200.0	
Land	Mean	179.5	0	179.5
	Median	179.5	0	
Transport	Mean	297.3	542.9	394.4
	Median	245.0	300.0	
Health	Mean	456.3	458.8	457.5
	Median	250.0	200.0	

Source: Calculated from the household questionnaire data

4.3 Household land resource and use

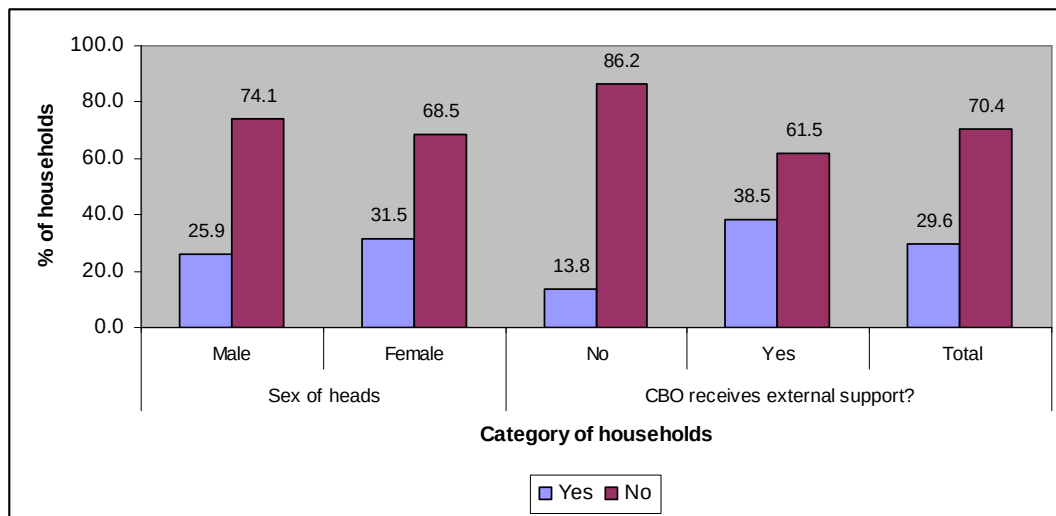
This section presents findings on landholdings and land utilization among the households that were surveyed. The data that was collected concerning landholding sizes, how households acquired their land, use of modern farming techniques and the proportion of land being put to use. Land resource and use are important in food production.

4.3.1 Land ownership status and use

The average landholding size was 0.94 hectares (ranging from 0.4 hectares to 3.64 hectares per household). Among male headed households, the average landholding size was 0.91 hectares (95% CI: 0.57 to 1.08) and was not significantly lower than among female headed households whose mean was 1 hectare (95% CI: 0.69 to 1.32) with half (median) of both male and female headed households possessing 0.81 hectares or less.

As regard the use, in approximately a third (30%) of the households, respondents said they were able to cultivate all their land after some members of their household became affected by HIV and AIDS. Comparing the MHH and FHH, 26% of the MHH as compared to 32% of the FHH are able to cultivate all their land. Similarly, 14% of the households from the CBOs that did not receive external support and 39% of the households from the CBOs that received external support are able to cultivate their land. Figure 4 shows the details.

Figure 4: Proportion of households reporting not using all their landholdings because of HIV and AIDS



Source: Calculated from the household questionnaire data

On average, households that had labour problems (N=57) reported cultivating only 81% of their available land with 19% being left to fallow. In FHH, they were cultivating 81% of their landholdings while among MHH 81.5% of their landholdings were being put to use. The land use were 82% and 80% among households whose CBOs had external support and those whose CBOs had no support, respectively.

FGDs and KIIs also focused on how HIV and AIDS had affected their communities and households. These reveal that, the sickness or death of an adult result in the inability of the household to cultivate all the land at its disposal. This is because attending to the sick takes a considerable amount of time, which then becomes no longer available for agriculture. However, the people are not willing to help the households as they are also busy working in their fields and it is not common for the people in the area to go and help

these people. Similarly, the CBOs do not assist these households. Thus fields are left fallow and the total output of the agricultural unit consequently declines.

4.3.2 Land acquisition and use of modern farming methods

Land in the study area is largely acquired through subdivision from family (51%) or through inheritance (21%) and from chiefs (18%). Leasehold (6%), renting (3.4%) and informal purchase (6.8%) are not common. Though fields are left to fallow because of failure to cultivate all the land, people do not rent out their land due to fear of losing the land.

Proper use and management of land help to improve productivity of the land. During the survey some data was collected regarding use of ridging, use of fertilizer, irrigation and use of hybrid seed. While soil fertility problems can be addressed using a number of interventions including purchase/use of inorganic and organic fertilizers, the study found that a good number of households in the area are unable to use fertilizer or manure. Fertilizer was used only on 62% of the plots (minda) that households cultivated in the season before the survey, manure was applied on 8% and a combination of both fertilizer and manure on 5%; fertilizer or manure were applied on a quarter of the plots. With regard to type of manure, mainly the people used livestock manure (84%) and 16% used compost manure. According to FGDs and KIIs, people fail to buy fertilizer because of lack of cash as the commodity is expensive. Additionally, it was revealed that most of the households did not benefit from the fertilizer subsidy programme. There is also a problem of lack of extension services on good agricultural practices like how to make

compost manure. Only 3% indicated that they practice crop rotation and this is largely due to limited landholdings.

Extensification may be defined as a situation where farmers diversify their livelihood portfolio and in many cases this involves cultivating a variety of crops either at the same time or in sequence, rearing a variety of livestock and practicing many other productivity and food security enhancing practices (Ellis, 2000). On average three crops are planted on one plot of land with maize being grown on almost all the plots although use of local varieties was found higher (53%). Maize was also reported to be mixed with other crops like cassava, pulses, groundnuts sweet potatoes and other crops. Cassava and pulses are the secondary crops that are grown in the area after maize. Table 12 below shows the types of crop stand on plot with mixed cropping being the commonly used crop stand. However, 30% of the respondents did not make ridges.

Table 12: Type of crop stand on plot

Crop stand	Frequency	Percent
Mono-cropping	27	15
Inter-cropping	28	16
Mixed cropping	112	63
Mixed farming	10	6

Source: Calculated from the household questionnaire data

The main source of the household inputs used by the households was own purchasing (36%) followed by the government (28%) through the input subsidy programme. However, it was revealed that most of the people do not benefit from the programme as they are being discriminated against because of their status. Other sources are self storage

(16%), NGOs (1%), relatives (18%) and through loans (1%). CBOs are not sources of inputs by the households.

4.4 Food security and food consumption patterns

This section presents findings on the food security situation of the households in the sample as extrapolated from findings on reported length that household own production takes before being exhausted or depleted (self-sufficiency) and how they solicit their food after running out of own stocks. According to the nutritional status conceptual framework, household food security resources comprise of quantity of food produced, diet diversity, cash income as well as food transfers (GoM and World Bank, 2007), hence food self-sufficiency is defined as the ability of a household to adequately feed from its own maize production (quantity of food produced through own production). A household is therefore not maize self-sufficient if it runs out of its own maize stocks before the next harvest and is therefore also food insecure.

The respondents were first asked questions about food production in a normal year (without long-term illness before the HIV problem was diagnosed) and then secondly, food production status after they started experiencing the current illness or death in their households. In this context, food crop was defined as maize because it is the main staple food in Malawi. Food consumption patterns across the year are a proxy indicator of households' food security. On this, the respondents were asked about their food consumption patterns in the last 12 months and the previous week. In addition, the

respondents were also asked about constraints or challenges that their households were facing with regard to food crop production.

4.4.1 Food Self-sufficiency

Table 13 shows the proportion of households reporting achieving food self sufficiency both in a normal year and after the HIV infection. Half of the respondents reported achieving household food self-sufficiency in a normal year, slightly higher among male headed households (55.6%) compared to female headed household (44.4%). Referring to the CBO type, 48.1% of the households whose CBOs received external support reported achieving household food self-sufficiency in a normal year compared to 48.3% of the households whose CBOs had no support. This was reported to drop by 39 percentage points, from 48.1% to as low as 8.6% since the HIV infection (mainly referring to the most recent season) in their households, 14.8% among male headed households, 5.6% among female headed households, 11.5% among the households whose CBOs received external support reported and 3.4% among the households whose CBOs had no support.

The significant drop in the proportion of households achieving food self-sufficiency could be a result of the fact that a majority of the households are unable to cultivate their land (70%, discussed above). The illness of self or the presence of the disease in the household makes it difficult for the household to do farming activities as normally would hence reduction in the outputs.

Table 13: Proportion of households reporting achieving food self-sufficiency before and after the HIV infection

	Normal Years			After Infection		
	Sex of Heads of households			Sex of Heads of households		
	Male (N=27)	Female (N=54)	Total (N=81)	Male (N=27)	Female (N=54)	Total (N=81)
Yes (self sufficient)	55.6	44.4	48.1	14.8	5.6	8.6
No (not self sufficient)	44.4	55.6	51.9	85.2	94.4	91.4
	CBO receives external support?			CBO receives external support?		
	Yes (N=52)	No (N=29)	Total (N=81)	Yes (N=52)	No (N=29)	Total (N=81)
Yes	48.1	48.3	48.1	11.5	3.4	8.6
No	51.9	51.7	51.9	88.5	96.6	91.4

Source: Calculated from the household questionnaire data

Households that reported not achieving food self-sufficiency were asked to state how many months (on average) it takes before they deplete their food produce (or how long it lasted in the most recent season). During analysis, households that achieve self-sufficiency were assumed to have 12 months of own stocks. On average before the infection was diagnosed, own food stocks lasted 8.8 months (median 10 months). This dropped to 5.3 months, after the HIV infection (median 5 months).

A t-test was conducted to see if there were differences in the average length that own food lasted before and after the HIV infection in months. The mean difference of months with own food stocks between a normal year before the HIV problem and after the HIV

infection was 3.52 months (95% CI: 2.83 to 4.21 months) implying that food production after the HIV infection had been reduced by 3.52 months on average but the true population difference (if all HIV affected households were included in the survey) would be between 2.83 months to 4.21 months and this difference was found to be statistically significant ($p < 0.05$). Table 14 below shows the details.

Table 14: Results of t-test on mean differences of length with own food stocks before and after the HIV infection

				95% Confidence Interval (CI)				
	Mean	Std. Deviation	Std. Error Mean	Upper	Lower	t	Df	Sig. (2-tailed)
Before – After	3.52	3.13	0.35	2.83	4.21	10.10	80.00	0.00

Source: Calculated from the household questionnaire data

Comparing male and female headed households with reference to Table 15, in a normal year before HIV was diagnosed, male headed households had an average of 9.7 months (median 12 months) compared to 8.4 months among female headed households (median 7.5 months). After the HIV infection, male headed households reported an average of 5.7 months of self-sufficiency (median 5.0 months) compared to 5.1 months among female headed households (median 5.0 months). However, these findings in the food sufficiency months both in the normal years and after the infection, were not significantly different ($p > 0.05$).

Similarly, comparing the CBO type, in households whose CBOs had external funding had an average of 8.9 months (median 9.5 months) while households from the CBOs which had no external funding had 8.7 months (median 10.0 months) in a normal year. The period dropped to 5.4 months (median 5.0 months) and 5.1 months (median 5.0 months) after the infection among households from the CBOs which had external and no external funding respectively. However, each category i.e. Male headed and female headed households, households whose CBOs had external funding and households from the CBOs which had no external funding, experienced significant drops in average months of self sufficiency.

Table 15: Months (average) of food self-sufficiency in the households

		Normal Years	With HIV
Male	Mean	9.7	5.7
	Median	12.0	5.0
Female	Mean	8.4	5.1
	Median	7.5	5.0
CBO with external support	Mean	8.9	5.4
	Median	9.5	5.0
CBO without external support	Mean	8.7	5.1
	Median	10,0	5.0
Total	Mean	8.8	5.3
	Median	10.0	5.0

Source: Calculated from the household questionnaire data

It is also worth noting that food security is considered synonymous with being ‘well-off’. The concepts of food security were beyond just availability, or affordability and/or

entitlement to food. Box 1 shows a detailed summary of the characteristics of food secure and food insecure households as provided by the FGD participants.

Generally, a household is perceived food secure if it has enough '*maize*' (called food-*chakudya*) for the whole household throughout the year and it should be able to sell some of the food, eat three times a day and have health children. Such households were said to have good crops since their gardens are well cared for and they use fertilizer. Additionally the households lead a very happy life, they are able to employ others to work on their gardens and own a good number of assets.

Comparatively, food insecure households are said to be those who start using maize from own production while green (*chitibu*) and the stock would last 2-3 months after harvest. By the time the study was being conducted (June/July) these food insecure households were said to have already started buying maize. These households usually take one meal in a day, they experience ill health quite often, have no assets, have difficulties to cultivate crops (*amalima movutika*) and spend most of their time begging or doing *ganyu*.

Box 1: The categorization of households in terms of food security by FGDs

(1) Food secure households

Have enough food for the whole year and sell some
Eat three times a day
Have health children
Good crops (their gardens are well cared for)
Use fertilizer in their gardens
Have a very happy life
Are able to employ others to work on their gardens
Own a good number of assets

(2) A bit food secure

Have just enough food (would buy for may be 3-4 months)
Eat two to three times a day
Have healthy children but with little indications of lacking something
Use fertilizer in their gardens though “moperewera”
Have some assets

(3) Food insecure households

Start eating maize while green (*chitibu*)
Have food for 2-3 months after harvest
Have already started buying maize by the time of the study
Eat once a day
Have ill health
Have no assets
Amalima movutika
Spend most of their time begging
(Most of the HIV and AIDS affected households were said to be in this group and these household sell their assets or deplete their savings in order to search for food for the sick).

4.4.2 Food Consumption Patterns

Food consumption patterns are used to approximate the food security situation status of the people. In the survey, the respondents were asked to indicate the time (period) when they started eating maize from their garden in the most recent season, a question to which 67.9% said they started eating maize while green (*chitibu*) in the fields, an indication that

they had run out of food stocks from the last season long enough to wait for the current maize stand to dry properly for harvesting. The proportions were 65.5% among households from CBOs that don't receive any external support (n=29) and 69.2% among households whose CBOs received external support.

Respondents were asked to remember if in the last 12 months (asked as last year) their household never ate one meal in a day because there was no food in the home. They were also asked if a similar situation had happened in the last one week (last 7 days) or whether they ate a substitute food because their regular staple was not available in the home or whether they ate nothing the whole day. The findings of this are presented in Table 16. About sixty two percent (61.7%) of the households indicated that they had a day last year when their household did not eat anything the whole day because their household had no food. Chi-square tests showed non-significant differences in the observed proportions of male headed and female headed households that had no meals in the last year ($p>0.05$) but such differences were observed among the households in the CBOs that do not receive external support (75.9%) and those households from CBOs that do (53.8%).

Meal consumption patterns in the last 7 days were not significantly different between male headed and female-headed households and between households in CBOs that receive external support and those households belonging to CBOs that do not.

Table 16: Proportion of households reporting taking one meal in a day because there was no food in the household

	Sex of household heads		CBO receives external support?		Total (N=81)
	Male (n=27)	Female (n=54)	No (n=29)	Yes (n=52)	
Last year	59.3	63.0	75.9	53.8	61.7
Last 7 Days					
Only had one meal	70.4	75.9	86.2	67.3	74.1
Ate nothing at all	37.0	40.7	34.5	42.3	39.5
Ate substitute food only	63.0	59.3	65.5	57.7	60.5

Source: Calculated from the household questionnaire data

4.4.3 Meal frequency

Regular consumption of (nutritious) food is important for the body defense mechanisms of people living with HIV, just like any other sick people. For people with HIV or those on TB treatment (or with both), adherence to treatment has been shown to decline during period of food shortage (Chirwa et al, 2006; Kadzandira, 2003) because the treatment makes their bodies weaker if taken without proper food consumption. Information that was collected pertaining to meal frequency and consumption of certain selected foods which may only give a proxy picture of the nutritional uptake of the PLHA in the survey.

In Malawi, regular and normal meal frequency is at least three meals in a day comprising breakfast usually taken early in the morning before starting off to work (sometimes taken in late morning), lunch taken at mid day (or thereabouts) and supper taken just before going to bed/sleep. Table 17 shows the meal frequency among the households in the survey. Half of the households normally eat two meals in a day (51.9%) and an almost equal proportion eats three meals in a day (45.7%). Comparing male headed and female-

headed households, the findings showed more male-headed households eating two meals in a day (63%) compared to 46.3% of the female-headed households. Households belonging to CBOs that receive external support registered a higher (but non-significant) proportion that eats three meals in a day (48.1%) compared to those in CBOs that do not receive any external support (41.4%).

Table 17: Meal consumption frequency

	Sex of heads of households		CBO receives external support?		Total (N=81)
	Male (n=27)	Female (n=54)	No (n=29)	Yes (n=52)	
One	0.0	3.7	3.4	1.9	2.5
Two	63.0	46.3	55.2	50.0	51.9
Three	37.0	50.0	41.4	48.1	45.7

Source: Calculated from the household questionnaire data

The findings presented above show that only about half of the households normally eat three meals in a day. The respondents who said their households do not eat three meals in a day were asked to state which meals they usually eat in any given day. The findings on this are presented in Table 18. As the findings illustrate, lunch and supper are the commonest meals (50.6%). No major differences were observed between male headed and female-headed households or between household belonging to CBOs that receive external support or not.

Table 18: Combination of meals normally taken in any given day

	Sex of heads of households		CBO receives external support?		
	Male (n=27)	Female (n=54)	No (n=29)	Yes (n=52)	Total (N=81)
Breakfast and supper	3.7	1.9	0.0	3.8	2.5
Lunch and supper	59.3	46.3	55.2	48.1	50.6
Lunch only	0.0	1.9	3.4	0.0	1.2
Breakfast, lunch and supper	37.0	50.0	41.4	48.1	45.7

Source: Calculated from the household questionnaire data

The question about snack/or fruit consumption by the PLHA in the household was also asked and snack/fruit was defined as any food taken not as a main meal (breakfast, lunch or supper) whether in the home or outside. Table 19 shows the patterns in consumption of snacks or fruits among the households in the survey. Fruit consumption was generally very low at 56.8% and was twice as low in households whose CBOs received no external support (86.2% reported not eating any fruits or snack compared to 40.4% in households whose CBOs received external support).

Table 19: Frequency of eating fruits and snacks

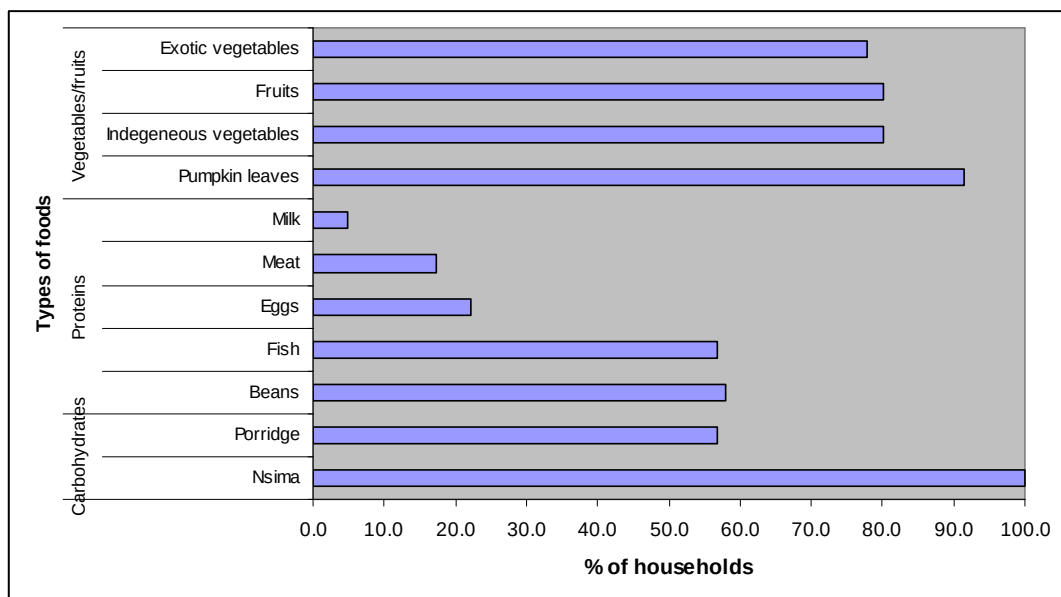
	Sex of heads of households		CBO receives external support?		
Frequency Per day	Male (n=27)	Female (n=54)	No (n=29)	Yes (n=52)	Total (N=81)
None at all	63.0	53.7	86.2	40.4	56.8
One	22.2	33.3	13.8	38.5	29.6
Two	7.4	7.4	0.0	11.5	7.4
Three	0.0	3.7	0.0	3.8	2.5
More than 3	7.4	1.9	0.0	5.8	3.7

Source: Calculated from the household questionnaire data

4.4.4 Consumption of selected foods in last 7 days

Nsima is by far the most consumed food in the households that were sampled and this is not very surprising considering that maize is the main staple in the whole country. It was eaten in all the households at least once in the last 7 days (Figure 5). Generally, nsima is eaten together with some relish which could be meat, eggs, fish or vegetables. The findings of the study show high consumption of vegetables (in general) in the last 7 days (>80%) compared with animal proteins (<25%) except fish and beans which were reported in ~60% of the households. The high consumption of fish could be attributed to proximity to Lake Chilwa but also generally, consumption of fish in Malawi is higher than meat mainly due to cost and availability.

Figure 5: Consumption of certain selected foods



The findings presented in Figure 5 show that the balance is tilted towards carbohydrates (Nshima/porridge) and vitamins (vegetables/fruits) but not much towards proteins. This would be an area requiring further research. However, this seems to concur with GoM and World Bank (2007) who observed that the Malawian diet is dominated by cereals in this case maize. This also further explains the over reliance on the single crop by the people.

4.5. Sources of food after exhausting own stocks

Respondents from households that do not harvest enough food to last them into the next harvesting period were asked to state where or how they obtain their food before reaching the next harvest. The respondents were allowed to mention several sources or ways of obtaining food. Table 20 shows common sources or strategies that were mentioned. The commonest source that was mentioned is purchasing from the local market (79%) followed by ganyu for cash or food (59.3%). Reliance on remittances was reported by 25.9% of the respondents, 9.9% from CBOs and 3.7% from government or NGOs. The findings presented in Table 20 point out the minimal reliance on ADMARC as a source of food when household exhaust their stocks.

Table 20: Sources of food after production stocks

	Male	Female	Total
Local markets/vendors	81.5	77.8	79.0
Ganyu	55.6	61.1	59.3
Food transfers (Relatives)	18.5	29.6	25.9
Begging	14.8	25.9	22.2
ADMARC	11.1	24.1	19.8
Food Transfers (CBOs)	3.7	13.0	9.9
Credit from money lenders	0.0	7.4	4.9
Food Transfers (Government/NGOs)	0.0	5.6	3.7
Other	0.0	3.7	2.5

Source: Calculated from the household questionnaire data

The results shown on table 20 also concur with that from FGDs. According to these participants, ganyu for food or cash and thereafter purchasing from the local markets were the commonest sources of food. Ganyu was said to be common because they are unable to undertake income generating activities (IGAs) due to capital constraints:

“We rely on ganyu as we can not even carry out IGAs as you know we are poor and have no money to do business. All the money that we get from ganyu is spent on buying food from the local market, Jali” (Male PLHA, Lomoni CBO, Zomba)”

Some authors have however argued that although ganyu is seen as a viable coping strategy by many poor people, ganyu deprives the household time and labour for their farming and other productive activities (Kadzandira et al, 2005) and keeps the families to cope in a short term since it will provide only a plate of flour for a day’s labour. This is because of poor cash wage for ganyu in Malawi especially during months when people

are desperate for food. Additionally, it was revealed that some women and girls indulge in transactional sex, either for cash or for food, thereby spreading the infection even further.

4.6 Constraints to increased food production and agricultural productivity

Various constraints to improved food production and agricultural productivity (in general) were cited by the respondents to the household questionnaire. Illnesses dominated the list (63%), lack of agricultural implements (61.7%), lack of agricultural inputs or inputs markets (48.1%), labour shortages (45.7%), limited access to land (27%) and the associated costs of procuring the inputs (25.9%). Table 21 provides the whole details.

Lack of extension services, low produce prices and poverty were discussed at length in the study as also affecting agricultural production. In one FGD participants talked of having seen an extension worker four years ago. In other instances the extension worker was criticized for working with the ‘well-to-do’ farmers only and according to the participant who talked on this,

“the extension worker likes visiting rich farmers who by the end of the day prepare gifts or allowances for them” (Female Community member, CAPA, Zomba).

One Key informant said that:

“the extension officers say that they are always busy because there are a few of them. They only visit where there are funded programmes like the European Union (EU). They told us that if people ask us whether we

*together with them or not we should be saying that we work with them”-
(Key informant, DAO CBO, Zomba, during pilot study).*

Table 21: Factors affecting agricultural productivity

	Male (n=27)	Female (n=54)	Total (N=81)
Illness	55.6	66.7	63.0
Lack of agricultural implements	48.1	68.5	61.7
Lack of agricultural input markets	48.1	48.1	48.1
Labour shortages	48.1	44.4	45.7
Limited landholdings	14.8	33.3	27.2
Increase in costs of inputs	22.2	27.8	25.9
Livestock diseases and pests	3.7	16.7	12.3
Lack of extension services	14.8	9.3	11.1
Lack of credit	3.7	9.3	7.4
Poor crop prices	3.7	5.6	4.9
Lack of produce markets	0.0	1.9	1.2

Source: Calculated from the household questionnaire data

The list of constraints discussed by the participants both at household level and in FGDs would be categorized into human capital (illnesses and labour shortage), physical capital, financial capital as well as natural capital. Illnesses and labour shortages reflect the aspects of human capital in the livelihood platform. According to SLA principles human capital in form of skills and knowledge, ability to labour and good health constitute human capital which is a vital asset in the realization of livelihood strategies (FAO, 2007). HIV and AIDS afflicted persons have ill health hence unproductive human capital. It was revealed in the FGDs and KIIs that because they are often sickly and do not go in the fields most of the times.

On the other hand, they are not allowed by relatives and friends to do heavy work because of their status, as a result their work capacity has been reduced and hence they produce little food. However, the relative are also not willing to help as they are said to

be busy in their fields. This is in line with what Palamuleni et al (2003) found that HIV and AIDS affects household food security through its effects on human capital that due to the illnesses and care that is provided, farming and other productive activities are withdrawn. Because of chronic illnesses and the consequent loss of labour and skills of the person who is sick and the caretakers and also through the diversion of the available income to treatment and care of the sick family members, food production is affected and this leads to food insecurity. This declining productivity, in turn, leads to declines in household income through decreases in the household's own production as well as decrease in off farm income. This is because people in this area, which is rural, depend on sale of crops as their main source of income.

Ellis (2000) states that the natural capital is enhanced when it is brought under human control that increases its productivity. However, loss of labour and skills in the affected households is rendering land unproductive either through failure to cultivate or failing to undertake good farming methods. Additionally, the lack of income in the household (as savings are depleted, assets sold to cater for the HIV and AIDS demands) will also make the households lack agricultural implements and lack of agricultural inputs.

4.7 Experiences with long-term illness and death of household members

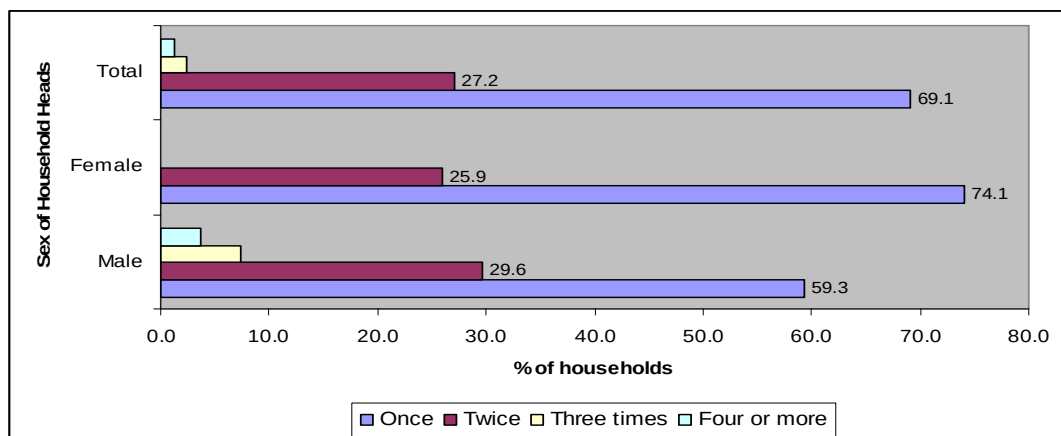
This section provides findings on the experiences of the households with HIV-related long-term illness and/or deaths in the last 5 years in terms of the impact that these illnesses and/or deaths brought on their households. The section also discusses the main

external support that the households received, sources of the various support and how they adjusted (or have adjusted) to the illnesses or deaths.

4.7.1 Number of HIV-related illnesses and deaths experienced in the last five years

Respondents were asked to state the number of times they have been faced with a long term illness or death that could be related to HIV and AIDS in the last 5 years. Figure 6 provides the detail on how the households experienced the problem in the last five year. The results show that a majority of the households experienced a long term illness or death that could be related to HIV and AIDS once (69%). While 27%, 3% and 1% were experiencing it for the second, third and seventh time respectively. Female headed households had more one episode of experience (74%) compared to male headed households (59%), who, on the other hand had more episodes on average, 30% two episodes, ~8% three episodes and 5% four or more episodes.

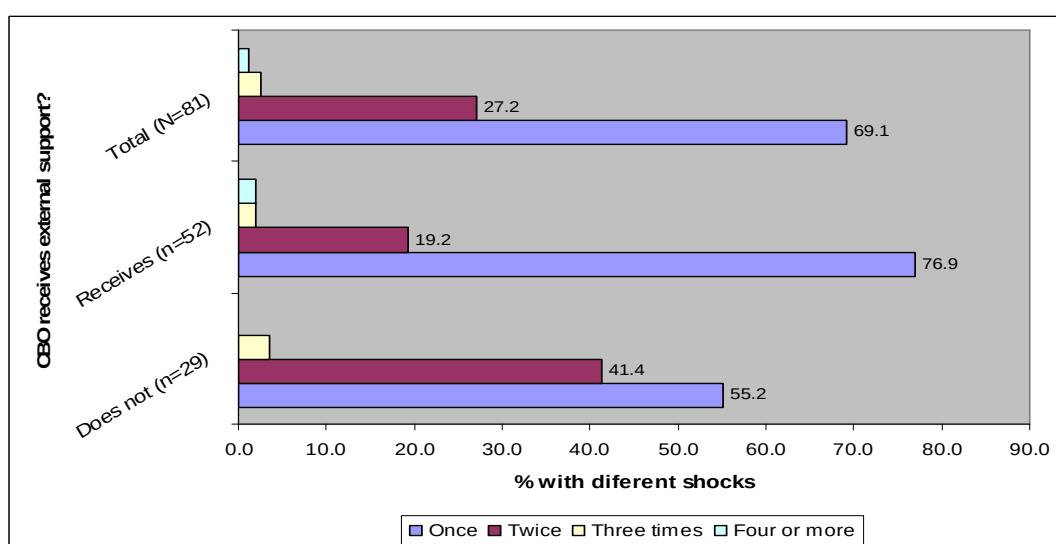
Figure 6: Number of HIV-related illnesses and deaths experienced in the last five years disaggregated by sex of the heads of households



Source: Calculated from the household questionnaire data

Comparing the households from the CBOs that received external support and the households whose CBOs did not receive external support, as provided in Figure 7, it shows that three quarters (76.9%) of the households whose CBOs receive external support had one episode of either death or illness compared to 55% of the households whose CBOs did not receive external support,. The differences were not significant between the two groups of CBOs when it comes to 2 or fewer experiences.

Figure 7: Number of HIV-related illnesses and deaths experienced in last 5 years disaggregated by whether their CBO receives external support or not



Source: Calculated from the household questionnaire data

4.7.2 Impacts of the deaths and/or illness on the household

The respondents were also asked about what would be the impact of death or long term illness in their households. The following table is showing what the respondents said are the impacts of death of a member of the household and long term illness in the households.

Table 22: The Impact of death and Long term illness

Impacts	Death		Long-term illness	
	N	%	n	%
Loss of labour	9	19.2	20	25.6
Time & other resources	8	17.0	14	17.0
Loss of financial support	24	51.1	38	48.7
Psychological effect	6	12.8	6	8.0

Source: Calculated from the household questionnaire data

The results show that the households experienced loss of financial support both in the households that have experienced death of their member(s) and have nursed/is nursing a member suffering from HIV and AIDS (51%) and in the households with a member suffering from long term illness (48.72%). The households may have to sell most of their household assets before the death of the patient and on the other hand the death itself carries high costs. This further explains that the breadwinners of the households are the ones that are dying or falling ill. This loss of financial support is followed by loss of labour, loss of time and resources and psychological effect.

As HIV and AIDS related illnesses are blamed to be the main cause of deaths among the prime and economically active persons in the community, there are also aspects of culture that affect production. Whenever there is death in the community, family members and other relatives as well as community members are socially and culturally expected to suspend all their activities like farming and assist the bereaved family as they are burying the dead relative. Although FGD participants were aware of the problems with these cultural obligations, they also said they had very little to do because society expects them to follow the norms.

4.7.3 Main external support received during illnesses or deaths in last 5 years

Table 23 shows the various supports that the households received in their last long term illness (present) and death due to HIV and AIDS. The households mostly received counseling from the community members (34.6%) while 14.8% received external support from the CBOs, 12.3% received support to start small businesses and 12.3% were offered ganyu.

Table 23: Main type of support that households received during illness/deaths in last 5 years

	Sex of heads of Households		Does CBO receive external support?		Total (N=81)
	Male (n=27)	Female (n=54)	No (n=29)	Yes (n=52)	
Received counseling	33.3	35.2	41.4	30.8	34.6
Support from CBO	7.4	18.5	17.2	13.5	14.8
Small business	14.8	11.1	20.7	7.7	12.3
Ganyu	14.8	11.1	3.4	17.3	12.3
Sold assets	11.1	7.4	6.9	9.6	8.6
Support from Govt/NGO	7.4	7.4	3.4	9.6	7.4
Support from relative	3.7	1.9	3.4	1.9	2.5
Sale of crops	0.0	3.7	3.4	1.9	2.5
Other	7.4	3.7	0.0	7.7	4.9

Source: Calculated from the household questionnaire data

Table 23 also shows that households whose CBOs did not receive external support mostly received counseling (41%) while 17% got support from CBO and 21% runs small business as compared to their counterparts which had 31%,14% and 8% respectively. Thus the households from the CBOs that had external support mostly received counseling

(31%), had to look for ganyu (17%) and also got support from the CBOs (14%). However, the most common support available in the area is counseling. This further explains the fact that the household do not rely much on the CBOs on food security related issues.

It was also further revealed in FGD that extended family members as well as other people in the community are generally willing to help but most are failing to do so because of their problems as well because a lot of people in the villages are poor. This further explains the fact that support from relative was rated lowly in table 23. Hence low social capital.

4.7.4 Proportion of households currently receiving nutritional support because of HIV infected member in the household

Approximately a third (29.6%) of the households stated that they were receiving nutritional support because of the chronically ill individuals in their households at the time of the study, 40.7% among female-headed households and 7% among male-headed households. Just over one-fifth (23%) of the households from the CBOs that receive external support were also receiving nutritional support compared to 41% of the household from the CBOs that did not receive external support. Details are in Table 24.

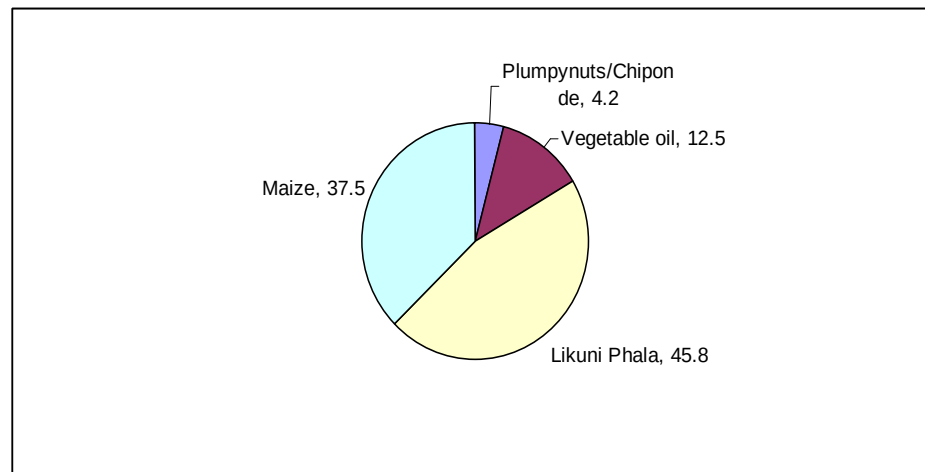
Table 24: Proportion of households currently receiving nutritional support because of HIV infected member in the household

	Sex of head of household		CBO receives external support?		Total
	Male	Female	No	Yes	
Yes	7.4	40.7	41.4	23.1	29.6
No	92.6	59.3	58.6	76.9	70.4

Source: Calculated from the household questionnaire data

Figure 8 shows the types of nutritional support which the households were receiving and these included: Plumpynuts/Chiponde, Vegetable oil, Likuni Phala and Maize. The majority of the households receive Likuni Phala (45.8%) followed by maize (37.5%).

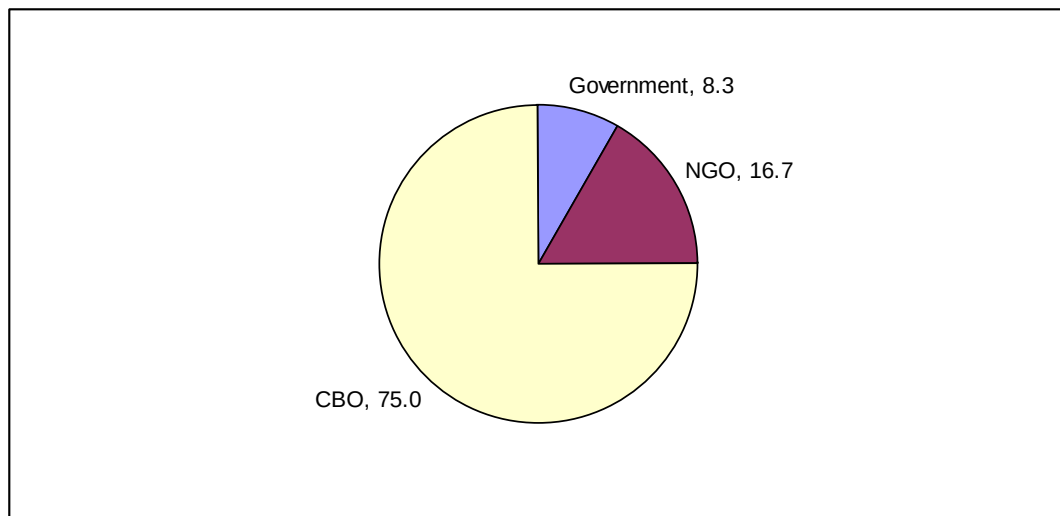
Figure 8: Type of nutritional support currently being received because of HIV infected member



Source: Calculated from the household questionnaire data

Results also show that the CBOs provide most of the nutritional support (75%) followed by Government (17%) and NGOs (8%) (figure 9). However, the CBOs get the food from other organisations like Red Cross, DAPP, Dignitus International etc, government as well as from community contributions. The government through the NAC provides the CBOs with funds which are then used to buy food. This is why the CBOs are seen as the major source of nutritional support. For those CBOs who have not accessed funds from NAC, the community members contribute to the CBOs.

Figure 9: Source of nutritional support currently being received to care for HIV infected member



Source: Calculated from the household questionnaire data

4.7.5 Household adjustment and coping with long term illness and death of relative in last five years

In order to cope with the long term illness or the death of a household member the households use a number of strategies, both adaptive and coping. Table 25 presents the different coping mechanisms that the households in the survey use. The most common adjustment is reducing the size of land cultivated for both household that have a person suffering from HIV and AIDS and those whose relation has died of the diseases (26.6% and 30.4% respectively). The reduction of the land being cultivated is due to the fact that the households lack finances to buy farm inputs like fertilizer or experiences labour shortages both due to the fact that they can not afford hiring labour because of lack of money and that other member(s) that would have been part of labour are sick or caring for the sick. On the other hand it also happens that the person who was the breadwinner has died and hence the household has no finances. Households which have a sick person

also rely on the CBOs more, as compared to the ones whose patients have died. This further explains that the CBOs mainly help the households that are nursing the sick as compared to the households whose member has died.

Table 25: Coping with Long term illness and death of relative

Coping Strategy	Deaths		Long-term illness	
	N	%	N	%
Rely on community support	4	8.7	11	13.9
Rely on CBO support	6	13.0	18	22.8
Rely on Govt/NGO support	4	8.7	2	2.5
Credit from money lenders	1	2.2	5	6.3
Withdraw children from school	6	13.0	5	6.3
Reduced size of land cultivated	14	30.4	21	26.6
Starting growing labour saving crops	3	6.5	1	1.3
Reduced number of meals in a day	8	17.4	13	16.5
Sell assets	0	0	2	2.5
Support from relatives	0	0	1	1.3

Source: Calculated from the household questionnaire data

4.8 Social protection programmes by non-governmental organisations and international organisations

4.8.1 Overview: Non-Governmental organisations and international organisations

In the area where the study was conducted a number of non-governmental organisations (NGOs) operate (or were operating but have ceased their operations). Through discussions with key informants (CBO groups) and participants to focus group discussions, 13 NGOs were identified namely: (i) Malawi Red Cross, (ii) Development Aid from People to People (DAPP), (iii) Malawi AIDS Counseling and Resource

Organisation (MACRO), (iv) the Hunger Project, (v) World Vision, (vi) World Food Programme (WFP), (vii) National Initiative for Civic Education (NICE), (viii) Malawi Social Action Fund (MASAF), (ix) Zomba Action Project (x) Dignitas International, (xi) the Catholic Development Commission (CADECOM), (xii) European Union (EU) and (xiii) Orphan Support Africa (OSA). These different organisations including the government are undertaking different programmes so as to help the poor and vulnerable households such as those affected by the HIV and AIDS, the elderly and households taking care of orphans.

4.8.2 Overall assessment of the various programmes

Types of support being provided varied from NGO to NGO but most were into food security, food relief, and HIV testing and counseling and development programmes. All the 13 NGOs passed the timeliness of the interventions because people were in need of the support but none performed well on the frequency because the support was reportedly erratic and unreliable. On adequacy of the support, only three organizations performed well. The rest were vied to be poor because they only targeted the person who was sick or the orphan/elderly in the household while excluding other members and the rations were for less than 1 week. All performed poorly on distribution points as these were far from the intended beneficiaries.

According to the various discussions on the selection of beneficiaries (inclusion and exclusion), the targeting criteria that are followed by the identified NGOs were said to be good. All the NGOs had consultations with the chiefs and the community members in

order to come up with the list of their beneficiaries. However, there were still some reports of exclusion of some intended beneficiaries arising from infrequent updating of the lists. On the other hand there was also alleged inclusion of other people who were not targeted from other areas as well as from the targeted area a situation which made the actual 'would be' beneficiaries to miss out. The chiefs as well as the programme officers were also said to be selling some of the items.

In relation to the proximity to the beneficiaries, the distribution points were said to be a problem to the people. Most of the points were located at long distances. This made it difficult for some intended beneficiaries to access the support, for example, food. Those who had no one to collect the support on their behalf were excluded. In some instances, PLWHAs opted to do ganyu than spending on transport just to get very little food support.

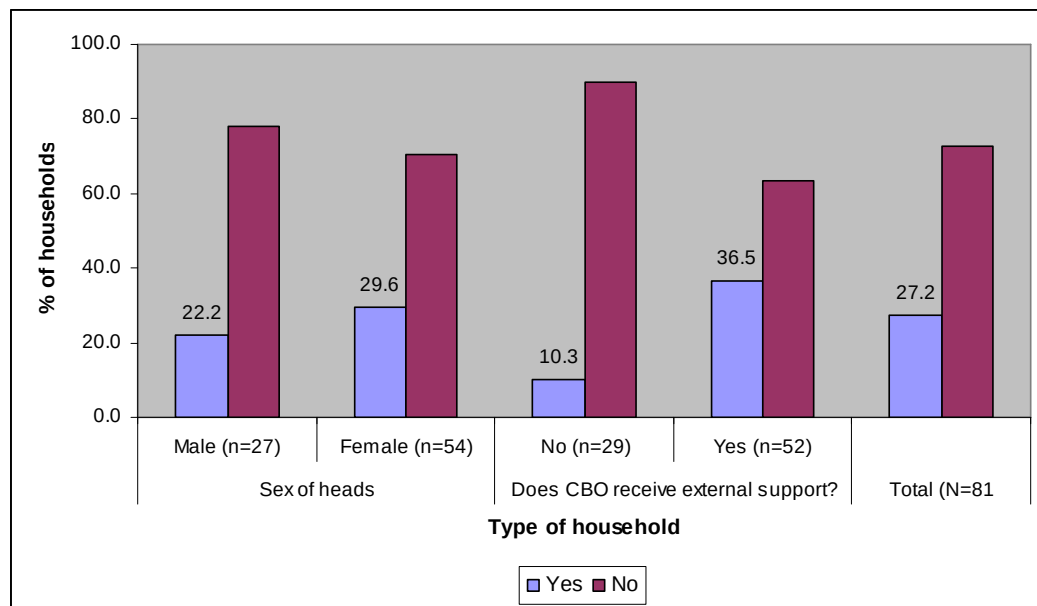
As regards the timeliness of the support, all the support provided by the different organisations came on time in the sense that they were provided to the people when they were 'in need' of help. Food support came during the time/ months when a lot of households had their stocks finished.

4.8.3 Proportion of households reporting ever benefiting from a social protection programme in last 5 years

Households were asked if they have ever participated in any external assistance support programme not directed at PLWHA only but other vulnerable members as well. Figure

10 shows the proportion of households ever benefited from social protection programme in last five years. Only 27% said that they have received support from other organisations and the majority of these talked about participating in road rehabilitation works and having received some form of food handouts

Figure 10: Proportion of households reporting ever benefiting from a social protection programme in last 5 years



4.9 The Community Based Organisations

4.9.1 History and mandates

Appendix 3 provides background information on the CBOs that were visited. All were established between 2001 and 2006. Some have had funding from different organisations including NAC. The beneficiaries of the CBOs are children, patients and the elderly.

The study found that the CBOs in the area under study undertake a number of activities and the following are the major activities: child feeding centres that are also operating as nursery schools, food aid programmes, animal husbandry-piggery, cattle and IGAs like

tin smith, making charcoal burners. From these activities, the most common activities are the child feeding centres and the food aid programmes. These were found in all the CBOs that were visited. These activities are run using funds from different sources. In the CBOs where financial support was received from NAC, the food aid programmes and the running of the child feed centres depend on the funds provided by NAC. Thus the activities are undertaken in a specified manner as stipulated in the funding agreement. On the other hand these activities are not sustainable since most of the programmes are no longer done after the end of the funding. The other CBOs that have not received any external support, rely on the contributions from the members of the community.

Although the households were identified from the CBOs beneficiary list, the respondents were also asked to state if they have ever benefited from the CBOs. Only 60% of the respondents said that they have benefited from the CBOs. This percentage also explains that there is exclusion of the intended beneficiaries although the CBOs are supposed to benefit every body. The support of the CBOs is not reaching all the intended beneficiaries. This was also one of the complaints made during some of the FGDs that were done in the CBOs that were funded by other organisations. One participant openly said that “anangobwera kudzatilemba koma sitinalandireko chithandizo china chili chonse.” (They just came to list our names but we have not been given any help).

Table 26 shows the support provided by the CBOs. The most common type of support they got from the CBOs is food (76%) followed by psychological support (10%).

Table 26: Types of Support got from the CBOs

Type of support	Frequency	Percent
Food Aid	38	76
Money	4	8
Psychological	5	10
Other (clothes, etc)	3	6

Source: Calculated from the household questionnaire data

In relation to the frequency of this support, most of the CBOs (KI) reported that they provide support (food aid) monthly to their beneficiaries. However the data from the individual household questionnaire reveals that the majority of the households got the support only once (40%) while 32% indicated that support is provided mostly when the CBOs have resources, 26% said they get the support monthly and 2% weekly. It was further noted during the study that in one of the CBOs the maize that was stored for distribution was going bad and yet most of the households were complaining that the amount given is just too small compared to what was said that will be given to them. This is further making the effectiveness of the support questionable.

The households were then asked if they are able to have enough food since the CBOs started helping them in the area. Only 12 responded in affirmation while 88% of the households said that since they started getting help from the CBOs, they are still unable to have enough food which would take them to the next harvest.

The food aid being provided by the CBOs helps the households in smoothing their food consumption. However, this is in short term since the activity is not done continuously.

Because of this, households in the area do not rely on the food aid support provided by the CBOs as their coping strategy i.e. only 4% indicated this as their coping strategy. But according to FGDs, the food which is provided assists the affected households to concentrate in their gardens instead of going out doing ganyu for survival. On the other hand, the food given, help the sick people since they lack of sufficient food and adequate nutrition is particularly detrimental for the health and well-being of people living with HIV/AIDS. Malnutrition which weakens the immune system and leading to the accelerated development of AIDS-related illnesses in HIV-positive people would be controlled.

Furthermore, lack of food is assumed to be forcing people into increasingly high-risk survival strategies. The FGDs reports reveal that in the area, food shortages are driving more women and girls to transactional sex, either for cash or for food. The activities that are run by the CBOs are said to be helping the people as they become desperate for food and other resources. Hence, preventing people from adopting risky survival strategies. For instance the tin making is helping the youth to keep them busy thereby reducing their vulnerability to HIV infection, in the long run they would have money which could be used to buy food.

Despite the fact that all the CBOs have a number of programmes being undertaken, food aid programme is preferred most as it benefits a lot of people. Participants of the FGDs said that money would not be good because most times money is always spent on useless things even though the core idea would be to purchase food or do business.

4.9.2 Identification of beneficiaries for the CBOs

The beneficiaries of the CBOs are identified by the volunteers that are obtained from the villages surrounding the CBOs through the chiefs. In other situations, the sick, they visit the CBOs themselves for registration. To make sure that exclusion is controlled, the CBOs coordinating team carry out sensitization meetings in the villages so that people are aware of what is happening and register with the CBOs. However, most of the respondents also said that the targeting of the beneficiaries done by the CBOs is poor (44%). It was further revealed that even though the CBOs do the listing of the possible beneficiaries, most of the persons are left out and even other people on the list are not provided with the intended support. This is due to lack of adequate resources by the CBOs.

4.9.3 Sustainability of CBOs and their activities

The CBOs were asked how the activities are done in order to understand how they are sustained over time. It was found that the sustainability of the CBOs activities depends on the availability of enabling resources e.g. funds. The funds are obtained from donors or own contributions. All the CBOs involved in the survey indicated that problems of sustainability would arise upon the depletion of their financial base. For example, if the grant facility from NAC and other donors would come to an end most of the activities done in the CBOs come to an end. The study also reveals that due to the problem of funds other CBOs have ceased to operate before/after funding ends. For instance, of the 6 CBOs that were firstly selected 2 of them are no longer operational.

However, a few CBOs engage in other Income Generating Activities (IGAs) in order to sustain their activities but the amounts realized from these IGA's are too far below adequate levels to sustain the activities of CBOs. There are also monthly contributions towards the running of these CBOs. The CBOs in the area levy membership fees from their members (Board of Trustees and the Executive Team of the CBO) on a monthly basis. This membership fee has been found to range from K50 to K100. The Board of Trustees also help the CBOs whenever need arises. Additionally, for some CBOs, such contributions are sourced from every household within the catchment area of the CBOs but in other CBOs these are sourced only from the households which have a child attending the nursery schools. Such fees range from a minimum of twenty kwacha to a maximum of two hundred kwacha. Thus funding from donors compliments and boosts the local efforts and actually scales up the delivery of services to the beneficiaries. Other CBOs also have their own gardens where they cultivate their own crops. The yields are then distributed to the beneficiaries. Others are sold and the money is used in the CBO activities

Additionally the CBOs are supposed to be owned by the communities. However, the spirit of volunteerism upon which the sustainability of the CBOs rests is not there. A lot of volunteers that are identified from the village around the CBOs catchment area, have stopped helping in the running of the CBOs such that other CBOs have to source other volunteers every now and then. Due to this, the sense of ownership and responsibility which can contribute to the sustainability of the CBOs and their activities is still questionable in the CBOs visited since the activities are not done frequently.

4.10 Chapter summary

It has been found in this chapter that the majority of the respondents were the patients themselves, the major segment of the population are females, nearly half of the total population of children aged 18 and below are orphan, there are more FHH than MHH but the majority of the FHH is widowed as compared to MHH whose majority are married, more women heads are uneducated and the farming is the main source of livelihood.

It has been found in this chapter that ownership of livestock and assets is low. However, there are no differences between MHH and FHH as regards the livestock ownership. The asset ownership on the other hand differentiates with MHH having more than the FHH. Additionally, the selling of livestock and assets to cater for HIV related needs is very common with the selling of livestock 2-3 times more likely than the sales of assets. It is worth noting that households food security dimensions are conceived beyond having food in the home but also include aspects of well-being, good health and a happy social life.

It has also been found that most of the households are experiencing/ have experienced the problem once with FHHs being the majority and households from the CBOs that get external support. The deaths and illnesses are impacting more on the finances and labour of the households. Households are coping mostly by reducing the size of land being cultivated while the main support the households are getting is counseling.

The households are also benefiting from social protection programmes by different NGO and more households that are benefiting are from the CBOs that receive external support and females. The social protection programmes are coming on time however the frequency and the distribution points are not good. The CBOs are also undertaking a number of activities to help out in food security of the households.

CHAPTER FIVE

5.0 CONCLUSIONS

5.1 Introduction

This chapter presents the summary and conclusions based on the research results discussed in Chapter 4.

5.2 Summary and conclusions

The study was aimed at exploring the role the CBOs are playing in enhancing the food security of the HIV and AIDS affected household. The objectives of the study were firstly to assess the food security situation of the HIV and AIDS affected households that benefiting from the CBOs. The second one was to explore other food security coping mechanisms of HIV and AIDS affected households benefiting from the CBOs and the third was to identify and characterize different food security initiatives by the community based organizations aimed at enhancing food security of affected households.

A survey was conducted in TA Mwambo in Zomba where 81 households who are the beneficiaries of the CBOs were involved. Both qualitative and quantitative methods were used. Information was obtained using questionnaires which were administered to households and checklist for FGDs and KIIs respectively. The analysis conducted included descriptive statistics, frequency calculations, Chi square test and T-test.

The results from the computation of LU and AU have shown that the livestock and asset ownership was low. Asset and livestock ownership is also low since few people own

them. However, the MHH had higher ownership of both the livestock and assets but there are no significant differences between MHH and FHH as regards the livestock ownership. The asset ownership on the other hand differentiates with MHH having more than the FHH. With regard the type of CBO, the households from the CBOs that had external support had higher ownership of assets while livestock ownership was similar. On the other hand there is high asset-livestock portfolio among the MHH than FHH and among households whose CBOs had external support. The households sell their assets and livestock to cover HIV and AIDS expenses. The average sales of the AU, LU and CALI were not significantly different between the MHH and FHH but the sales of livestock are two times more than the sales of assets.

Farming is still the main source of livelihood for the majority of the households in the area. However, though the land holding sizes are generally very small. Households are suffering from labour losses due to illness or death, lack of agricultural implements and lack of agricultural inputs. These are reducing agricultural production thereby increasing food insecurity.

The results show that most of the households do not have sufficient food to last them for the whole year, as food production levels were low. On average food from own production lasted for 8.8 months in a normal year. This was found to have dropped to about five months (5.3months) after the HIV infection. These were statistically different according to t-test results with a mean difference of 3.52 months. Comparing male and female households, the survey did not find significant differences in the food sufficiency

months both in normal year and after infection. After the depletion of own stock, households rely mostly on buying from the local markets and ganyu in order to have food. As regards the consumption, no significant differences were found in the observed proportions of MHH and FHH that had no meals in the last year but there were differences in the households in the CBOs that do not receive external support and those that receive external support.

The agricultural productivity and food production is affected by number constraints which are categorized into human, financial, physical as well as natural capital. However, illnesses were the major problems that influence the low production reflecting human capital problem.

The study has also shown that CBOs in Zomba district are running a number of activities in order to enhance the food security status of the affected households. These activities are: food aid, child feeding centres that are also running as nursery school, animal husbandry as well as training the youths on various skills like tinsmith. These activities aim at increasing the household food supply directly and not in line with increase in the own production. However, most of these activities are not sustainable. They are done in short term. This is due to lack of enabling resources especially financial resources. As such, households that are benefiting from the CBOs activities are still facing food problems. Where food aid is provided, the aid does not reach all the intended beneficiaries during most of the times.

It has been revealed that the households that are from the CBOs that receive external support are generally better off than those from the CBOs that had no external support. However, it can not be concluded that the CBOs contributed to this since the CBOs are mainly helping in food consumption smoothing.

On the other hand, while the people have their problem, the role of the extension workers is also important. However, the agricultural services which are supposed to be provided by the extension workers are seen as ineffective largely because few villagers come into contact with them. The agricultural extension services appear to be nonexistent in the area and certainly failing to deliver appropriate advice as regards issues of agriculture. It was also revealed however that no CBO has the activities that would somehow link the people in the area with the extension workers.

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APPENDICES

Appendix 1: Number of households visited in each village

Name of GVH	Frequency	Percent
Kadewere	7	8.6
Mindano	35	43.2
Nambeso	1	1.2
Jali	15	18.5
Mnyanya	13	16.0
Chirunga	10	12.3

Appendix 2: Ownership of Productive Assets and Livestock

Livestock	% of N	Assets	% of N
Cattle	3	Hoes	93
Goats	13	Axe/Bush knife	56
Sheep	2	Treadle pump	3
Pigs	6	Cooking pots	98
Chickens	43	Mortar	62
Turkey	0	Plates/bowls	96
Nkhanga	2	Buckets	98
Kalulu	2	Hurricane lamps	25
Ducks	2	Torch	6
Pegions	7	Bed	25
Watch/clock	10	Bee hive	0
Mobile phone	4	Sickle	21
Sofa or dinning set	10	Water cane	16
Radios	28	Mattress	18
TV	6	Ngolo	4
Sewing machine	4		
Bicycle	13		
Motor bike	3		
Tractor	0		
Plough or ridger	3		

Appendix 3: CBOs Background information

CBO	Year of establishment	Number of Villages	Outside Support	Number of Beneficiaries	Child Feeding Centres
Namikhate	2003	9	NAC, DAPP, UCC	19 patients, 120 Children 10 elderly	1 (2003), 1 (2007)
Lomoni	2000	9	NAC Dignitus	27 patients 54 children	1 (2005), 1 (2006)
Mawa ndi Anthu	2001	10	NAC MASAF ZA Action Project	93 children 35 patients 35 elderly	1 (2003)
CAPA	2006	10	No outside help	290 children	2 (2006), 2
Makoka	2006	21	No outside help	11 patients 187 children 52 elderly 29chronically ill	2 (2006), 2 (2007) and 1(2008)
Sitima	2005	-	No outside help	0 (had two patients but are all dead and their families are no longer there)	1 (2005)
DAO (pilot)	2003	-	CADECOM OSA, Firewright International (USA) Dignitus	185 patients 105 children 89 elderly	3 (2005), 2 (2006) and 2 (2007)

Appendix 4: Household Questionnaire

Household Number:

HOUSEHOLD SURVEY

Date of the Interview:

Interview start time:

IDENTIFICATION ISSUES

1. District:	Zomba	2.Traditional Authority:	Mwambo
3.Name of group village head		4. Name of Village:	
5.Name of head of household		6. Sex of head of household	1. Male 2. Female
7.Age of head of household	years		

8. Marital status of the head of household
1 = Single (never married before)
2 = Married
3 = Separated/Divorced
4 = Widowed
5 = Estranged/Abandoned
9. Main source of livelihood for the household
1 = Farming
2 = Fishing
3 = Business (established business)
4 = Business (petty trading)
5 = Salaried job
6 = Ganyu (on-farm)
7 = Ganyu (off-farm)
8 = Artisanal work
9 = Charity
10 = Remittances
87 = Other, specify _____

10. Household Demography

Please give me the names of persons who usually live in this household and how these are related to the head of the household

S/N	Name (Start with the head)	Age	Sex	Relation to the head	M/status	Parental status (if <18 years)	Highest Educational level	If 5-20 years Is (Name) still in school?
01								
02								
03								
04								
05								
06								
07								
11								

- | | | | | |
|-----------|----------------|---------------------------|----------------------|--------------|
| | 0. No relation | 1 = Single | 0= No parents | 0=None |
| 1. Male | 1. Head | 2 = Married | 1= Only mother alive | 1= Std 1 |
| 2. Female | 2. Spouse | 3 = Separated/ Divorced | 2= Only father alive | 2=Std 2 |
| | Child | 4 = Widowed | 3 = Both alive | 3=std 3 |
| | Brother/Sister | 5= Estranged or abandoned | | 4=std 4 |
| | Father/Mother | | | |
| | Grand child | | | 9=form 1 |
| | Nephew/niece | | | 10. form 2 |
| | Other, specify | | | 11. form 3 |
| | _____ | | | 12. form 4 |
| | | | | 13. Tertiary |

Number of orphans living in the household: _____

HOUSEHOLD LIVESTOCK AND ASSETS

11. Do you have the following assets?

Item	No. Owned	No. Sold to cover HIV and AIDS expenses (food, transport, medical)	Value of the sold assets
Hoe			
Axe or bush knife			
Treadle pump			
Cooking Pots (both metallic and clay)			
Mortar/ pestle (<i>Ntondo ndi musi</i>)			
Bowl/Plates			
Bucket (<i>Ndowa</i>) or Water Container (Jerrican)			
Hurricane Lamp/Tilly			
Torch			
Bed			
Watch/Clock			
Mobile Phone			
Sofa or dining set			
Radio/ Cassette/ or CD Player			
Television			
Telephone			
Sewing Machine			
Bicycle			
Motorbike			
Tractor			
Ox Plough/ Ridger			
Oxcart or donkey cart (<i>Ngolo</i>)			
Mattress			
Watering cane			
Sickle (<i>Chisikilo/Chikwakwa</i>)			
Bee hive (<i>ming'oma ya njuchi</i>)			

12. Do you have the following livestock?

Code	Livestock Type	Number owned	No. sold to cover HIV and AIDS (food, medical)	Sold to HIV and expenses transport,	Value of the sold live stock
1	Cattle				
2	Goats				
3	Sheep				
4	Pigs				
5	Chickens**				
6	Turkey**				
7	Guinea Fowl (Nkhanga)**				
8	Rabbit (Kalulu)				
9	Ducks				
10	Pigeons (Nkhunda)				
11	Other.....				

** Count only adult chickens, guinea fowls and turkeys

INCOME SOURCES AND EXPENDITURE

13. What are the sources of income in this household? (Tick all mentioned)

- | | |
|--------------------------|-----------------------------|
| 1 = Crop sales | 2 = Livestock Sales |
| 3 = Small Business | 4 = Income Transfers |
| 5 = Salaried Farm Job | 6 = Salaried Non-Farm Job |
| 7 = <i>Ganyu</i> on Farm | 8 = Other <i>Ganyu</i> |
| 9 = Land Rentals | 10 = Other (specify _____) |

14. What are the two major sources of income for this household?

- | | | |
|----------------------|-----------------------------|-----------------|
| 1 = Crop sales | 5 = Salaried Farm Job | 1 st |
| 2 = Livestock Sales | 6 = Salaried Non-Farm Job | |
| 3 = Small Business | 7 = <i>Ganyu</i> on Farm | 2 nd |
| 4 = Income Transfers | 8 = Other <i>Ganyu</i> | |
| | 9 = Land Rentals | |
| | 10 = Other (specify _____) | |

15. How much do you get from the two major sources of income per month?

1 st	
2 nd	

16. What is the total monthly income for the household? _____

17. Does your household spend on the following and how much on average per month?

	1=Yes 2=No	Average monthly spending
a) Food Items		
b) Education		
c) Land Rentals		
d) Housing		
e) Clothing		
f) Transport		
g) Health (Pills & Hospital fees)		
h) Farm inputs and labour		
i) Assets/Household Items		
j) Remittances (Transfers)		

18. Do you or any member of your household save money?

1 = Yes 2 = No

19. How much is saved? _____

20. With the problem of HIV and AIDS in your household, are the savings affected?

1 = Yes 2 = No

21. If 'Yes', how have they been affected?

1 = decreased 2 = increased 3 = completely depleted

HOUSEHOLD LAND RESOURCES AND USE

22. How many pieces of land does the household have or own or lease?

Number of fields (*Minda*)

Number of riverside land (*Madimba*)

Total land area (Acres)

23. With the problem of HIV and AIDS are/were you able to cultivate the whole area of land you have/had?

1 = Yes 2 = No

Ask for each plot cultivated this season (2007/2008)

Plot ID	24. What area of the plot was under cultivation? (Acres)	25. How did you acquire each plot? (Use Land Acquisition Code)	What farming system or/and technology did you use on the plot?							
			26. Type of crop stand on the plot? 1=Mono-cropping 2= Inter-cropping 3=Mixed cropping 4=Mixed farming	27. Ridging 1=Yes 2= No	28. Crop Rotation 1=Yes 2= No	29. Irrigation 1=Yes 2= No	30. Do you apply fertiliser or manure or both? 0=Nothing 1=Fertiliser only (Enter code) 2=Manure only (Enter code) 3=Both Fertiliser & manure (enter code)	31. Use of Hybrid Seeds 1=Yes 2= No	32. input sources (fertiliser + seeds) 1. CBO 2. Government 3. Other NGOs 4. Self storage 5. Purchasing 6. Loan 7. Other (e.g. relative etc.)	
							Type Code	Type code for manure		
01										
02										
03										

Codes for Land Acquisition (Q25): 1 = Chief/Traditional 2 = Subdivision from family 3 = Inherited 4 = Leasehold 5 = Rented
6 = Tenancy 9 = Informal purchase Other (specify)_____

Code for Irrigation in Q29: 1 = Treadle Pump; 2 = Bucket/Water can; 3 = Motorized; 4 = Canal; 5=Other (specify)_____

Code for Organic Manure in Q30: 1 = Khola; 2 = Compost; 3 = Other (specify)_____

For each plot owned or used by the household the nature of rights, and land use this season (2007/2008)

Plot ID	33. How many crops in total were grown on this plot?	34. What is the main crop grown on the plot this season? (Use Crop Code)	35. What is the secondary crop grown on the plot this season? (Use Crop Code)
01			
02			
03			
04			
05			

Crop Codes: 1 = Local Maize 2 = Hybrid Maize 3 = Cassava 4 = Rice
5 = Potatoes 6 = Pulses (**Mbeu za mtedza kapena nyemba**)
7 = Groundnuts 8 = Vegetables 9 = Tobacco 10 = All Others 12 = Fallow (**Malo ogonera**) 13 = Non

FOOD PRODUCTION AND FOOD SECURITY

36. Under a normal weather year, was the household able to produce adequate food to meet food requirements from one harvest to the next harvest?

1 = Yes 2 = No

37. If '**NO**', for how many months does your household have enough food from your own production?

Number of months

38. Does the household produce adequate food to meet food requirements from one harvest to the next harvest since the problem of HIV and AIDS was diagnosed?

1 = Yes 2 = No

39. If '**NO**', for how many months does your household have enough food from your own production?

Number of months

40. What does the household usually do to meet its food requirements when it runs out of own production?

- a) Purchase from ADMARC
- b) Purchase from Local Market/Traders

1 = Yes 2 = No

- | | |
|--|--|
| c) Rely on Food Transfers from relatives | |
| d) Rely on Food Transfers from Govt/NGOs | |
| e) <i>Ganyu</i> Labour for Food/Cash | |
| f) Begging | |
| g) Credit from money lenders | |
| h) Rely on Food Transfers from CBO | |
| i) Other (specify_____) | |

41. What problems does the household experience in farming because of your status?

DO NOT READ OPTIONS

- | | 1 = Yes
2 = No |
|--|-------------------|
| a) Limited access to land | |
| b) Lack of credit | |
| c) Lack of extension services | |
| d) Lack of agricultural implements | |
| e) Labour shortages | |
| f) Lack of agricultural inputs/Markets | |
| g) Lack of produce markets | |
| h) Increase in costs of inputs | |
| i) Poor crop prices | |
| j) Livestock diseases & deaths | |
| h) Illnesses | |

42. When did you start eating your maize from your garden last year?

1=green (chitibu) 2=dry (after harvest)

FOOD CONSUMPTION

43. Last year, was there a day that your household did not eat anything the whole day? (Excluding water)
1= Yes 2=No
44. In the last 7 days, was there a day that your household did not eat anything the whole day? (Excluding water)
1= Yes 2=No
45. In the last 7 days, was there a day that your household **ate other foods** because your regular food was not available?
1= Yes 2=No
46. In the last seven days, was there a day that your household **only had one meal the whole day** because there was no food?

1= Yes 2=No

47. The last time that you had only one meal in a day, which meal did you take? (**One answer only**)

- | | |
|------------------|-------------------|
| 1. Early morning | 2. Mid morning |
| 3. Noon | 4. Late afternoon |
| 5. Evening | |

48. Normally, how many meals does your household have in a day?

- | | |
|----------|----------------|
| 1. One | 2. Two |
| 3. Three | 4. More than 3 |

49. Normally, how many times in a day does your household eat snacks (such as paw paws, guava, Nzimbe, pear, masawu, cassava, groundnuts, potatoes etc)

- | | |
|----------------|----------|
| 0. None at all | 1. One |
| 2. Two | 3. Three |
| 3. More than 3 | |

50. Which meals does your household normally consume in a day? (Read out options but circle one response only)

- | | |
|--------------------------------|-------------------------|
| 1. Breakfast and lunch | 2. Breakfast and supper |
| 3. Lunch and supper | 4. Breakfast only |
| 5. Lunch only | 6. Supper only |
| 7. Breakfast, lunch and supper | |

51. In the last 2 weeks, did you eat the following foods in your household?

Food type	
Fish	
Meat (cattle, goat, sheep, chicken etc)	
Eggs	
Beans, groundnuts and pulses	
Cassava and sweet potatoes	
Cassava, sweet potato or pumpkin leaves	
Nsima	
Porridge	
Milk (fresh or dry)	
Exotic vegetables	
Indigenous vegetables (e.g. thelere, chisoso etc)	
Fruits	

52. Does the person who is sick (the afflicted) eat the same food as every one else in the household?

1 = Yes 2 = No

53. If 'NO' what foods are also given to the sick

Food type	
Fish	
Meat (cattle, goat, sheep, chicken etc)	
Eggs	

Beans, groundnuts and pulses	
Cassava and sweet potatoes	
Cassava, sweet potato or pumpkin leaves	
Milk (fresh or dry)	
Exotic vegetables	
Indigenous vegetables (e.g. thelere, chisoso etc)	
Fruits	

54. Is the household receiving any nutritional support because of the chronically ill patients?

1 = Yes 2 = No

55. If yes, what type of nutritional support is it?
1= Plumpynuts/chiponde, 2=vegetable oil, 3=Likuni Phala, 4=maize, 5=other (specify)_____

56. If yes, what is the source of the support?
1=Government, 2=NGO, 3= CBO, 4=other (specify)_____

SHOCKS OF LIFE (death due to HIV and AIDS and long term illness)

57. How many times has this household experienced a long term illness or death that could be related to HIV and AIDS in the last five years? (probe for HIV and AIDS related deaths or number of persons who are sick)

58. How did you cope with the situation?

1. Received counselling
2. Received external support from Govt/NGO(financial, material, nutritional)
3. Received external support from the CBO(financial, material, nutritional)
4. Sold assets
87. Other, specify

59. Has your household ever received any external assistance to support members that have long-term illness in the last 5 years?

1. Yes 2. No

60. What form of assistance has been received?

	Form of assistance	Sex of member (tick where applicable)	
		1. Male	2. Female
1	Nutrition/Food		
2	Financial/Cash		
3	Material		
4	Spiritual		
5	Psychosocial		
6	Other (specify)		

61. What impacts did the death of the last member (HIV and AIDS related death) bring to your household? **(for the households whose patient has since died)**
1. Loss of labour
 2. Time and other resources
 3. Loss of financial support
 4. Psychological effect
 5. N/A (if the household did not experience any death)
 6. Other, specify
62. How are you coping after the death of your relative? **(for the households whose patient has since died)**
1. rely on community support
 2. rely on CBO support
 3. Rely on Govt/NGO support
 4. credit from money lenders
 5. withdraw children from school
 6. reduced size of land cultivated
 7. started growing labour saving crops
 8. reduced number and quantity of meals in a day
 9. Sell assets
 10. other (specify_____)
63. What impact is/was the long-term illness bringing to your household?
1. Loss of labour
 2. Time and other resources
 3. Loss of financial support
 4. Psychological effect
 5. Other, specify
64. How are/were you coping with the long-term illness?
1. rely on community support
 2. Rely on CBO support
 3. Rely on Govt/NGO support
 4. credit from money lenders
 5. withdraw children from school
 6. reduced size of land cultivated
 7. started growing labour saving crops
 8. reduced number and quantity of meals in a day
 9. sell assets
 10. other (specify_____)

ACCESS TO SOCIAL PROTECTION PROGRAMMES AND CBO

65. Has this house received any form of support from an outside organisation in the last 5 years?

1. Yes

2. No

What types of support was received?

	Type of support	1. Yes 2. No	Which organisations provided the support?	How many times was support received?	Who was targeted in the household?
66	Financial				
67	Food				
68	Nutritional supplementation				
69	Psychosocial				
70	Spiritual				
71	Material				
72	Seed				
73	Other, specify				

Code for organisations: 1=Red Cross; 2=CADECOM; 3=Water Aid; 4=Ministry of Health/MSH; 5 = WFP; 6=Social Islamic Development; 7=WVI; 8=CRECCOM; 9=OSA; 87= Other specify 99=DK

Codes for target groups: 1=Underfive children; 2=Orphans; 3=The chronically ill; 4=Pregnant women; 5=The elderly; 6=Whole household; 87=Other specify..... 99=DK

74. Have you ever benefited from this CBO?

1 = Yes 2 = No

75. If yes, what kind of support do you get?

1. food aid 2. money
3. food for work 4. Casual work
5. Agricultural inputs 6. psychological support
7. other specify.....

76. How often do you get help from the CBO?

1. Once 2. Daily
3. weekly 4. monthly
5. other specify.....

77. Since you started getting help from the CBO, are you able to produce (have) enough food which takes you to the next harvest?

1 = Yes 2 = No

78. In general, what are your comments with regard to targeting of beneficiary households by the CBO in this community?

1. Very good

2. Average

3. Very poor

4. Good

5. Poor

79. Any comments regarding how the CBO (name the CBO) can best help in enhancing food security

Appendix 5: Focus Group/ Key Informant Interview Checklist

COMMUNITY PERCEPTIONS ABOUT HIV/AIDS, CARE AND SUPPORT

- Is HIV/AIDS a problem in your communities? What evidence is there to show that it is a problem?
- Is this problem worsening or not? Explain.
- Any intervention programmes in the area? By who? Targeting who? How is the community involved?
- How does the community care for chronically ill members? What structures are in place to assist people who have been sick for a long time? Orphans? The elderly who are taking care of AIDS orphans?
- Are men, women and children who are sick cared in the same way? If not, what determines the difference?
- Are there any organisations that take care of people that are HIV positive? Where do they get their funding? How does the community assist such an organisation?
- How do households that have a sick person adjust their livelihood? Orphans?
- *FOOD SECURITY*
- How do you understand food security in this community?
- How do you define a food secure household in this community?
- How is food security changing over time
- In general, what food crops are grown in this area? What cash crops?
- What livestock are common here? Any changes to the numbers or types in past five years? Why?
- In general, what do you think are the factors leading to declining agricultural productivity in the area? *Hint: (if not mentioned) Probe for land issues, farm inputs, labour, weather, HIV and AIDS, extensionservices etc.*

FOOD INSECURITY AND HIV/AIDS

- How would you describe the prevalence of HIV and AIDS
- When did AIDS become a major problem here (CBO catchment area)?
- Which categories of people have been affected more and why?
- What do you think is causing HIV and AIDS to spread faster here?
- What do you see as the relationship between HIV and AIDS and food security/insecurity in this community?
- How are HIV and AIDS affecting agricultural production/food security?
- In general, how has HIV and AIDS affected the food crops production in this area? What about the cash crops? Any changes to the numbers or types of livestock in past five years because of the existence of HIV and AIDS? Why?
- What is happening in households affected by HIV and AIDS or chronic illness or that have experienced death due to AIDS?

- What is happening in households where one parent or both have died?
- What leads to or causes the other between HIV and AIDS and food insecurity in this area?
- How do the affected or community cope?

SAFETY NETS

- Where do you get help in case of need?

Informal safety nets

- In general, how would you describe the type of assistance that exists in this area (is it both inter and intra-family?)
- On what issues are households willing to assist?
- On what issues are households not willing to assist?
- What local support exists for households led by orphans? Sick parents? Female headed households?
- How have HIV and AIDS affected these safety nets

Formal safety nets and CBO

- What types of government (or donor/NGO) assistance do the affected households receive in this area in order to enhance their food security status
- **(List all and for each ask the following:)**
- Who issues out the assistance and how frequent (per week or month)?
- How much (kg or bags or Kwachas) was being received?
- Who are the beneficiaries and how are they selected? By who?
- If you were to rank the institutions which provided the assistance, where would you place each? timeliness of the assistance, adequacy, targeting criteria, dependability, reliability, non-exclusion, inclusion frequency of the assistance, distance to distribution points etc.,
- Please describe to us about the CBO in your area(name the CBO):
- How it started? Who funded it in the beginning?
- What activities are done by the CBO in enhancing food production and security (since the CBO started)?
- Number of child feeding centres and how it has centres increased over time
- How are the beneficiaries identified?
- How has the number of beneficiaries increased over the period?
- Which initiative on food security would you rate as being the most successful in enhancing food security of the affected households?
- Why do you think these most successful? What evidence is there that you can show me or you can give me?
- Who were the beneficiaries? How were they selected?
- What is the status of this initiative (continuity)?
- What measures of sustainability did (or have) you put in place?
- Which funding sources have you had since the CBO started on HIV and AIDS more especially on food security and for which activities? How was the CBO identified as a beneficiary for funding?

Year	Funding Source	Type of food security initiative	Status i.e. completed or on-going Or to be received
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- Which activities/interventions on HIV/AIDS would you rate as the least successful? Why
- How have HIV and AIDS affected these safety nets
- Any comments regarding how best the CBOs can help in enhancing food security of the affected households