# Adaptive Strategies and Coping Mechanisms of Families and Communities Affected by HIV/AIDS in Malawi

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"AIDS is clearly a disaster, effectively wiping out developmental gains of the past decades and sabotaging the future", Nelson Mandela, former President of South Africa.

## Introduction

> Ngozi is in her late 30s. She lives in a village in western Rumphi district of northern Malawi. Her husband was in the army and during his career as a soldier he travelled to neighbouring Mozambique several times while his wife stayed at his home village farming. The husband visited her once or twice a year and she received remittances from him. In the early 1990s she started falling sick regularly, became skinny and coughed constantly. Two sons born at this time died at birth. When she gave birth to her last born in 1994 she kept on bleeding for weeks and her condition worsened. In 1993 her husband came back to the village permanently but he fell ill only a few months later and died soon after. Ngozi was pregnant and had four surviving sons. While the wife said that her husband died of drinking bad water and stomach problems, her father in-law believed that his son died of AIDS which he contracted in Mozambique. In the village rumours said that no one would marry a widow suspected of being infected with HIV/AIDS.
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> For her, life as a widow with five children demanded quite a lot. Her two eldest sons were sent to the capital, Lilongwe, to live with one of her brother in-laws. They visited her once a year during the school holidays. The other three children stayed with her but they often ate with her father in-law or one of her brothers in-law. She continued to cultivate the land but had not been able to harvest sufficient maize for several years due to her illness. Her two remaining sons assist her but they are too young to do all the work and still go to school. The wives of her husband's brothers support her from time to time. Also, she has spent a lot of money seeking help from traditional healers and hospitals. Though her children are being taken care of by her late husband's family, she is forced to keep on working on the land, pounding maize and fetching water for the household. While her father in-law says that she is free to go permanently and stay with her family, she does not want to do that as it means leaving behind her children as they belong to the husband's family (Mastwijk, 1999).

This is one of many stories of the impacts of HIV/AIDS illness and death and of the coping mechanisms of households and families to adopt to the changes caused by the pandemic. Food security is compromised, income is lost, assets are sold, and children are dispersed. During periods of illness, Ngozi (and others like her) get some support from the wives of her late husband's brothers as well as from her own family which has even paid some of her hospital bills. The existence of these kinship relations in Malawian societies tends to cushion the economic and social shocks brought about by HIV/AIDS-related illnesses and death. The HIV/AIDS pandemic places tremendous strains on households and communities to care for those who are chronically ill as well as the orphans and the elderly. This paper looks at some of the coping mechanisms seen within Malawian families and communities as they respond to the HIV/AIDS pandemic.

HIV/AIDS in Malawi is overwhelming. With an HIV prevalence rate of 14 per cent in the economically productive age group of 15-49 years, Malawi is one of the countries most affected by HIV/AIDS in the world[1]. The first case of AIDS was diagnosed in 1985. In the mid-1980s 2 per cent of pregnant women attending antenatal clinics were HIV infected; in less than two decades an estimated 35 per cent of pregnant women were infected (Kalipeni, 2001). According to the National AIDS Control Programme the prevalence of HIV in the economically productive age group is estimated at 26 per cent in the urban areas and 12 per cent in the rural areas. In the same age group, the prevalence of HIV in the northern region is estimated at 9 per cent, 11 per cent in the central region and 18 per cent in the south (Strategic Planning Unit and National AIDS Control Programme, 1999). According to Government of Malawi and World Bank, high rates of urbanisation and labor migration are the most important contributing factors to the high rates of HIV in the Southern Region (Government of Malawi and World Bank, 1998).

Tuberculosis is an opportunistic infection closely associated with HIV infection and in Malawi an estimated 70 per cent of people reported with tuberculosis are also HIV infected (Kumwenda, 2001).

[1]Some countries in southern Africa have worse scenarios than Malawi. For example Botswana (35 per cent), Zimbabwe (25 per cent), Lesotho (23 per cent), Zambia (20 per cent) and 19 per cent in Namibia (Refer to Toolis & Mendel, 2000).

Reported tuberculosis cases have risen from 5,000 in 1985 to 24,000 in 2000 (Kumwenda, 2001 and Glynn et al, 1997). These trends in HIV and tuberculosis infections have put a severe strain on the government's health budget because close to 80 per cent of people admitted to hospital wards suffer from HIV/AIDS related problems compared to 20 per cent in 1990.

In Malawi in 1987 the dependency ratio was at 1.01; by 1998 when the last census was conducted this had risen to 1.3 (National Economic Council, 2000). The increase has mainly been attributed to the HIV/AIDS pandemic as it is causing the death of productive men and women. In addition to this, HIV/AIDS has led to the decrease in life expectancy. In Malawi, for example, life expectancy in 1985 was estimated at 45.2 years and expected to rise to 57.4 years by the year 2000. Now, however, it is estimated that the life expectancy rate for Malawi is around 36 years of age.

**The impacts of HIV/AIDS on communities**

One of the outcomes of the HIV/AIDS pandemic in Malawi is that the general demise of the young and economically productive men and women leaves behind children and their grandparents with limited social and economic support. HIV/AIDS impacts negatively on AIDS affected family members' capacity to generate income and produce adequate food. The reduction in yields of food crops and income is made worse because members of the family spend most of the time and resources on providing care and support for the patient (Munthali and Ali, 2000). A study conducted in Blantyre shows that persistent illness or death of proprietors resulted in the closure of small scale businesses and abandonment or reduction in size of gardens being cultivated. Families reported declines in food availability since the onset of illness (Munthali, 1998)[2]. In other instances, people in households affected by HIV/AIDS will seek casual labor on other people's farms to earn money so that they can meet the needs of the patient and the household, but at the expense of working on their own plots of land (see Munthali & Ali, 2000). Thus, while poverty contributes to HIV/AIDS, at the same time AIDS creates poverty as resources are spent on caring for the patient and maintaining the household.

Children and their grandparents suffer greatly because of the loss of social and economic support. Even though the parents may leave behind some economic resources for their children, in some instances relatives of the husband may grab the property, leaving the children destitute. For grandparents, the AIDS pandemic has ushered in the responsibility of looking after orphaned grandchildren and they are bringing up a whole new generation.

The Malawi government defines an orphan as any child aged between 0 and 18 years who has been deprived of one or both parents. However, in most African societies the definition of orphanhood is mainly the loss of the mother because women are the primary caregivers (Jacques, 1998). When a mother dies and children are left in the care of their father, there is generally a feeling that the fathers are not responsible enough as indicated in the following remarks by orphaned children in Mzimba District during focus group discussions:

> Most of the male parents drink beer. When your mother dies, the father spends all the time drinking beer and that means that whatever money comes his way is spent on beer. There is nothing left for his children to buy food and other needs. We are also deprived of the love which was there when both parents were alive.

According to the Ministry of Youth, Community Services and Social Welfare, at the end of December 2000 there were approximately 1.2 million orphans (see Munthali & Ali, 2000). A number of studies (see Foppena, 1996; Cook et al, 1999 and Munthali & Ali, 2000) have identified the problems faced by children orphaned by HIV/AIDS. They may be HIV positive themselves and will likely suffer and die before they reach the age of five years. Economic deprivation, and its consequences, is likely to

[2]Studies in urban households of Cote d'Ivoire, for example, show that when a family member has AIDS, income falls by 52 to 67 per cent while expenditures on health care quadruple (Unicef, 1999). Savings are depleted and people often get into debt to care for their sick. Food consumption has been found to drop by 41 per cent (op. cit). The Malawi NACP has projected that a minimum of 25 per cent and as much as 50 per cent of people currently employed in the urban based sectors will have died of AIDS related illnesses by the year 2005 (SITAN, 2001).

occur. Children orphaned by AIDS—and orphaned for other reasons—may have lost many of their parents' assets during the period of illness and to relatives. In addition, the general lack of food and income are real worries for orphaned children (Munthali, 1998). Some orphans also lack shelter because of the inability of their frail grandparents to repair or build houses. Access to education may be denied, if school costs cannot be met. The government introduced free primary school education in 1994, but orphans will drop out of school if they do not have school uniform, soap for bathing and washing their clothes, exercise books and writing materials. In the case of older orphans who are in secondary school they may lack school fees hence they may decide not to go on with their studies. Even though school fees might be available from well-wishers, older orphans may make a decision to drop out of school because there is nobody else in the home to care for their younger siblings. Attendance at school can be a problem because sometimes guardians tell them not to go to school but instead to work in the house. A young girl is quoted as saying: "I do not go to school. I would like to go but I have to find firewood or help in the field when there is a lot of weeding to do." (Mastwijk, 2000).

Education for all children suffers, as teachers and administrators become ill, experience absences from classroom teaching and supervision, and eventually die. AIDS is the leading cause of death among teachers and it is estimated that approximately 10 per cent of the country's teachers have already died of AIDS.

In addition to physical deprivation, orphaned children experience psychosocial problems which include the general lack of parental care, stigmatization, and untold grief (see Cook et al 1999). Most programs in Malawi are addressing the physical needs but not much has been done on the psychosocial needs. Indeed, the difficulties faced by orphaned children have sometimes been denied by policy makers who refer to the presence of traditional relations and the extended family[3].

Early marriage, at the expense of schooling, is a coping strategy for some girls and their families (Foppena, 1996; Cook et al, 1999 and Munthali & Ali, 2001; see also Mastwijk, 2000). Sexual relations are another way some young women seek to cope with the economic pressures caused by HIV/AIDS. One young women said:

> "I was made pregnant in 1998 just after sitting for my Primary School Leaving Certificate[4] (PSLC) examinations. At that time my mother was very sick so I had to find someone who could give me money to help my mother as my father had died two years earlier. I am the eldest in the family of five, three girls and two boys. So I met this boy who was working in town on my way from school and this is why I fell into a trap. The child's father ran away as soon as I told him that I was pregnant. Unfortunately my mother died a month later without knowing that I was in such a condition." (Munthali & Ali, 2000).

[3] In 1997 a very high ranking Government of Malawi district official brushed aside the issue of orphans suffering, arguing that the Malawi culture does not permit such a thing to happen (personal communication).

[4] PSLC are examinations that pupils take at the end of their primary school education and after this they can go to secondary school.

### The Extended Family System

Both patrilineal and matrilineal kinship systems exist in Malawi and these have implications on how households cope with death, illness, orphanhood, and inheritance.

Patrilineal systems of descent are practised in the northern region of Malawi and in the lower Shire River valley in the far south. When a woman marries, she goes to stay with her husband in his home village. When she dies she is buried there. Marriage in patrilineal systems also involves the transfer of bride wealth from the husband's family to the woman's family. A number of reasons have been given for the payment of bride wealth: compensation of the bride's family for the loss of her companionship and labour; making the children born out of that marriage to be full members of the husband's family and his clan (only if bride wealth is paid in full); and recognition of the man as the legitimate husband of their daughter (see Munthali, 2001b). Sons inherit their father's property, and women are denied any property rights to land and livestock, creating a women's economic dependency on men in the family (Mastwijk, 1999).

This type of arrangement has implications on coping mechanisms and strategies. If the husband dies the woman may choose to remain in her husband's home village where she, together with her children, will be taken care of by the relatives of her late husband as exemplified by the case at the beginning of the paper. Though the assistance provided might be inadequate as the late husband's relatives might also be providing for their families, this is nevertheless a coping strategy for not only those families affected by HIV/AIDS but for other families as well.

In the past when the husband died one of his relatives (especially the younger brother or cousin) was supposed to inherit the widow and cater for her and her children's needs and he could also bear children with her in the name of the deceased brother. Among the Tumbuka in northern Malawi, wife inheritance has been a form of social security for the woman and her children. The Tumbuka society is, however, changing and wife inheritance, though still being practised, is on the decline and one of the reasons for this change is that the practise enhances the transmission of HIV/AIDS and surviving widows are suspected of being infected (Cook et al, 1999).

In certain circumstances brothers may inherit their late brother's wife just because of interest in property or money left behind by the relative; once that money is finished then it marks the end of marriage leaving the woman and her children with nothing at all[5]. In some cases when the widow is not inherited she goes back to her home village where she re-marries. Re-marrying especially for women is also a form of coping.

In matrilineal systems[6] of descent as is practised among the Chewa, Yao and Lomwe of central and southern Malawi, upon marriage, the husband goes to live in the wife's home village. Domestic authority is exercised by the wife's brother who has control over his sister's children. In this context kinship and inheritance is traced through the maternal line and in general children belong to the mother and her clan. Though descent is matrilineal, control over resources is still in the hands of the men. In a matrilineal system, unlike in patriliny, the woman is in a better position because she stays with her kin in her own village and she can always call on them in times of illness or death. She also farms her own land (see SITAN, 2001).

In recent decades, with the monetization of economies and the introduction of wage labour, it is evident that many women from matrilineal societies migrate with their husbands to urban areas for employment. After the death of the husband, there are increasing tendencies that members of his family claim children as is the case in patrilineal systems. Such changes in family social structures were evident by the early 1980s and probably earlier (Phiri, 1982). The migration into urban areas distances the women from their kin groups who provide care and support in cases of illness. The removal of children by the

[5] Focus group discussion with community members from Kayithazi Village near Ekwendeni in Mzimba District.

[6] There are matrilineal systems where the wife goes to live with the husbands family in his village. In this paper I refer to situations of uxorilocal residence only

husband's kin also robs these women in matrilineal descent groups of an important old age insurance (Mastwijk, 2000).

### Care in Extended Families

Despite rapid social change, the extended family remains the most important social safety net in Malawi. In times of illness, the next of kin are responsible for the provision of care; and the role of people who are not relations is usually minimal. People count on support from their families. Thus, in a study conducted by Munthali & Ali (2000), informants stressed the importance of keeping good relations with relatives to assure that they would provide care if a person were sick. If necessary, the extended family system can alter household composition, either through sending away some dependents to live with relatives or inviting the sick to join a household (see the opening story).

Despite the strength of family relations, HIV/AIDS has stimulated change and combined with other factors to create more complex and fluid forms of social relations and responses, to be discussed below. These responses are necessary, because the burden of caring for the sick can be overwhelming for both families and communities. The dwindling of community support for those who are chronically ill, as well as for the aged, has been attributed to the loss of values that are an important part of Tumbuka customs, as well as to the Europeanization of life styles, which emphasise individualism, and the general monetization of economies.[7] The importance of monetization is underlined by an old grandmother who was looking after 15 grandchildren in Mzimba District:

> At present, everything must be bought and this brings problems when there is need to assist your relatives. You need to buy everything while, in the past, for example meat was never bought because everyone had cattle.

Still, while the monetization of the economy is one of the contributing explanations of declining capacity to cope with the epidemic, the demise of productive young men and women with HIV/AIDS, as well as the large number of chronically ill people, also negatively affect community support. Coupled with this is the high prevalence of abject poverty in Malawi, where an estimated 60 per cent of the people in the rural areas and 65 per cent of those in the urban areas live below the poverty line (GoM and UNDP, 1993). Thus, even where members of the extended family may want to assist relatives affected by HIV/AIDS, they themselves are struggling to make ends meet. Such families suffer even more "when a member falls ill or dies, when they take in orphans or when a sick member returns home. They are further impoverished when the adult labour is reduced by death or illness" (Hunter & Williamson, 1998).

Two quotes (from Mastwijk, 2000:20) illustrate the difficulties faced by extended family care givers who have neither the resources nor the ability to care adequately for sick relatives and orphaned grandchildren:

> Last year my brother died and left four children that are now living in my house. I have five children and I have to feed them all but this is giving problems as there is not enough nsima for all of them. (poor middle-aged man, Rumphi).
>
> I am a 70 year old woman and I had 8 children. Four of them died and left me with 18 orphans to take care of. They do help me in the field. I get some support from the church and my other children but that is not enough. Every morning I am struggling to get some food for them so they don't get to school or to the field on an empty stomach. (elder widow, Mchinji District).

### Sibling-headed Families

While the extended family system seeks to meet the needs of orphans and those who are sick, then, this is not always possible. Some orphaned children, though of an age when they have to be at school, are forced to care for themselves and their siblings. These orphans survive by engaging in small-scale businesses such as selling prepared food, doing ganyu (casual labor), or selling land

[7] "There is nothing free these days. Everything costs money," is how one person put it. (Mastwijk, 1999).

inherited from their parents. Thus HIV/AIDS has forced many children to grow up overnight and start heading families. Older orphans tend to leave school to take care of their fellow siblings. This situation also arises when the remaining parent is too sick to care for his or her children. An older woman said, "These older children are a source of good support when their parents are sick. They go out and do ganyu and the money is used to buy some of the things needed for caring for their parents."

Orphans also carry sand, mould bricks, sell firewood, produce and sell charcoal (Munthali & Ali, 2000). They are paid very low wages and are vulnerable to maltreatment. In some instances, children are forced onto the streets to beg, or into prostitution, early marriages and sometimes crime in order to survive. A priest in south Nkhata Bay in northern Malawi noted:

> Some of the orphans, knowing that their grandparents are too old to control them, refuse to listen to whatever they say. They even refuse to work in the gardens and, as a result, the yields are very poor and there is not enough food to eat. This encourages the orphans to start stealing, so that they can sell the items and buy food and other things they want.

**Coping with the Impact of HIV/AIDS**

A family of nine sisters (eldest being 21 years old) along the Chileka Road in Blantyre lost both parents in 1996[1] and were taking care of an ailing elder brother who had dropped out of paid employment. There was no one in employment and the household relied on casual work (ganyu) for survival. None of the older members had gone beyond standard 6 and seven children were at school and were distributed from classes 1 to 3. They once were selling mandasi (doughnuts) but failed to sustain the business. They had also been selling their land around their home to other people who were seen building new homes. These people provided ganyu to the girls and once this work was finished the girls said that they did not know what they would do next. Their parents had sold all household property during sickness. They were not able to get medication for the sick member and had serious problems obtaining food. They were not receiving any external assistance despite having some relatives. (Munthali, 1998).

**Communities Facing HIV/AIDS**

**The Role of Religious Groups**

Religion is an important tool that brings people together (both relations and non-relations) in this age when communal ties seem to be disintegrating. In some circles the church has been referred to as a social parent which brings spiritual as well as moral support to its members (see Munthali & Ali, 2000). In both Christian and Islamic communities women's, men's and youth guilds play an important supportive role in times of illness as well as death.

During funerals and illness episodes religious groups support members by offering prayers of hope and giving financial, moral and material assistance. Some Christian groups have set aside Sunday afternoons to visit and cheer the sick. Church members contribute some money, maize flour, firewood, and other items to sick parishioners. As for the aged they may assist them cleaning the house, drawing water, and farming their gardens. In Rumphi district Mastwijk found church guild members collectively