Malawi: Nutrition Profile

Malnutrition in childhood and pregnancy has many adverse consequences for child survival and long-term well-being. It also has far-reaching consequences for human capital, economic productivity, and national development overall. While Malawi has demonstrated advances in reducing acute malnutrition (estimated to be 3 percent in 2017), policymakers remain concerned about the consequences of undernutrition in the country, where 37 percent of children are stunted (have low height-for-age), according to the most recent Demographic and Health Survey (DHS) (NSO and ICF 2017).

Background

Malawi has a primarily rural population, with only 17 percent of the population residing in urban areas. It also has a relatively youthful population; 45 percent of the population is under the age of 15 (PRB 2019). Fertility rates are declining, down from 5.7 children per woman in 2010 to 4.4 in 2015–2016 (NSO and ICF Macro 2011; NSO and ICF 2017).

Malawi has benefited from decades of peace and political stability, but the country is susceptible to climate shocks. The 2015–2016 growing season was negatively affected by El Niño, which caused late rains and prolonged dry spells (MVAC 2016).

Malawi's economy is highly dependent on agriculture; 80 percent of the population are smallholder farmers, and the agriculture sector contributes 30 percent of the country's gross national product (GDP). Malawi's GDP growth rate is expected to improve if weather patterns continue to improve and remain favorable for agricultural production (USAID 2020; World Bank 2019). However, despite projected economic improvement, nearly 70 percent of the population continues to live on less than U.S.$1.90 a day (Sachs et al. 2019).

Currently, Malawi ranks 146th out of 162 countries in progress toward meeting the Sustainable Development Goals (SDGs) (Sachs et al. 2019). According to the most recent DHS (2015–2016), 16 percent of female deaths are related to pregnancy or childbearing, and 1 in 16 children will die before the age of five, with two-thirds of these deaths occurring during infancy (NSO and ICF 2017).

Nutrition and Food Security Situation

In response to COVID-19, Malawi took action to preserve food security. The Protection and Social Support Cluster, in coordination with the Food Security Cluster and the Cash Working Group, designed a Crisis Urban Cash Intervention (CUCI), which provided income replacement assistance, in line with the minimum wage (35,000 MWK per household), to vulnerable and income insecure hotspots in urban and peri-urban areas. The urban and peri-urban areas were prioritized, with rural areas to follow.

To protect nutrition in COVID-19, the United Nations Children's Fund (UNICEF) supported the Ministry of Health's nutrition unit with ongoing onsite orientation of health workers in Nutrition Rehabilitation Units and Outpatients Therapeutic Program sites on the amended Community Based Management of Acute Malnutrition (CMAM) guidelines and maternal, infant, and young child feeding in the context of COVID-19. In addition, the World Food Programme and sister United Nations (UN) agencies supported the government in drafting a cluster COVID-19 Preparedness and Response Plan for the Nutrition Cluster. This was activated as part of the overall COVID-19 National Preparedness and

Response Plan, specifically including infection prevention among children with acute malnutrition and providing replacement feeding for infants unable to be breastfed, and nutritional support for patients with COVID-19.

The August 2020 assessment, conducted by the Malawi Vulnerability Assessment Committee (MVAC), that 2,617,986 people are unable to meet their food needs during the 2020/21 consumption period. This represents 15 percent of the total projected population and a 39 percent increase from the previous consumption period due to weather-related hazards that affected crop production and the impacts of COVID-19, including job loss and lower levels of income (Masanjala 2020).

Malnutrition in women and children remains a persistent public health and development challenge in Malawi. According to the 2015–2016 Micronutrient Survey Data, 28 percent of children under five are anemic, as are 20 percent of women (NSO et al. 2016). Dietary diversity metrics are highly concerning. While 61 percent of children zero–five months are exclusively breastfed, this figure drops to 34 percent among children four–five months. Feeding practices continue to deteriorate as children get older; only 9 percent of children 6–23 months receive a minimum acceptable diet. Twelve percent of children under age five are underweight and 3 percent are wasted (NSO and ICF 2017).

Patterns have emerged for multiple indicators, revealing a higher risk of malnutrition related to education level, wealth quintile, and rural residence. For example, among children 6–23 months born to mothers with no education, only 5 percent receive a minimum acceptable diet; this number increases to 13 percent among mothers with secondary education. Minimum acceptable diet is 4 percent among children 6–23 months in the lowest income quintile and 17 percent among the highest income quintiles. Differences in stunting levels can be seen according to maternal education and wealth levels; stunting ranges from 30 percent among children whose mothers have a secondary education or higher to 43 percent among those whose mothers have no education. Similarly, 24 percent of children in the highest wealth quintile are stunted, while 46 percent of children in the lowest wealth quintile are stunted (NSO and ICF 2017).

Several additional factors contribute to poor nutrition outcomes in Malawi. First, childbearing begins early in Malawi. By age 19, 59.2 percent of adolescent girls had begun childbearing in 2015–2016, which is a slight decrease from 63.5 percent in 2010 (NSO and ICF Macro 2011; NSO and ICF 2017). This has serious consequences because, relative to older mothers, adolescent girls are more likely to be malnourished and have a low-birth-weight baby who is more likely to become malnourished and at increased risk of illness and death than those born to older mothers (NSO and ICF Macro 2011; NSO and ICF 2017).

Malawi also has high HIV prevalence of 6.4 percent among men and 10.8 percent among women (NSO and ICF 2017). HIV and tuberculosis (TB) co-infection is also a problem in Malawi; 52 percent of those with TB are also infected with HIV (USAID 2016). Infections, such as HIV and TB, can reduce appetite, decrease the body's absorption of nutrients, and make the body use nutrients faster than usual to repair the immune system. HIV can cause or aggravate malnutrition through reduced food intake, increased energy needs, and poor nutrient absorption. In turn, malnutrition can hasten the progression of HIV and worsen its impact by weakening the immune system and impairing an individual's ability to fight and recover from illness. HIV affects nutritional status early in the infection, even before other symptoms appear. High rates of infection among women further exacerbate their already poor nutritional status, especially during pregnancy.

Malawi is among the developing countries experiencing the double burden of malnutrition, with high prevalence of both undernutrition and overweight/obesity. Overweight/obesity is of particular concern for women in the highest income quintile (36 percent), with the highest education levels (41 percent), and in urban areas (36 percent) (NSO and ICF 2017). This rise in overweight/obesity can lead to increases in non-communicable diseases (NCDs), such as diabetes, hypertension, and cardiovascular conditions. NCDs are estimated to account for 32 percent of total deaths in Malawi, with 10 percent attributed to cardiovascular conditions, 10 percent to cancers, 2 percent to chronic respiratory diseases, 1 percent to diabetes, and 9 percent to other NCDs (WHO 2018).

Malawi Nutrition Data (DHS 2010 and 2015–2016)		
Population 2018 (UNICEF 2019)	18.1 million	
Population under 5 years (0–59 months) 2018 (UNICEF 2019)	2.8 million	
	2010	2015–2016
Prevalence of stunting among children under 5 years (0–59 months)	47%	37%
Prevalence of underweight among children under 5 years (0–59 months)	13%	12%
Prevalence of wasting among children under 5 years (0–59 months)	4%	3%
Prevalence of low birth weight (less than 2.5 kg) (of children whose birth weights are known)	12%	12%
Prevalence of anemia among children 6–59 months[1]	63%	63%
Prevalence of children 6–23 months receiving minimum acceptable diet	19%	8%
Prevalence of children 6–23 months fed minimum dietary diversity	29%	25%
Prevalence of children 6–23 months fed minimum meal frequency	54%	29%
Prevalence of anemia among women of reproductive age (15–49 years)[2]	28% non-pregnant women and 38% pregnant women	33% pregnant and non-pregnant women
Prevalence of thinness among women of reproductive age (15–49 years)	9%	7%
Prevalence of thinness among adolescent girls (15–19 years)	16%	13%
Prevalence of children 0–5 months exclusively breastfed	71%	61%
Prevalence of children 4–5 months exclusively breastfed	41%	34%
Prevalence of early initiation of breastfeeding (i.e., put to the breast within one hour of birth)	95%	76%
Prevalence of children who receive a pre-lacteal feed	3%	3%
Prevalence of breastfed children 6–23 months receiving minimum acceptable diet	20%	9%
Prevalence of overweight/obesity among children under 5 years (0–59 months)	8%	5%
Prevalence of overweight/obesity among women of reproductive age (15–49 years)	17%	21%
Coverage of iron for pregnant women (for at least 90 days)	32%	33%
Coverage of vitamin A supplements for children (6–59 months, in the last 6 months)	86%	64%
Percentage of children 6–59 months living in households with iodized salt	97%	89%

[1] Results from the, *2015–2016 Malawi Micronutrient Survey Key Indicators Report,* show that levels of anemia among pre-school-age children and school-age children were 28.2 percent and 20.8 percent, respectively.

[2] Results from the, *2015–2016 Malawi Micronutrient Survey Key Indicators Report,* show that the level of anemia among non-pregnant women of reproductive age was 20.9 percent.

Global and Regional Commitment to Nutrition and Agriculture

Malawi has made the following global and regional commitments to nutrition and agriculture:

Year of Commitment	Name	Description
2013	New Alliance for Food Security and Nutrition	In June 2013, Malawi joined the New Alliance for Food Security and Nutrition, a partnership among African heads of state, corporate leaders, and G8 members to accelerate implementation of Comprehensive Africa Agriculture Development Programme (CAADP) strategies.
2012	Ending Preventable Child and Maternal Deaths: A Promise Renewed	Malawi pledged to reduce under-5 mortality to 20 or fewer deaths per 1,000 live births by 2035 by reducing the leading preventable causes of child mortality, including undernutrition (UNICEF 2017).
2011	Scaling Up Nutrition (SUN) Movement	SUN is a global movement that unites national leaders, civil society, bilateral and multilateral organizations, donors, businesses, and researchers in a collective effort to improve nutrition (SUN 2017). The Civil Society Alliance in Malawi (CSONA) is also active in Malawi.
2010	Comprehensive Africa Agriculture Development Programme (CAADP) Compact	CAADP is an Africa-led program bringing together governments and diverse stakeholders to reduce hunger and poverty and promote economic growth in African countries through agricultural development. Malawi's national Agriculture Sector Wide Approach is aligned with the CAADP pillars and the country's overarching Malawi Growth and Development Strategy.

National Nutrition Policies/Legislation, Strategies, and Initiatives

Malawi's commitment to improving nutrition is outlined in the following documents, which are aligned with the Malawi Growth and Development Strategy III (2017–2020) and the Vision 2020:

- Health Sector Strategic Plan (2017–2022)
- National Multi-Sector Nutrition Policy (2018–2022)
- National Multi-Sector Nutrition Strategic Plan (2017–2021)
- National HIV and AIDS Strategic Plan (2015–2020)
- National Agriculture Policy (NAP) (2016)
- National Education Policy (2013)
- National Gender Policy (2015)

A National Multi-Sector Nutrition Committee leads coordination on nutrition across sectors and development partners. The committee's main function is to mobilize resources and support for implementing nutrition interventions in line with the National Multi-Sector Nutrition Policy, as well as to monitor progress and evaluate impact. Additionally, the Department of Nutrition, HIV, and AIDS (DNHA) coordinates implementation of nutrition interventions across government ministries and sectors. At the district level, governance structures, including District Coordination Committees (DNCCs), have been established to facilitate implementation of nutrition activities at the district and community levels.

USAID Programs: Accelerating Progress in Nutrition

As of April 2020, the following USAID programs with a focus on nutrition were active in Malawi:

Selected Projects and Programs Incorporating Nutrition in Malawi		
Name	**Dates**	**Description**
Alliance for Inclusive and Nutritious Food Processing (AINFP)	2019–2023	AINFP builds competitive food processing businesses and industries and increases the availability of safe, affordable, and nutritious food in Malawi. Training sessions cover nutrition, fortification, food safety, and quality standards. AINFP leverages the power of the private sector to create better nutritional outcomes for base-of-the-pyramid consumers and more profitable market opportunities for local farmers.
Feed the Future Nutrition Innovation Lab	2012–2021	The Nutrition Innovation Lab in Malawi aims to build pre-service capacity in nutrition. The Nutrition Innovation Lab partners with Bunda College of LUANAR University, the College of Medicine, and several ministries of the Government of Malawi.
Feed the Future Malawi Agriculture Diversification (AgDiv)	2016–2021	AgDiv promotes agricultural production, nutrition, resilience, and economic growth by helping farmers diversify away from maize into more profitable and nutritious crops—including legumes and orange-fleshed sweet potatoes (OFSP). Activities focus on increasing the productivity of legumes and OFSP, promoting nutrition and gender-related behavior change, and improved dietary diversity.
Feed the Future Strengthening Agricultural and Nutrition Extension in Malawi (SANE)	2015–2020	SANE strengthens the capacity of the Government of Malawi's (GoM) Department of Agricultural Extension Services (DAES) to mobilize and work with service providers to deliver agricultural and nutrition extension and advisory services more effectively and in a coordinated manner in the Feed the Future zone of influence.
Health Communication for Life (HC4L)	2016–2021	HC4L supports efforts by the GoM to increase public demand for quality, sustainable priority health services, and products. Specifically, the project focuses on expanding the demand for the following priority services: maternal, neonatal, and child health; HIV; family planning and reproductive health; malaria; nutrition; and water, sanitation, and hygiene (WASH).
Health Policy Plus (HP+)	2015–2020	HP+ improves the enabling environment for equitable and sustainable health services, supplies, and delivery systems through policy development and implementation. It emphasizes voluntary, rights-based health programs, and by strengthening in-country partners' capacity to navigate complex environments for effective policy design, implementation. It includes a nutrition-specific Baby Friendly Hospital Initiative activity, which promotes exclusive breastfeeding.

Organized Network of Services for Everyone's Health Activity (ONSE)	2016–2021	ONSE is USAID/Malawi's flagship health project, which aims to reduce maternal, newborn, and child morbidity and mortality. The project operates in 16 districts with a primary focus at the district, facility, and community levels. Activities focus on health systems strengthening and the following four health areas: family planning and reproductive health; maternal, newborn, and child health; malaria; and WASH.
Titukalane	2019–2024	Titukalane is a Bureau of Humanitarian Assistance Development Food Security Activity (DFSA), implemented by CARE in two districts: Zomba and Mangochi. The project supports the GoM's National Resilience Strategy, with Theory of Change pathways reflecting its pillars. Nutrition activities are integrated into both the household and district-level approaches.
Tiwalere II	2015–2020	Tiwalere II focuses on improving nutrition and WASH, as well as on community mobilization activities. This project is a partnership between USAID, Feed the Children, and two for-profit companies: Nu Skin and Proctor and Gamble.

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