GOVERNMENT OF MALAWI

PERCEPTIONS REGARDING HEALTHY AND UNHEALTHY FAMILIES:

Formative research findings from selected districts in Malawi

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List of acronyms

Acronym	Name in full
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
CBO	Community Based Organization
CCP	Center for Communication Programs
CHAM	Christian Health Association of Malawi
CHW	Community Health Worker
CRECCOM	Creative Centre for Community Mobilisation
CZ	Central Zone
DH	District Hospital
DHO	District Health Office(r)
EHP	Essential Health Package
FBO	Faith Based Organization
FGD	Focus Group Discussion
FP	Family Planning
GVH	Group Village Head
HC	Health Center
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IPC	Infection Prevention and Control
IRS	Indoor Residual Spraying
JHU	Johns Hopkins University
KII	Key Informant Interview
LA	Lumefantrine Arthemether
MBC	Malawi Broadcasting Corporation
NAC	National AIDS Commission
NGO	Non-Governmental Organization
NHSRC	National Health Sciences Research Committee
PSI	Population Services International
SBCC	Social and Behavior Change Communication
SEZ	South East Zone
SSDI	Support for Service Delivery Integration
SSDI-C	Support for Service Delivery Integration - Communication
SSI	Semi-structured Interview
STI	Sexually Transmitted Infection
SWZ	South West Zone
TA	Traditional Authority
TOR	Terms of Reference
TV	Television

USAID	United States Agency for International Development
VDC	Village Development Committee
VH	Village Head
VSL	Village Savings and Loans (village bank)
YONECO	Youthnet and Counseling
ZBS	Zodiak Broadcasting Corporation

Executive Summary

Overview

This qualitative study was conducted to gain insight into Malawian men' and women's perceptions of "health," what factors enable and support positive health practices and what factors are considered barriers to good health practices and good health outcomes. Respondents were also asked about the role of malaria as a threat to health, their perceptions regarding health care facilities and their preferences regarding sources of information. The aim of the research is to inform the design and implementation of health communication programs. It is also anticipated that these findings will be utilized in tandem with quantitative research findings.

Methodology

This study comprised 32 focus group discussions (FGDs) and 49 key informant interviews (KIIs). In each of the four study districts – Chitipa, Nsanje, Phalombe and Salima – 4 FGDs were conducted with men and 4 with women at various life stages (single adults, new parents, parents of several children, and elders). The study team relied on semi-structured guidelines to engage and elicit responses from the participants. A social ecological approach, which includes analysis of variables at the individual, family, social network, community and national levels, guides the presentation of the findings.

Key findings

Attributes of the healthy family

Based on drawings of healthy and unhealthy families in tandem with the ensuing conversations about the drawings, the following attributes were identified:

- Small family, typically with mother, father and two children, who were happy, well-nourished and well-dressed
- Separate living, cooking, bathing, and toilet quarters
- Well-built house with windows and a front door
- Fenced yard with trees and a clothes line
- Separate quarters for animals (a kraal)
- A plot to represent farming
- Very clean environment.

Attributes of the unhealthy family

- Many children, typically 6 or 7
- Mud hut with thatched roof
- Malnourished, poorly dressed family members
- Open defecation
- Animals living with humans.

Factors associated with healthy and unhealthy families

Structural factors

Although there were wide-ranging discussions about structural factors that affect health outcomes, four key areas stood out:

- Poverty, particularly with respect to the implications for food security
- Access to education
- Hygienic conditions
- Access to health services, bed nets and information sources.

Family-level factors

- Appropriate use of contraception and limiting the family to two, and not more than three, children.
- Food security and access to the six food groups linked to positive health outcomes; food insecurity associated with poor health outcomes.
- Use of a covered toilet to avoid diarrhea, cholera and other fly-borne diseases.
- Washing with soap and water to avoid disease transmission.
- Loving and harmonious relationships within the family; mutual faithfulness.

Individual-level factors

- Practicing abstinence, faithfulness or safer sex.
- Working hard and consistently throughout the year.

Malaria

- Malaria considered a major threat to health.
- Participants keenly aware of signs and symptoms associated with malaria; readily identified prevention methods, quite knowledgeable about treatment.
- Cost is key barrier to bed net use.
- Medical attention recognized as vital; fees and distance are the main barriers to seeking appropriate care.

Health facilities

- Access to health care facilities is highly valued, essential to attain and maintain health.
- Women and children main users of health facilities; men are beginning to seek medical attention for themselves and accompany family members to the facilities.
- Poverty is the primary barrier to seeking health care services.
- Distance and the associated costs of transport are the main barriers to seeking care at public facilities.
- Participants expressed dissatisfaction with the conditions (e.g., lack of water) and quality and availability of services in the local clinics.
- Private health facilities are considered better than public clinics, but again, the barrier is cost.

Information sources

- Participants expressed appreciation for the health information they receive, which they consider essential for good health.
- Key sources of information: Health centers at the service level; HSAs, chiefs and community dramas at the community level, and radio to echo and amplify key messages.

Conclusions

Participants tended to be positive and focus on actions that could be taken at the community, family and individual levels, even as they identified many structural factors that are real or potential barriers to health. Most strikingly, the findings point to the widespread belief that small families with two or three children are healthier, better educated and happier, in general, than is true of large families. This seems to contradict quantitative research, and so requires further inquiry. There was also a good deal of emphasis on self-help through hard work, marital harmony, staying in school for a better future and maintaining a hygienic environment.

Selected Recommendations[1]

Structural Level

- Advocate for: A constant supply of family planning methods so that those desiring to use them have access; better conditions in health services; increased suppliers and supply of nets to overcome the scarcity identified by participants.

Services

- Reconstitute the Health Center Committees where they are no longer active, or reorient active committees to ensure better relationships between facility and surrounding community.

Community Level

- Prevention Continue to promote the social norms of net use, family planning, HIV testing and condom use.
- Family planning: Promote contraceptives that are available at clinics and at the community level.
- Water and sanitation: Encourage communities to work together to build boreholes and maintain, and to adopt an "Elimination of open defecation policy".
- Information sources: Work with village heads, chiefs, and HSAs to serve as primary channels for health information; reinforce messages through the use of community drama and radio programming.

Family/Individual Level (via communication programs, including radio)

- Focus greater efforts on prevention – using nets, FP, better hygiene and sanitation - so that people have less need to go to clinics.
- Family planning: Continue to emphasize the advantages of the small family; make contraceptives available to households, possibly through HSAs.
- Hygiene: Work with families to encourage them to make their environment more hygienic; continue to emphasize the importance of hand washing with soap and water after using the toilet, changing or washing a baby's nappy, before preparing food, before eating or feeding a child.
- Clean water: Continue promotion of chlorine and waterguard to increase access to clean water; explore the option of promoting solar disinfection, which is free and easy to use;
- Nutrition: Work with families to teach them how to access the six food groups, particularly in light of the limited resources available in the village; inform families that pregnant women need an extra meal per day and breastfeeding women need two extra meals.
- Men's involvement: Encourage men to become more engaged with family wellbeing, where feasible – so the burden is not all on women to be the caretakers.
- Malaria

[1]The full list is at the end of the report; this is only an illustrative list.

- Increase knowledge around the importance of getting to the clinic without delay with small children who have fever, while ensuring at the service level that staff members are available to see them.
- In the event of insufficient nets in a household, encourage parents to communicate and decide together which family members should be sleeping under the net.
- Program interventions should continue to highlight the increased susceptibility and severity of malaria in pregnant women and children under 5.

Chapter 1: Introduction

1.1 Background

a. National Context

Malawi is a sub-Saharan African country located south of the equator. The country is divided into three regions: Northern, Central and Southern. There are 28 districts in the country: 13 in the Southern Region, 9 in the Central Region, and 6 in the Northern Region. Administratively, districts are subdivided into traditional authorities (TAs) that are presided over by chiefs. Each TA is composed of villages, which are the smallest administrative units and presided over by Village Heads.

According to the 2008 Population and Housing Census, the population in Malawi is estimated at 13.1 million with an intercensal population growth rate of 2.8 percent per year. Population density increased from 105 persons per square kilometer in 1998 to 139 persons per square kilometer in 2008 (NSO, 2008).

Life expectancy at birth in Malawi is estimated at 52.3 years for women and 49.6 years for men (NSO, 2008). According to the Malawi Demographic and Health Survey (MDHS) 2004 and 2010 there was a decrease in under-5 mortality rate from 133 deaths per 1,000 live births from 2000-2004 to 112 deaths per 1,000 live births from 2005-2010 (NSO and ORC Macro, 2005 and NSO and ICF Macro 2011). The maternal mortality ratio has also declined from 984 deaths per 100,000 live births from 1998-2004 (NSO and ORC Macro, 2005) to 675 deaths per 100,000 live births from 2004-2010 (NSO and ICF Macro 2011).

Malaria is endemic throughout Malawi and continues to be a major public health problem. It is the leading cause if morbidity and mortality in children under 5 and among pregnant women. It is estimated that Malawi experiences about 6 million episodes of malaria annually (HMIS, 2011).

Malnutrition among children remains high in Malawi though it has declined since 2004. The stunting rate declined from 53 percent in 2004 to 47 percent in 2010. Anemia prevalence among children declined from 73 percent in 2004 to 63 percent in 2010 (NSO and ICF Macro 2011).

Figure 2: Map of Malawi

b. SSDI-Communication Project

SSDI-Communication is a social and behavior change communication (SBCC) project that promotes normative and behavior change in several health areas including Malaria, Maternal, Neonatal and Child Health (MNCH), Family Planning, Nutrition, HIV/AIDS and Water, Sanitation and Hygiene (WASH). The Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU. CCP) implements the project in partnership with Save the Children International and several local organizations including CRECCOM, YONECO, Story Workshop, Galaxy Media and the University of Malawi. The project began in September 2011 and will run through 2016. An important feature of this project is that it is one among three allied projects that collectively form USAID's Support for Service Delivery Integration (SSDI) program. The other two projects focus on service delivery (SSDI-Services) and policy and systems strengthening (SSDI-Systems). SSDI-Services is an important collaborator on the project as SSDI-Communication strategies and SSDI-Services mobilization strategies build on one another. The geographic focus of SSDI-Communication is two-fold:

- Nationwide coverage, particularly through mass media, campaigns and capacity building, and
- Intensive implementation in the districts of SSDI-Services (through the project's local partners). These districts are: Mangochi, Machinga, Balaka, Zomba, Mulanje, Phalombe, Nkhotakota, Nsanje, Chikhwawa, Kasungu, Dowa, Salima, Lilongwe (urban and rural), Chitipa and Karonga.

The goal of the SSDI program, including SSDI-Communication, is to contribute to progress in three critical areas:

i. Reducing fertility and population growth, which are essential for attaining broad based economic growth;
ii. Lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity; and
iii. Lowering maternal, infant and under-five mortality rates.

1.2 Objectives of the Formative Research

The primary objective of this formative research is to use qualitative methods to gain an in-depth understanding of what factors Malawians associate with a "healthy family" and what challenges they face as they seek to attain and maintain good health. The underlying assumption behind this effort is that such an understanding can assist the project in developing, implementing and evaluating a multilevel program that promotes the health and wellbeing of families and communities.

The specific objectives of this research are to:

- Gain insight into how Malawian men and women characterize and understand what constitutes "health," what factors promote positive health practices and what factors are perceived to stand in the way of good health, including the role of malaria;
- Gain a clearer understanding of how Malawian men and women perceive health care facilities and information sources, and
- Provide meaningful input to the design and implementation of health communication programs.

1.3 Conceptual Framework

Most research regarding the causes of disease and ill health has focused on individual behaviors, which are the proximal causes of disease. Consequently, most health interventions have been designed to exhort individuals to change their behaviors.

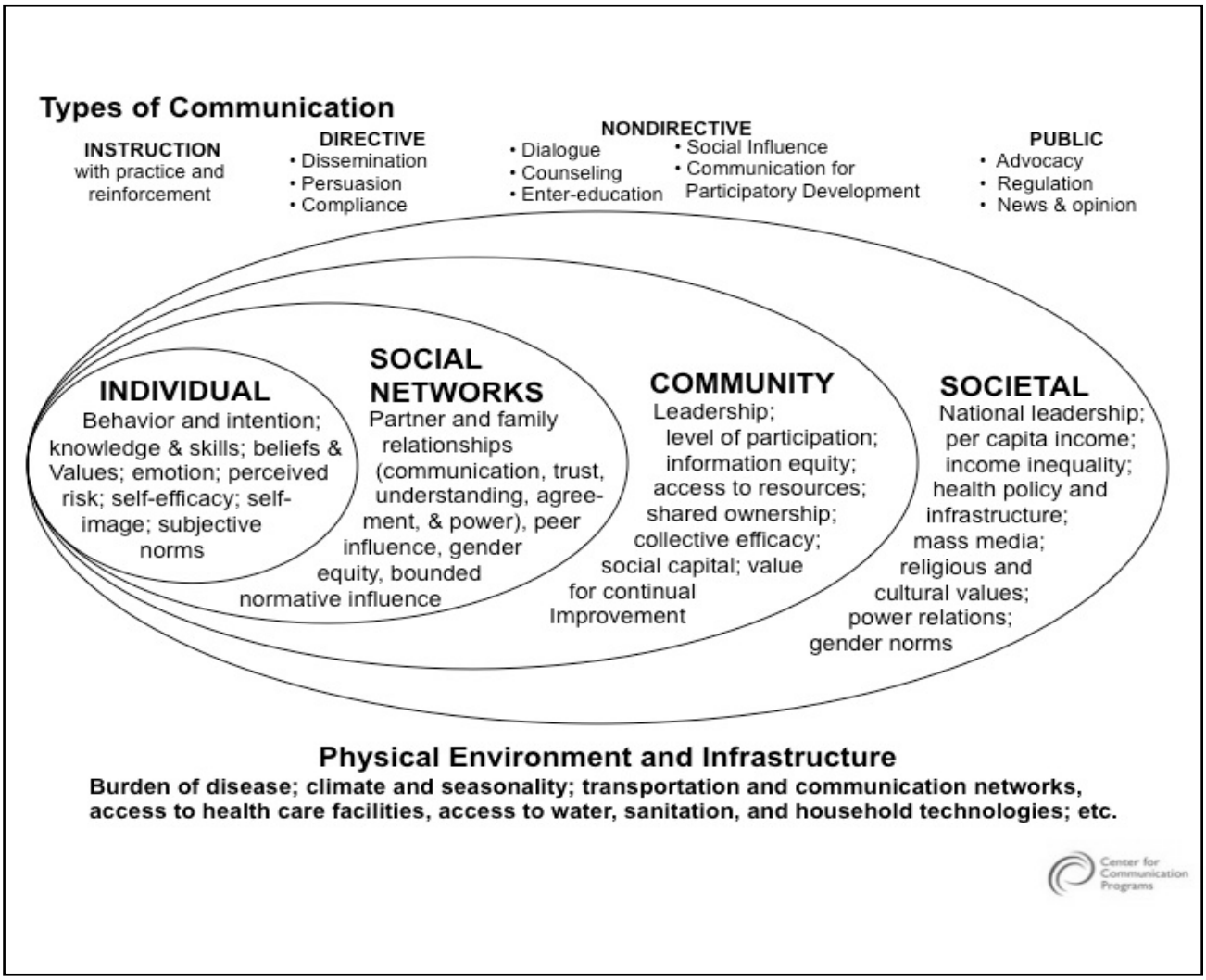


Figure 2: Social ecological framework

Increasingly, however, public health scholars and practitioners alike have come to recognize that distal factors – such as economic conditions, levels of inequality and differential access to essential resources – must be taken into account when designing health interventions. In their seminal article entitled "Social Conditions as Fundamental Causes of Disease" (1995) Link and Phelan argue that socio-economic conditions cause disease (or enable health) through differential access to knowledge, money, power, prestige and advantageous social connections. They note further that it is vital to understand what puts individuals or families "at risk of disease," in short, to identify the contextual factors that create unhealthy conditions that are often associated with unhealthy behaviors.

This research was therefore informed by a social ecological (SE) framework (Figure 2), which posits that individual, household, social network, community, and national factors affect the health and wellbeing of community members by influencing, directly or indirectly, families' and individuals' ability or propensity to act (Bronfenbrenner, 1979; Rose, 1985; Institute of Medicine, 2001; Krieger, 1994)., Findings are presented within this SE framework.

Chapter 2: Formative Research Methods

2.1 Overview of the methodology

This formative research study was designed to generate insight into how communities understand and characterize "health" and "wellbeing," and what it means to be healthy at various stages of life (from newborn to adulthood). Given that malaria is such a critical health problem in Malawi, participants were asked a set of questions specifically about malaria prevention and treatment. Since service delivery is integral to SSDI, questions were asked regarding the local health facilities, such as who uses them and why.

2.2 Research sites

Research was conducted in Chitipa, Nsanje, Phalombe and Salima, which are among the 15 target districts for the project. The districts were selected based on the five health zones, with one district per zone, except for the Central West zone.. Cultural diversity was another factor in the selection of the districts. Physical location in terms of proximity to the lakeshore was considered as these locations have different cultural settings. As shown in Table 1, a total of 32 focus group discussions (FGDs) were held, 16 with women and 16 with men, grouped according to life stage. There were also 49 key informant interviews (KIIs) conducted across the four study sites.

Table 1. Types and numbers of FGD participants and key informants involved in the study

Type of Session	Age group (# of FGDs)	# of Respondents
Female FGDs	Single (4)	38
	1 child (4)	46
	2-3 children (4)	49
	Elderly (4)	52
	Sub-total (16)	185
Male FGDs	Single (4)	42
	1 child (4)	36
	2-3 children (4)	45
	Elderly (4)	39
	Sub-total (16)	162
Key Informant Interviews (KIIs)	Nurses/Clinicians	4
	HSAs	5
	Health Volunteers	3
	Traditional practitioners	3
	Teachers	2
	Chiefs	9
	CBO/FBO/VDC leaders	21
	Religious leader(s)	2
	Sub-total KIIs	49
	ALL RESPONDENTS	396

Data analysis

All FGDs and KIIs were tape recorded, transcribed in the local language and then translated into English. Both the Malawi- and Baltimore-based teams coded the transcripts. Differences in coding were discussed and all changes were based on mutual agreement prior to data analysis.

Chapter 3: Healthy and Unhealthy Families

3.1 Perceptions regarding healthy and unhealthy families

Following introductions, the facilitators read the approved informant consent form to the participants, obtained their oral consent, and then initiated the discussion by asking participants to break up into two groups. One group was asked to draw a healthy family while the second group drew an unhealthy family. This exercise is a projective technique[2] and was intended to serve both as a warm-up and to jumpstart the conversation about what constitutes a healthy or unhealthy family, without any guidance from the facilitators.

a. The healthy family

Figure 3 was drawn by one of the FGD groups when asked to draw a healthy family. The drawing depicts many of the components that study participants would associate with healthy living over the course of their discussions, including a well-nourished, well-dressed nuclear family with two children, chairs to sit on, separate living, cooking, bathing, and toilet quarters, a fenced yard with trees and a clothes line, separate quarters for animals (a kraal), a plot to represent farming and a very clean environment. In addition to the tangible facets of healthy living, many of the pictures evoke a sense of harmony within the family.

Figure 3: A healthy family

[2]Projective techniques are an unstructured and indirect form of questioning that encourages respondents to project their underlying motivations, beliefs, attitudes or feelings regarding the issues of concern without guidance or direction from the research team.

There were slightly different perspectives presented by the various groups, with some discussing tranquility within the household and others focusing on the details of house and yard:

> *…This family is a healthy one because both the man and the woman look healthy (plump), the house looks good; they have a water tap, a kitchen and a toilet; the house looks clean, with flowers . . . there is a vegetable garden where they grow crops . . .a kraal for cattle, goats and chickens. They also have a maize garden. The family has two children. (FGD, women with 2-3 children, Salima District)*

b. The unhealthy family

Drawings of unhealthy families, such as shown in Figure 4, typically depicted a couple with seven or more children living in a thatched-roof hut with no kitchen, toilet or bathroom. The surroundings are extremely unkempt, there are no chairs, family members are poorly dressed, dishes are on the ground and a child is defecating in the grass.

In describing the pictures they drew, participants talked of unhygienic living spaces, fighting between the couple, and lack of other necessities.

P5: (Laughs first) *There the husband has drunk beer.*
P5: *Without reasoning.*
P1: *And again there is no toilet.*
F: No toilet?
P1: *Mmh, they go in the bush.*
P2: *Ah, the house too is of compacted earth.*
P1: *The wife and husband it seems there is no coordination.*
F: When you say there is no coordination what do you mean?
P2: *They don't agree with each other.*
P2*: When people don't agree in a house even people can know that there is no agreement in this house, just look at what is happening between the husband and the wife, there is nothing that the man….woman can do.* (FGD, men with 2-3 children, Chitipa District)

The discussion revolved largely around the basic necessities of living, including subsistence living with an emphasis on factors associated with access to adequate amounts of food in sufficient variety to provide the essential nutrients and calories – which was often linked to having "too many children."

Figure 4: An unhealthy family

3.2 Factors associated with healthy and unhealthy families

Table 2 presents the qualities linked to healthy families. A fuller presentation of the data gathered can be found in Appendix 1.

Table 2: Key attributes of healthy families identified by participants in 32 FGDs and 49 Key Informant Interviews (KIIs)

Attribute		Number of FGDs	Numberof KIIs
Food/diet	Diversification & adequacy	32	21
	Food secure throughout	22	32
Hygiene & sanitation	Possessing sanitary facilities	32	32
	Good clothing/personal hygiene	14	9
Family planning, health & nutrition	Fewer children/child spacing	30	17
	Healthy bodies/non-malnourished	18	23
	Fewer or no illnesses in family	32	16
	Hospital nearby	24	3
Peace, love & trust	Peace in household/no violence	25	17
	Faithfulness in the marriage	20	22
Access to social services	Educated members/children	27	18
	Access to potable water	22	11
Better housing	Good looking/strong house	27	17
	Clean house/surroundings	18	12

Not surprisingly, attributes associated with unhealthy families, shown in Table 3, were the opposite of those associated healthy families:

Table 3: Key attributes of unhealthy families identified by participants in 32 FGDs and 49 Key Informant Interviews (KIIs)

Attribute	Number of FGDs	Number of KIIs
Illnesses	28	21
Limited access to or expensive health care	22	19
Poor sources of water	23	18
Expensive farm inputs	23	18
Large family size	24	14
No or low levels of education	15	18
Violence/Lack of peace in families	17	12
Laziness	13	9
Lack of toilets	7	6

3.3 Structural/community factors

According to Wilson (2010), social structure refers to the way social positions, social roles, and social networks are organized in our institutions, such as the economy, politics, education, legal framework and enforcement. For the purposes of this report, social structure is defined as the "socially determined rules and systems that influence individuals' and groups' access to resources."

Structural barriers to health loom large in the lives of many Malawians, a fact that was reflected time and again in the group discussions and interviews. Given that the key objective of this research is to inform health communication programs, this report will focus primarily, though not exclusively, on factors that can be influenced by health communication and interventions to improve service delivery.

a. The economy and food security

The economic situation is a structural factor that supports, or fails to support, healthy families. Although household wealth varies within communities, the overall economic condition is one of poverty, and economic challenges are ubiquitous in the lives of rural Malawians. While references were made to individual agency and individual responsibility to work hard and do whatever was possible at the individual and family levels, there was also broad discussion of factors lying beyond the powers of the individual, that are key to health. Most of the identified structural factors ultimately affect access to four key resources. These are poverty, which was particularly linked to food security (whether access directly to food or to the money to purchase food), access to education, hygienic conditions (with a focus on access to potable water and adequate sanitation) and access to health services. There was a sense that most families, including those enjoying "good health," were struggling to maintain their wellbeing, primarily due to the difficult conditions in which most rural Malawians live. Yet, as described below in the sections on family- and individual-level factors, respondents were quick to identify actions that they could take to improve health outcomes, despite structural hurdles.

Just as "healthy" was often synonymous with "wealthy" in the respondents' discourse, "unhealthy" was used interchangeably with "poor." Study participants pointed to poverty as a key driver and a fundamental cause of poor health. Study respondents mentioned some of the structural factors that can make it difficult to escape from poverty. These include a local economy without the absorptive capacity to provide jobs for the working age population, as described by the following key informant:

> *…Poverty, I mean that it is possible that the person has gone to school, did not get employed, fine, because of a lack of jobs. The person maybe does not have a piece of land that he/she can cultivate . . . we don't have factories where people can go, those people that did not finish school . . . that means his/her everyday life it is a bit difficult, in terms of how can the person behave and what can the person do.* (HSA, Phalombe District)

Poverty leads to a vicious cycle: Poor people do not have the wherewithal to purchase or cultivate food sufficient to their needs, which leaves them too weak to work, and so on.

> *…Most of the times poverty makes it difficult for people to become healthy, when one is poor, it is difficult to develop the family, because you cannot go to work in the garden and you cannot go to do piecework when there is no food at your house.* (FGD, single young men, Nsanje District)

The fact that lack of food was mentioned in all FGDs and KIIs provides evidence that in rural Malawi food security is a key structural factor.

b. The environment

Since most respondents live in areas dependent on farming, they highlighted the need for fertile land sufficient to feed their families.

> *…Healthy life means . . . enough land to harvest the crops, then the children in this season can eat porridge . . . To us healthy life means being happy, the children being given enough food to eat, and farming.* (FGD, female elders, Salima District)

Despite hard work and determination to cultivate their fields, there are times when environmental conditions create difficulties.

> *…Some can prepare to work hard in fields in a particular year but then the rains are erratic or there is a dry spell and they do not have enough money to buy fertilizer, they end up being disappointed.* (FGD, women with 2-3 children, Phalombe District)

c. Access to good roads, markets and electricity

When people live in communities that are along passable roads, they are able to get their crops to the market, where they can sell them at a profit and purchase other necessary goods.

> *…If the road is in good condition . . . when people cultivate their seeds, they do see a good market indeed and buyers are available because they do follow that good road to the market and buy seeds and sell them also at high prices. Yes, it's important.* (VDC, Nsanje District)

Several of the men's and women's groups suggested that access to electricity contributes to health in various ways, including by expanding communication channels for health information and by saving time for food cultivation.

> *…I believe if we can have electricity, we will not travel long distances to the maize mill and this can help us . . . come back in good time and then go to the garden as well and irrigate our vegetables thereby assisting us in bumper harvest which will lead to good health . . .* (VDC, Phalombe District)

Some of the groups lived in areas with limited plots of tillable land, which they associated with poverty and difficulties in meeting their basic food needs. One group indicated that inadequate land to meet the farming needs of their community was a result of rapid population growth.

> *…But now the population is high, people are lacking places for farming so that they can get food. We are continuously farming (on the same land), but the land has lost its fertility.* (FGD, female elders, Phalombe District)

In other instances, land was available but its yields were low without fertilizer. Poor people are hard-pressed to purchase the fertilizers needed or even to procure loans for the purchase of fertilizers.

> *…They do not eat balanced meals because even if they cultivate crops, the fertilizer is not sufficient so they do not have enough food to eat.* (FGD, mothers with 2-3 children, Phalombe District)

Those farmers and villagers who happen to live in communities with inferior roads and inadequate transportation will struggle to get goods to the market, thus severely limiting their ability to sell any surplus crops.

> *…If you grow maize this year for example you need to think, where to sell your harvest? You must have a market where you can sell your produce. Like some people do grow crops but eventually, [the crops] rot in their respective homes.* (Unmarried man, Phalombe District)

d. Schooling

Access to schools is a structural factor in that whether schools are within walking distance of a given location and whether there are costs associated with school attendance are both decisions made by politicians and government authorities rather than by parents. However, a child's attendance at a local school can be family related and so it is also addressed in the section below on family-level factors.

Most of the respondents identified education as key to health as well as to overall success in life. Most FGDs and more than half of the key informants mentioned education as a key component of healthy living. Most also noted that, even when parents are unschooled, the children should go to school so that they can help their families as well as themselves. Referring back to the healthy families they had drawn, more than one group noted that family members "seem to be educated."

While a few respondents described cases in which parents failed to send their children to school because they were short-sighted and some faulted the child for laziness, many argued that the costs associated with schooling for poor children should be covered by others[3]. A few respondents called for the government to build schools near their communities.

[3]School fees as such were abolished in 1994, however, all primary schools levy various charges, which combined amount to be more than was paid in tuition fees. Secondary education is not free, and all secondary schools charge tuition fees.

> *…Because we were saying that there are some who . . . have the heart of going back to school but . . . We ask ourselves that if I start school again, who will pay my fees?* (FGD, new mothers, Chitipa District)
> *…If my child is attending school and doing well every year but lacks school fees, he/she goes to secondary school, organizations should come in and help by paying the school fees. In that way, the parents and child have been assisted.* (FGD, women with 2-3 children, Phalombe District)

e. Access to medical care

The use of and perceptions regarding health care services are described in Chapter 5, but it is worth noting that about two-thirds of the participants mentioned the need for access to medical services – meaning both physical proximity and affordability –as necessary to the maintenance of good health.

In particular, they noted the importance of treating illnesses promptly and the need for transportation, since facilities were not usually located in their communities. (See Chapter 5 for more details)

f. Potable water

Access to potable water is a community-level factor when it comes to digging boreholes and making piped water available. But it becomes a family-level factor if individual households are expected to treat their own water. Therefore, potable water is addressed both here and in the next section. As described in the following quote, maintaining boreholes requires community planning and involvement.

> *…We teach them about boreholes, we usually go round to these boreholes and teach them to have a separate fund in case the borehole breaks down. They should just use these funds so that they can always have good water.* (Health volunteer, Salima District)

Not all communities had access to potable water, yet almost all respondents were aware that unclean water is the source of many diseases. In fact, the lack of access to "clean" water was mentioned as a reason for poor health in two-thirds of the FGD sessions and half of the key informant interviews.

> *…They promote diarrhea because they drink water that is not covered and the cup used is just put on the floor. When a child comes he/she just picks the cup and draws the water and drinks. (FGD, women with 2-3 children, Nsanje District)*

> *…You can contract diseases like cholera [from water drawn] from the river . . . they defecate and . . . also pass out urine; then they drink the same water; they can suffer from cholera . . . (FGD, female elders, Chitipa District)*

g. Social networks and community-level barriers

The failure of community members to keep the community clean, to eliminate open defecation, and to protect water sources were all seen as reasons for poor health. There were some reports that resources such as fertilizer and loans provided by the government or even by the chiefs were unfairly distributed, leaving many families without the necessary resources to feed their families. Some respondents also noted a lack of security and an increase in theft.

Several groups and key informants suggested that community members should look to successful members of their community – that is, those who have income adequate to meet the needs of their

families – as role models whom they should emulate so that they, too, will be able to enjoy a better life.

> *…And also admiring your neighbor, how is my neighbor living life? Admiring, wanting to be like them, that can also help because looking at how your friends are, seeing how good their family is, that means they are able to understand one another because they listen to each other. Even yourself you can adopt their way of living, you ask them, "How are you living in your family?" And from them you get knowledge.* (FGD, new mothers, Chitipa District)

Comparison with others can be a double-edged sword, however, as at least as many FGD groups (though not key informants) argued that success often may come from wrongdoing, such as stealing from, or even killing, others.

> *…After seeing that things are going on well in this family, that there is development and understanding, people say bad things about this family. Saying that this family is boastful and they eat well. Not knowing what is making them develop. [To which another group member added] Yes, people say that they are developing fast because they killed people in order to get riches.* (FGD, women with 2-3 children, Salima District)

At least one FGD group in each of the four districts and several key informants asserted that successful people – i.e. healthy families who were better off than their neighbors – were envied and would be undermined by others in the community, implying that it is better not to stand out from others in the community.

> *…The other problem is that when a couple agrees to work hard and jointly, outsiders come who discourage them by saying, "Who do you want to be by doing this?" (That is to say, by working hard). "Do you want to be the best in the village?" This makes them discouraged. (FGD, women with 2-3 children, Phalombe District)*

> *…Their cattle might end up in someone else's kraal. (FGD, women with 2-3 children, Salima District)*

And in 11 FGD sessions, participants indicated that families that live healthy lives (healthy almost always implied "wealthy" as discussed above) and/or are considered rich sometimes fear that they will be the victims of witchcraft as a result of other villagers' jealousy and malice towards them.

> *. . . Some of their friends hate them because of what they are doing in life and they can attack them through witchcraft and magic . . . (FGD, women with 2-3 children, Nsanje District)*

> *…Some people have died from accidents…… these people get bewitched and die through bicycle accidents (falling from a bicycle) or they just faint. The accidents or illnesses just come unexpectedly and then they are taken to the health clinic….they don't find any medical causes with the victims…. so some well-to-do people do not feel good about this… they fail to sleep thinking of how to protect themselves and this affects their well-being and health status…(FGD, men with 2-3 children, Phalombe District)*

Nonetheless, there were some study participants who described a level of fellowship and mutual support amongst community members. Listening to the advice of others and joining community groups were seen as pathways to better health.

…You need to be found in groups where people help each other and you are supposed to be in those groups to hear what your friends are saying . . . so that we can discuss how to keep our homes clean. (FGD, new mothers, Salima District)

…They can also be helped in one way or the other by associating with others by joining different groups. By doing this they can easily attain good health. (Health volunteer, Salima District)

3.4 Family-level factors

a. Food security - quantity and quality

Access to food is influenced by the whole gamut of social ecological factors, as described above. Access to food is a community or local factor in that the variety and amount of food a household has to eat is to a considerable extent linked to the availability of farm inputs and with the environment. For these reasons, food security was addressed under structural factors related to the economy.

Yet, although individuals and families cannot always control their access to arable land, the level of effort invested in farming and food procurement is largely an individual-level factor, as we will see in the next section (Individual-level factors).

Working hard consistently throughout the year was associated with better access to food. And with sufficient food, one is better able to pursue more rewarding types of livelihood.

…Like poverty, if someone who wants not to have poverty in his life, firstly you need to have food and food is found through farming and you should farm for yourself so that you can have food throughout the year. (FGD, new mothers, Salima District)

….When you have enough food you won't be busy with low-paying piece work (ganyu) hence you will have enough time to do other things at home….(FGD, men with 2-3 children, Phalombe District)

In all FGDs and KIIs, access to adequate food in terms of calories, nutrients, and consumption of a variety of food was the fundamental concern that outweighed all others. Interestingly, several FGD groups and many of the key informants explicitly discussed the need to consume foods from the six food groups. And most groups were able to mention four to six food groups.

. . . The [healthy] family has a vegetable garden and when they buy fish or meat, they can make the six groups of food. They make the six groups when for example they cook vegetables with groundnuts, floor and tomatoes and then have eggs. (FGD, women with 2-3 children, Salima District)

…Yes we have six groups of food which we tell our clients to be eating…the first group is that of vegetable, for example Chinese (cabbage), bonongwe (amaranthus)…we also have energy giving food like Nsima, Rice, Cassava…we also have protein giving foods including fish, eggs, even meat too. There is also that group of fats like groundnuts, oil. The fruits group includes mango, pawpaw, and pulses, which include beans… (Key informant, Salima District)

Nearly two-thirds of the FGDs and most of the KIIs referred to concerns about food security, with several groups and key informants explicitly referring to persistent or periodic hunger as a problem. Some FGDs also reported that some households experience transient periods of hunger at various times of the year depending on the availability of food stored in the household. There are some households that have food throughout the year while others have adequate food only during the months immediately after harvest season.

> *…Food is also not enough . . . It's not all of us who are rich; it's only a few. Some are poor, in terms of food . . . With the hunger that is here this year. (FGD, women with 2-3 children, Salima District)*

The lack of food was also associated with a sequence of negative outcomes that could lead to a vicious cycle of anti-social behaviors and poor health outcomes.

> *…They should learn farming ... they should have gardens, plant things, then they will be well ... they will change and have healthy lives. They should especially have food and a house, because when they don't have food, the children can start stealing since they are hungry. If it's the woman ... she may go to other men and contract diseases in the end . . . (FGD, female elders, Chitipa District)*

b. Schooling

While the absence of schools within walking distance of a community and the costs of schooling were discussed under "structural barriers," some participants argued that it was parents who failed to exhort their children to study that leaves them in difficult straits today.

> *…So these ones are not educated and their parents did not support them, that's why they are in poverty. Had it been that they are educated they would have been like this one who is doing well here because their parents encouraged them. (FGD, male elders, Salima District)*

While the costs of schooling are a structural factor as they are largely determined at the national level, some participants associated the inability to pay such fees with having too many children, which is a family-level decision.

> *…With the [large] number of children . . . they cannot afford to pay their school fees because they are many. (FGD, women with 2-3 children, Nsanje District)*

> *…Some of our parents are poor; they don't have money to pay school fees, maybe we are a lot in the family so they can't afford school fees. (FGD, new mothers, Chitipa District)*

c. Susceptibility to illness

Although it wasn't typically the first topic introduced by study participants when discussing what constitutes health or healthy living, all FGDs and two-thirds of the key informants noted that a healthy family does not get sick often and when illness does strike – which is inevitable even in healthy families – such families seek care soon after the appearance of symptoms.

> *. . . if one has good health that means he or she does not get sick now and then . . . s/he stays strong because he does not get sick . . .* (Health volunteer, Salima District)

> *…Even if they are healthy their family suffers from illnesses. They may prevent malaria, diarrhea and some diseases that come due to lack of hygiene. But there are some diseases that just come unexpectedly.* (FGD, women with 2-3 children, Phalombe District)

There was one exception to healthier or "wealthier" men's lower relative susceptibility to illness: namely, relative to their less well-off counterparts, they were perceived to be at a higher risk of contracting HIV and other STIs as they were said to be more likely to have multiple sexual partners. (Parenthetically, it is worth noting that the respondents typically associated health with wealth; there was little mention of someone who was materially poor, but healthy and resourceful.)

> *. . . Well-to-do people are sexually immoral.....especially when the man would not resist a beautiful woman passing by ……they will call her, buy a bottle of Fanta with a scone/bread known as Obama[4], then give her a K1,000 note to kill all her resistance in addition to the Fanta which has already paralyzed her . . . the next thing he gets her phone number . . .(FGD, men with 2-3 children, Nsanje District)*

d. Income/cash

Healthy families were also identified as those who have access to money, whether through selling their crops, piecework, or through income from business. Cash or having a dependable source of income was cited as a key attribute to achieving the status of wellness or healthy living in families across the four districts. Cash allows families to buy farm inputs to intensify their farming, which results in harvesting more crops that household members can consume.. Thus food security and/or the ability to sell to purchase necessary goods and services is enhanced. Two-thirds of the FGDs and 9 key informants noted that cash enables families to buy food from the markets, whether to supplement their own production or diversify their dietary patterns.

> *. . . If you have money you can buy any relish you want to eat so that you live a better life for yourself…. (CBO, Salima District)*

Having cash on hand was also associated with the ability to pay school and clinic fees.

e. Shelter

Shelter was a key concern, discussed by almost all groups. Ideally, a family would have solid living quarters with a roof that didn't leak and the toilet far away from the kitchen. Over the course of the discussion, participants typically described four separate quarters for the home: the main house, a kitchen, a toilet and a structure for bathing or washing. It was often said that the kitchen should be far from the toilet. The house should be situated in clean surroundings.

> *….A good sleeping place helps one to have good health, if a person sleeps at place that is not good, like many of us we just sleep on the floor….you cannot say you are living healthily…..in this community there are bugs (mphutsi) that come from the floor if your children have bed-wetting problems…. these bugs they bite and they can even cause diseases…if a person is sleeping at a good place, say on a bed or mattress, then you can avoid these bugs ….*(Health volunteer, Salima District)

[4]The Obama scone is considered a "savior" because of its cheap price relative to size. Apparently, some rural people regarded President Obama of the USA as a savior to their economic problems when he first came to power. As such the scone was nicknamed after him.

f. Sanitation and hygiene

All groups and key informants discussed the need for sanitary facilities. A covered toilet "properly used" was considered key to avoiding diarrhea, cholera and other fly-borne diseases. About a quarter of the key informants and half of the FGDs mentioned the need to wash hands with soap and water.

> *…There is a toilet, a toilet is there for any waste but some time it may happen that you have a toilet and it is not properly used. But with this family they have a toilet and it is being used properly. If the toilet is not used properly children can be in danger, in terms of diseases.*(FGD, men with 2-3 children, Phalombe District)

> *…Things that make a person to have good health easily are: firstly a place to sleep that is good, secondly they should have a toilet that they can use – we also encourage that they should have a hand washing facility that they can use after using the toilet – soap should also be there; thirdly, a bathroom, fourthly a rubbish pit. (Health volunteer, Salima District)*

Washing clothes and bathing regularly were also cited by about a third of respondents. For some, it was a matter of the mother being clean so that she would not transfer germs to the family while she was cooking.

> *…Once you are back from the garden get some water and wash your body, even before going into the kitchen to start preparing meals, take a bath and change your clothes. When you do that it means you have taken care of yourself.* (FGD, female elders, Nsanje District)

For others, bathing was a matter of protecting oneself from diseases.

> *…For instance, a person who does not take a bath can easily get scabies because germs get hold of them often. Also, if they get a cut, the wound does not heal quickly. As a result they fail to work properly and cannot help their family as they have scabies because of not taking a bath. While if they take a bath it's difficult to get some skin diseases. They can even work better with energy. In addition, taking a bath gives energy, water has got vitamins when a person has taken a bath. That's why when a person is tired they take a bath with the aim of gaining energy.* (FGD, new fathers, Nsanje District)

g. Water treatment

Comments about taking care of drinking water by "adding medicine[5] to it" (FGD, single women, Nsanje and Salima Districts) were heard in a few group discussions, but the HSAs and health volunteers tended to focus on this issue more than other participants.

> *…Proper water helps that, especially if we say, firstly, I should say that, when say that proper water, it's water that a person should drink before eating any food or anytime, that water, should be treated with medicine. (HSA, Chitipa District)*

[5]'mankhwala' (Chichewa) is the term used for medicine and also chemical additives.

h. Car/bicycle ownership

Car or bicycle ownership was also viewed as important to the promotion of good health, both because reliable means of transportation improved economic opportunities and, as several groups noted, would make it possible to seek health services when needed.

> *…When some people have things to carry, they hire a car, thus income to the household…their children do not toil in carrying farm produce on their heads as the car can do that…. Also in time of illness, the car is handy to go to hospital…and a bicycle is very essential property in this community as most people are poor so it provides a cheap mode of transport to search for food in far places… (FGD, men with 2-3 children, Nsanje District)*

i. Small family, use of contraception

Interestingly, all but two FGDs and all but a few KIIs maintained that small families – two children were almost universally seen as ideal – were essential to good health and wellbeing and that couples should use family planning. Having a small family again linked back to basic subsistence in that families with fewer children could better feed them.

> *…The food in this family is available because the children are not many. They have one child, with one bag they can eat the whole month. (FGD, men with 2-3 children, Phalombe District)*

Small families, it was explained, not only mean that there will be enough food to go round, but having fewer children is associated with many positive outcomes, from having enough to eat to being able to pay for schooling.

> *…Because my problems will come to an end, since I am a father, since aah, now children will be able to bathe well, go to school, eating, they are eating well and may be they will not be getting sick oftentimes, not being malnourished they are eating well.*(FGD, men with 2-3 children, Chitipa District)

> *…The other thing is that of the house. You should not have many children . . . because when there could be many people that means you will be struggling . . . it can happen that school fees should be paid for six children and you should pay for all of them, which can't happen so there should be two children or three . . .(FGD, new fathers, Phalombe District)*

As is reflected in the following statement, many respondents also indicated that the couple should discuss family planning – among many other topics – with each other and reach mutual understanding.

> *…When you love each other, you discuss as a couple so many things…the number of children you want to have…you will agree to have the number of children that you can manage to take care of and live happily…(FGD, women with 2-3 children, Nsanje District)*

And family planning can contribute to the happiness of the couple.

> *…Family planning also helps because when you practice family planning, the family becomes happy. And you can "dance the magic" anytime (have sex) because the children go out to play. (FGD, women with 2-3 children, Salima District)*

Just as the judicious use of family planning and small families were associated with a healthy family, large families were widely perceived to constitute a key barrier to health at the family level. Families with more than 2-3 children were often described as having inadequate time to attend to the needs of the household, including finding sufficient opportunities to work and bring essential goods or money to support the family. Even when the parents worked, they would be hard pressed to cover the expenses of so many people.

> *…OK, if a person has many children that means the harvest may not be enough because the children are many. Even if he/she finds money it is not enough because he/she manages to find enough money but because children are many the money may seem not to be enough. So this brings about poverty in a household, it's as if they are not working but it is because children are many. In addition to that, if they are giving birth now and then that means there is no time to work, bring developmentinto the household since most of the times she looks after the children.* (HSA, Phalombe District)

j. Marital relationships

Love, understanding and trust between husband and wife were mentioned frequently as key to good health. Importantly, the role of discussions – spousal communication – was often cited as integral to mutual understanding.

> *…Because the husband and wife do their household chores and farm work agreeably without any misunderstandings. If you work hard and understand each other you accumulate a lot of assets for your family. (FGD, women with 2-3 children, Phalombe District)*
> *...When you have peace in the family the husband and wife treat each other with respect. For example your wife giving you what she knows best …. this can enhance the healthy life…* (Key informant, Chief, Salima District)

Faithfulness on the part of both husband and wife in tandem with good sexual relationships were considered key components of a loving and healthy family. Extramarital affairs were linked to STIs, including HIV.

> *…The husband should not have extra marital affairs and the wife as well should not have extramarital affairs because you will bring diseases in the family. If both the husband and the wife can stay together without extramarital affairs, then the marriage can be good. (FGD, women with 2-3 children, Phalombe District)*

Participants across the FGDs noted that both husband and wife must contribute to the healthy family. Many also indicated that the children should work hard and be encouraged by their parents to excel.

> P1: *The husband should work hard at work.*
> P2: *The wife should work hard in her business.*
> P3: *They should encourage their children about school. (FGD, new mothers, Salima District)*

> *…Being cooperative in the family, they can eat well both the parents and the children and will be able to buy good foods to feed the children …. If they work hard everyday…. they will eat. If there is cooperation in the family there will be healthy life.* (FGD, female elders, Salima District)

Violence or lack of peace in families was cited in almost half of the FGDs as one of the major inhibitors to achieving a state of wellness or healthy living. Based on the comments of FGDs and participants who spoke to this point, violence seemed to be fairly common in their communities and this was said to affect men as well as women, though women were mentioned more often as the victims of physical violence. Fighting among children was also discussed in several groups; such fighting was often linked to large families and the (associated) lack of sufficient food.

> *…They could be coming from the farm and the man would tell his wife, could you be fast, you put warm water for me to bath…. And when the woman says, just wait I should rest a little bit, then fights start again…(FGD, new fathers, Phalombe District)*

> *. . . If there are quarrels in the family, it also hinders people in that family from being healthy because sometimes you quarrel over useless things and you don't concentrate on things that will improve your life… (CBO Key informant, Salima District)*

There was also considerable discussion about the detrimental effects on health of disrespectful, dishonest or angry spousal relationships. Marital discord was also widely discussed, often precipitated by infidelity, which led to STIs and conflict.

…The difficulties can be lack of trust in the family. Maybe the man says let's do this and you also say different things. Then every one does his/her own things and the man starts having extramarital affairs because the woman does not respect him. In steady of being healthy they slowly become unhealthy due to the extramarital affairs. (FGD, mothers with 2-3 children, Phalombe District)

> *…You all need to be cooperative without having extramarital affairs because when one goes to have sex outside the matrimonial home and comes back, he/she infects the spouse so the illness affects the family.* (FGD, female elders, Nsanje District)

k. HIV testing as a couple

A few FGDs and several key informants suggested that one aspect of a healthy, loving couple was their willingness to go together to be tested for HIV.

> *…On marriage there, it is required that with your loved one you should go for testing so that you should know your status, with the aim that if you go into marriage you are not to face problems like HIV/AIDS.* (HSA, Salima District)

> *…But even if we say we should love one another but you can't trust each other. We should be going for HIV testing frequentlyto know whether we have HIV or not.* (FGD, women with 2-3 children, Nsanje District)

l. Gender equity

Although not mentioned very frequently, there were a few references to gender equity, as reflected in the following statement:

> *…[The husband and wife should] share one plate when eating . . . and eat equal relish so that one would not be fatter than the other.* (FGD, single women, Nsanje District)

There was some evidence that participants used a gender lens to assign responsibility for health-related actions.

> *You should just say that my husband didn't do it, … you would have said I am married, because the mopping is mine, pots are mine so the other ones like digging a pit is the husband's (FGD, new mothers, Phalombe District)*

3.5 Individual-level factors

While most health-related behaviors were discussed within the context of the family, study participants identified several actions or positive behaviors that individuals could take to attain and maintain health. Foremost among these were that the individual must work hard and avoid laziness; practice abstinence (when not in a long-term relationship) or, barring that, use condoms; get tested for HIV and, if HIV positive, take ARVs; sleep under a bed net (see Chapter 4 on Malaria); and avoid beer drinking.

a. Hard work versus laziness

Many groups asserted that the adults – men and women – should "work hard" in farming and/or in business, and "avoid laziness," while children should "work hard" at school. Working hard was associated with obtaining food and other life necessities, albeit with the understanding that environmental factors beyond the individual's control could intervene.

> *...By working hard, we mean that a person works harder to meet some production they desire and that makes hard-working households food sufficient and thus with improved wellbeing.....whatever you need in your life, is available....and the harder you work, the more you harvest and the less you work, so is the yield..... the same is also true for children...there is no way the children can benefit if they do not work hard in school...(FGD, men with 2-3 children, Nsanje District)*

Several FGD participants indicated that the individual should be self-reliant and augment hard work with resourcefulness, as described below:

> *. . . Do not depend on your husband every time or depend on help from somewhere because even the Bible says that God helps a person who helps him/herself. So you should first start depending on yourself then when others see that you are a hard worker sponsors follow you . . . (FGD, new mothers, Chitipa District)*

> *…No, the issue is the same we must work hard on our own; they look at how you are doing. No person can help you if you just stay, he/she will say if I help him/her, he/she will just squander it. But if you are resourceful, helpers are found, whether those NGOs they give money saying these people want to be helped in their lives, they help you. (FGD, new fathers, Nsanje District)*

Laziness was cited by about a third of FGDs and key informants as a reason for poor health. While laziness was sometimes described as a response to frustrations with non-responsive systems (e.g. no drugs in clinics or poor market prices for goods), it was generally considered an individual weakness.

. . . If the woman is supposed to cook and she just stays without doing anything, it's laziness. If you do not go to work in your garden, it's laziness.
P4: They do not have time for work. Their job is sitting on the verandah and backbiting instead of working to get money. Backbiting does not pay. (FGD, mothers with 2-3 children, Salima District)

The discussions about economic participation of households as well as the discussions on hygiene and sanitation often included a reference to laziness, suggesting that men and women don't participate in gainful economic activities, such as farming or business ventures to secure necessities for themselves and their families or even to make the effort to create more hygienic surroundings by undertaking activities that do not entail costs beyond their own time and labor. This was then associated with unhealthy living conditions.

…Laziness is there because there are certain things he can do on his own without the need of money. For example digging a pit latrine. So to conclude, this person [without a pit latrine] is lazy. (Father with 2-3 children, Phalombe District)

As one group summarized, "laziness, firstly, [leads to] disease" and, secondly, "to living a difficult life" (FGD, male elders, Salima District).

b. Safer sex

With respect to reproductive health, many study participants mentioned abstinence as protective against disease, but it was also common to recommend condom use when abstinence was not chosen. Unprotected sex was usually associated with the risk of STI transmission.

…So while you staying alone they is a need to take care, you should take care of yourself, you should abstain a lot, you should just do one thing so that you should be in the state of wellness. Because if you just loosen yourself you might find out that you have a virus, AIDS; that means your healthy life will not be maintained. (FGD, new mothers, Chitipa District)

…Also when [adolescents] indulge in sexual behavior and use condoms, they find that they still progress . . . When they reach the stage when they experience sexual desires, they should move with condoms. They should use the condoms in preventing HIV, syphilis, gonorrhea, and "chikhutula". (FGD, mothers with 2-3 children, Salima District)

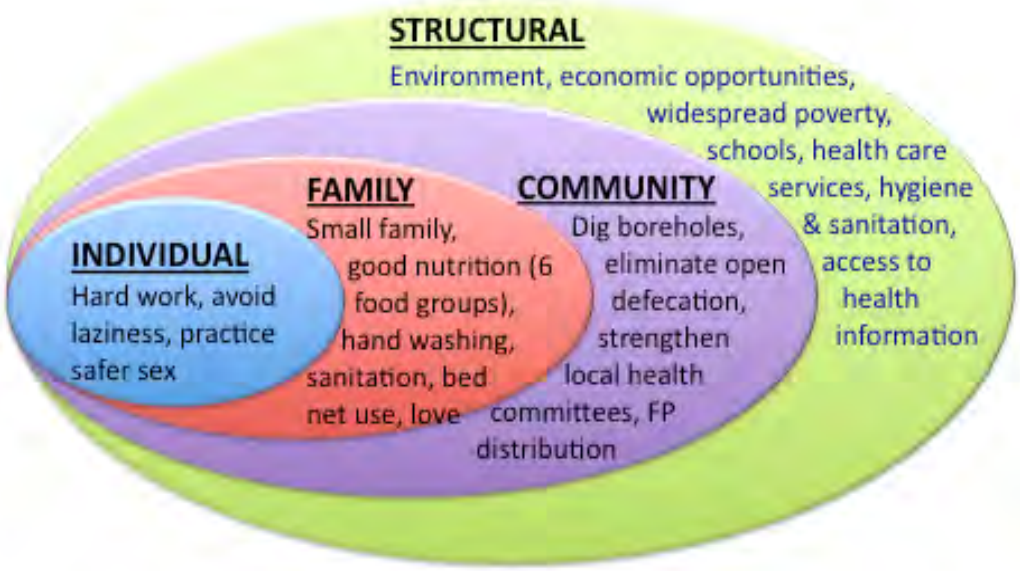
c HIV testing

About one-fifth of FGDs, but only four key informants, mentioned testing for HIV as essential for health. When discussed, testing was often linked to treatment, but also with the need to use condoms if found HIV positive.

…Go for blood testing, after you have been tested if you have been found with the virus, some of us hide instead of going to receive ARVs. So she is saying that you should be going to receive ARVs for your lives to be healthy. (FGD, new mothers, Chitipa District)

…Having one family or one partner but also going for testing to know your body status. If you are positive you need to protect yourself when having sex for your life to still keep going. (CBO, Phalombe District)

Figure 5. Factors Participants Associated with Family Health



d. Beer consumption

Several FGD respondents as well as key informants linked beer consumption to poor health outcomes and to food insecurity due to the expenditure of limited income on beer rather than to meet basic food requirements. Alcohol consumption was also associated with family arguments and, by some, with laziness.

> *…Laziness, he has energy to work but because he spends most of his time drinking beer at the pubs so fails to do his work. (Father with 2-3 children, Phalombe District)*

> *…If we get money and spend it on beer, definitely our bodies cannot be healthy. (Parents mixed, Salima District)*

3.6 Summary: Key factors associated with family health

The diagram below shows the social ecological framework within which the research findings have been presented here, showing the factors listed under structural, community, family and individual levels.

3.7 Potential solutions for unhealthy families

When asked what unhealthy families could do to attain better health outcomes or what once-healthy families could do to regain better health status, respondents referred to the need for multi-level inputs, ranging from structural changes to changes at the individual level (Table 4 below). In many instances, the same themes that arose during the questioning about healthy and unhealthy families came again to the forefront. As in the previous sections, the data are reported here by social ecological level.

Table 4: Partial list of external support that would enable families to achieve, maintain or regain status of wellness or healthy living as cited by FGD and KII participants*

Field	Type of support	KII Sessions	FGD Sessions
Social protection	Food support	23	18
Health	Public hospital or free medical care	17	19
	Mosquito nets	11	4
Social services	Improved water sources	22	18
	School	11	16
Agriculture	Fertilizer or other farm inputs	19	16
	Irrigation equipment	13	9
Income generation	Microloans/Village Savings & Loans (VS&L)	16	21
	Public work programs	3	5
Infrastructure	Roads/public transport	3	8

*For the complete list, see Appendix 2.

a. Structural / Community levels

Respondents were asked what types of support from external sources families in their communities would need to achieve or maintain a good health status. Answers ranged from food support to irrigation assistance, and from access to clinics to schools.

Respondents were aware of government subsidies for fertilizers, but some thought that the farm input subsidy program was inadequate. They argued that very few households receive the coupons to enable them buy the fertilizer and besides, the coupons are often distributed to beneficiaries late in the growing season.

> *. . . The reason is that everyone should be able to purchase the fertilizer when the prices are reduced, even the ones in village. We should all be buying for ourselves not only 400 people who receive the coupons when there are more than 1000 in this village... 'NO' that is killing us.....what about the ones who did not receive? . . . I feel sorry for myself when they are complaining because they are also my people . . . (Chief, key informant, Phalombe District)*

While discussing how a family can maintain or recover from an unhealthy situation, at least one group mentioned the need for job skills training.

> *…Those external organizations should also teach people skilled jobs…because food distribution will have a timeframe ….but if there can be something reliable that people can do which can help them in future…(FGD, women with 2-3 children, Nsanje District)*

Food support was also prominently mentioned and according to the informants who spoke on this, many people in their areas did not harvest sufficient edible crops in the 2011-2012 growing season, resulting in hunger.

> *…Like poverty, if someone who wants not to have poverty in his life, firstly you need to have food and food is found through farming and you should farm for yourself so that you can have food throughout the year. (FGD, new mothers, Salima District)*

At least a third of participants called for the government to build schools in their communities and/or provide assistance to needy families for costs associated with schooling and uniforms. NGOs were also called upon to cover the costs of school fees.

> *…They cannot send children to school because of school fees, they have to contact other organizations for school fees. (FGD, single women, Salima District)*

Others thought that neighbors should step in to help with school supplies.

> *…Also encouraging the kids to go to school, if they are lacking pens and books if the neighbor has them, they should help them so that they go to school. (FGD, single women, Phalombe District)*

With respect to school, it was noted that in some communities young women who had dropped out of school to give birth were reluctant to return out of fear that others would make disparaging remarks. This suggests a need for social normative change and acceptance of young mothers who want to pursue their education.

> *…What if I go back to school, so that I should start again making my future, my friends will laugh at me they be like eee look at this friend of mine she has children but she is still at school, look at her, she is coming from marriage (husband) but she is coming here to school. So because of shyness they stop going to school, they just stay at home feeling sorry ("kumvera chisoni") because of shyness. (FGD, new mothers, Chitipa District)*

With regard to other structural factors at the community level, there was support for the construction of ecosan latrines (slabs) in all four districts. In addition, access to mosquito nets and medical care were widely mentioned; these two issues are addressed in Chapters 4 and 5.

b. Social networks

Respondents noted that government agents, NGO and donor staff, and people in their own communities could all contribute to better health outcomes. Community groups or clubs were seen as important sources of information and advice. According to some participants, farmers' clubs can prove vital to families by providing access to loans and other inputs for community groups; they can also bargain for market prices and transport costs. In one FGD in Chitipa, some participants proposed the concept of "One village, one product[6]" where the villagers would be involved in the production of a product that

6'One village, one product' (OVOP) is a project supported by the government of Japan.

would generate income for their economic recovery by selling outside their own community. Advice from agricultural extension agents was also appreciated.

> *….Nowadays what is required is One village one product...if the village goes for maize, let's encourage each other to grow maize….. we should be in clubs, so that we can learn a lot from them…(FGD, men with 2-3 children, Chitipa District)*

> *….For them to be healthier again they have to meet agricultural advisors…..maybe health advisors so that they can be taught where things are not going well and again they should pray to God for his intervention. (FGD, men with 2-3 children, Chitipa District)*

Some respondents, particularly in Nsanje, advocated for the establishment of community policing units.

> *...Well-to-do people need to reason with some organizations to bring a police unit in our community because we have no security here....thieves would be afraid if they knew that the police are armed…. (FGD, men with 2-3 children, Nsanje District)*

c. Family and individual behavior change

Study participants mentioned ways in which families and individuals could improve their health outcomes, such as by having smaller families, being faithful and improving marital relations, reducing or eliminating alcohol consumption, overcoming a tendency towards laziness, better stewardship of money and adopting more hygienic practices.

Not surprisingly given the almost universal support for the small family in the FGDs and KIIs, many respondents indicated that unhealthy families should turn to contraception as one way to improve their overall wellbeing.

> *…For the difficulties in this family to be reduced, if there is no child spacing you need to agree the two of you (husband and wife) to start using family planning methods or you can just stop having children 'pongoseketsa' and take care of the ones you already have. If you continue bearing children, then your problems will continue. (FGD, female elders, Nsanje District)*

According to some FGD participants, some husbands and wives sell or pawn their farm produce and assets without the knowledge of the other and use the cash for personal issues. Apart from leading to conflicts in the family, this was also associated with poverty and failure of resilience at the family level, that is to say, the family cannot withstand life shocks because they have sold their assets and farm produce. Therefore prudent financial spending and stopping the practice of selling household assets were cited as possible means through which a family can recover from unhealthy situations.

As discussed above, extramarital affairs were cited as the leading cause of conflicts between husbands and wives, which eventually lead to unhealthy living, as described above in the section on 'The unhealthy family'. Extramarital affairs were singled out as sources of STI infections, including HIV, in families, and so behavior change regarding sexual morality was mentioned as a means through which families can recover from unhealthy situations. Such a change would increase the level of trust between the spouses, leading to joint planning at the family level. At the same time, the couple will avoid spending money on medical treatment of STIs, and they will avoid contracting HIV and AIDS and its associated consequences later in life.

And regardless of marital status, it was thought that individuals should avoid unprotected sex.

> *P3: If you have been fornicating for a long time, you should stop because you will get diseases.*
> *F: What type of diseases?*
> *P3: HIV & AIDS.*
> *P6: And there also some other diseases like gonorrhea.*
> *F: So what would you do when wanting to regain the health that was destroyed by other factors?*
> *P3: Protecting yourself during sex.*
> *P6: Like using Chishango condoms. (FGD, single women, Phalombe District)*

Reducing or eliminating the consumption of alcohol and the use of other drugs, such as hemp, were cited as key to recovering from unhealthy situations. According to participants from the various FGD and KII sessions (across age and gender groups), some men overindulge in alcohol to the extent that they don't participate in farming or business activities alongside their family members. In some cases, they also sell household produce or assets because they want to raise cash for beer. The participants felt that if such men were counseled to cease alcohol consumption their situation could improve. In 15 FGD and 8 KII sessions, participants said women are also increasingly partaking in alcohol, and the participants said in cases where both the husband and wife drink, the situation becomes almost irreversible.

Finally, according to the FGD and KII participants, improving hygiene practices does not require outside intervention because this involves tasks such as constructing latrines and bath houses, sweeping around the house, treating water, etc. These are all activities that families can undertake themselves to reduce illness, thereby reducing the cost of seeking treatment, and in turn giving family members time to concentrate on productive activities.

Chapter 4: Malaria as a barrier to good health

Malaria is one of the major causes of morbidity and mortality in Malawi. Various programs have been implemented to sensitize Malawians about its causes, prevention options, and treatment options. As a result, participants were keenly aware of the predisposing factors to malaria, readily identified prevention methods, and were quite knowledgeable about treatment.

4.1 How malaria affects a 'healthy' life

With regard to malaria and its effects on participants' wellness or healthy living, deaths and frequent malaria episodes were cited as disturbing household incomes and leading to opportunity costs to engage in other household activities. Overwhelmingly, participants agreed that malaria had a substantial negative effect on a family and community:

> *…Also development in the village goes backward because of illness (like malaria). The time that is spent tending to the patient is time that we could have been busy with development of our village, or our family.* (FGD, new fathers, Nsanje District)

> *…When a member of the family suffers from malaria, things do not go the normal way… the man may spend some days in the hospital if it is a serious case and he may be given drips of water, while a child can die of malaria...*(FGD, single men, Nsanje District)

The effect of malaria on the household breadwinner was particularly problematic, as it leads to additional negative consequences:

> *…When you are suffering from malaria, especially if you are the breadwinner at home, it becomes difficult at home for people to cope, which also affects their health. Sometimes it encourages ill behavior for them to find food for the home when the breadwinner is down with malaria.* (FGD, men with 2-3 children, Nsanje District)

All participants stated that malaria affected one's ability to participate in livelihood activities such as informal employment (farming) and formal employment. Consequently, households or families that have frequent episodes of malaria eventually become food insecure. It should be noted that when participants were asked to describe attributes of a healthy family, the majority of groups described a healthy family as one where the family members slept under nets regularly, and were malaria-free.

4.2 Knowledge of malaria transmission and signs and symptoms of malaria

While most participants understood that mosquitoes transmitted malaria, some participants believed that malaria was caused by various other factors, such as lack of food, drinking unsafe water, lack of rubbish pits, air and soil pollution, an unclean environment, and lack of latrines. (It is worth noting that the Chichewa word for fever is 'malungo,' a word often used to refer to malaria.) Food intake was linked to malaria susceptibility, as articulated by this female elder:

…The reason that malaria gets into one's body… they don't get enough food and become stunted, so malaria rushes into their bodies. (FGD, female elders, Chitipa District)

Additionally, cleanliness and sanitary conditions were also identified as factors that could lead to malaria:

…There are tiny germs in the mud, once you step on them you can get malaria. (FGD, female elders, Phalombe District)

Others believed that in addition to sleeping under a net, sanitary living conditions were important in preventing malaria:

…(You can prevent malaria) by sleeping in a protected mosquito net… drinking clean water and taking care of the household… a good toilet. (FGD, single men, Chitipa District)

Regarding malaria signs and symptoms, findings suggest high levels of awareness among all participants. This was attributed to HSAs, community health volunteers and staff from NGOs. The participants said that health workers like nurses and clinicians provide information about malaria during clinic sessions. Radios were also mentioned as sources of information on malaria, and female FGD participants with children reported that they get information during antenatal clinics (ANC) and growth monitoring sessions. (For more information regarding information sources, see Chapter 6.)

Participants were asked to articulate their understanding of the common signs and symptoms of malaria. Across the FGDs and KIIs, a variety of signs were identified, as shown in Table 5, which lists the most common sign (fever) first and the least common sign (shivers) last. In addition, weight loss and anemia were identified as possible signs of malaria, particularly among pregnant women.

Table 5. Respondents' perceptions regarding common signs and symptoms of malaria

Fever	All FGDs and KIIs
Diarrhea	All FGDs and KIIs
Vomiting	24 FGDs and 12 KIIs
Loss of appetite	All FGDs and 6 KIIs
Convulsions	19 FGDs and 16 KIIs
Jaundice/yellowing of the skin	12 FGDs
Shivers	7 FGDs and 3 KIIs

4.3 Malaria prevention methods

The majority of participants acknowledged that nets are the most effective option in malaria prevention. Although participants mentioned a range of barriers to bed net use (more below), nets were still seen as the most effective way to prevent mosquito bites.

> *…Because if a person sleeps in a net it means he has protected himself…malaria cannot attack you because you are sleeping in a net but if (you are using) coil, that is a problem, because the mosquito will be biting you.*(FGD, new mothers, Phalombe District)

With regard to alternative methods to reduce risk of exposure, participants used the smoking method, the draining of water method, and sanitary practices. The smoking method was the most common ; in this method, shrubs/plants/materials are burnt in the evening, and family members vacate the house to ensure the concentration of smoke. Participants believed that the smoke would drive the mosquitoes away, cause them to be drowsy, or kill them. A number of materials were identified that were used in this method: maize husks, mango skins, leaves and bushes (amaranthus), cattle dung, and rubber/plastic. However, several participants asserted that the smoking method was not particularly effective:

> *…By burning cow feces/dried feces inside the house before sleeping time, therefore when smoke spreads all over, some mosquitoes escape…(FGD, female elders, Phalombe District)*

Draining water was another commonly mentioned method, as stagnant water was identified as a factor that could increase malaria transmission. Participants filled pits and holes around their homes with grass or bushes to prevent water accumulation.

As **insanitary conditions** were identified as a cause of malaria, some participants engaged in the slashing of all thick grass near their houses. Additionally, they attempted to ensure that banana plantations were not established close to their houses. Finally, keeping a clean house was another method participants chose:

> *…By clearing the bush near/around home and sweeping the ground then throwing the litter in the pit and covering them so that when rain comes water shouldn't stand around our home…cleaning the house… if the house has got windows, we have to keep them open to allow fresh air to go in and remove some mosquitoes…(FGD, female elders, Phalombe District)*

Besides these more traditional prevention methods, mosquito nets (treated or untreated) and use of repellent sprays and coils were also discussed. Only two KIIs mentioned indoor residual spraying (IRS) as a prevention method.

Although nets were mentioned as the most effective preventive method, participants pointed to a number of barriers in using nets, with the shortage of nets being the most pressing. The most commonly cited challenge in using a net was cost. Although in some communities households received free treated nets from the government and NGOs, the nets were not able to cover everyone in the household:

> *…Yes, there is a problem. The problem is shortage of the nets in the family. The number of bed nets given to a family is less than the number of people in the family. That's the problem. (FGD, female elders, Nsanje District)*

Additionally, few places distributed nets:

> *…The place where nets are found - at the hospital and also other organizations that help (distribute) these nets… the nets have to be available, but they have to have enough money or time so that they can come and distribute… the nets are scarce in an area or in communities and it causes the people of that community to be suffering from malaria.*(FGD, single men, Salima District)

Others believed that since pregnant women were given nets before others, other families suffered:

> *…The scarcity of the nets, in the recent past they have been distributing nets to pregnant women only. But (not every family) can have a pregnant woman hence it is quite hard for some families to have net.* (FGD, men with 2-3 children, Phalombe District)

Finally, the majority of participants said there were no issues in using a net. However, some participants believed that sleeping under a net interfered with sexual activity or increased the temperature in the house making it uncomfortable to sleep, caused allergies or skin irritations, and caused respiratory issues.

> *…When you are going to sleep …since they wash (the net) with medicine you start scratching yourself.* (FGD, men with 2-3 children, Chitipa District)

Men were particularly concerned about sleeping under a net because it could reduce sexual prowess:

> *…The issue is we hear a lot about nets, people say when you have sex inside a net you just do it once per day but you are expected to do it twice or thrice per day outside of a net. It happens that you run out of energy and you do it just once before dawn.* (FGD, new fathers, Nsanje District)

Although not explored at length, some participants reported cases of misuse and abuse of the freely distributed nets, such as selling them to make money.

4.4 Malaria treatment methods

Malaria was one of the top, if not the top, reason healthy and unhealthy families went to a health facility. Participants were aware of the need to seek care from health facilities or local health workers within one day of noticing the signs and symptoms associated with malaria. However, participants mentioned that some households would treat their children at home with antibiotics or painkillers prior to going to the hospital.

Proximity of a health facility was an important factor in the decisions mothers made about treating children with suspected malaria:

> *…If it's at home… if it's far from the hospital, we give them panadol at home then start off with the child… if it's close… we hurry to the hospital...as soon as the child is sick and it is malaria that's when we take him/her to the hospital.* (FGD, women with 2-3 children, ChitipaDistrict)

> *…We quickly carry the child to the hospital… and maybe you are alone no husband in the house, you just rush to the hospital without fearing the darkness, since the hospital is very close.* (FGD, female elders, Salima District)

Some individuals turned to home remedies when money was not available:

> *…We take mango leaves and boil them and then you cover the head with a blanket, then you take your face and put it where there is heat, then when the steam comes you breathe it inside so that the steam should go in the stomach…(FGD, new mothers, Salima District)*

Even though some participants visited traditional healers for malaria treatment, most did not believe that going to a traditional healer would treat malaria:

> *…No… there is no traditional medicine for malaria, if a person has malaria and takes traditional medicine they cannot be healed unless they go to the hospital and get tested, that's when you take the medicine, it's (what) will make you feel better.* (FGD, female elders, Salima District)

The majority of participants agreed that the only way to determine if an individual has malaria is through blood testing.

> *…When we are in the village and have not gone to hospital we cannot know it's malaria but when we go to the hospital and get tested, that's when we are told that it's malaria.* (FGD, female elders, Salima District)

4.5 Malaria information sources

Three groups mentioned that health information related to malaria came mostly through the words of chiefs, while other groups talked about health facility workers as the key source of such information:

> *… The encouragement was not only about sleeping in mosquito nets but the mosquito nets being dipped in its chemical 'mankhwala' also, sleeping in them throughout the year, every night.* (FGD, new mothers, Salima District)

> *…They [health workers] tell us that nowadays we should take care because malaria kills. It comes suddenly. They also discourage us from waiting for relatives like brothers and uncles, in order to go with them to the hospital. Malaria is not a joke. Relatives may come later after you have already gone to the hospital. Some even go to the hospital even if they don't have a single tambala because of the severity of malaria.* (FGD, women with 2-3 children, Salima District)

Outside of interpersonal sources, some participants stated that they learned about malaria information through community events (music bands sponsored by PSI, for example) and through radio programs.

Chapter 5: Perceptions about and use of local health facilities

Respondents gave many reasons for going to a health facility [7] – from getting treatment for illnesses to antenatal care and delivery, from getting food for malnourished children to obtaining products such as nets, condoms and contraceptives, from advice on how to stay healthy to guidance on disease prevention. As mentioned in the previous section, treatment for malaria was one of the main reasons cited for visiting health facilities.

The primary reason was to receive treatment for an illness, which included getting confirmation through a blood test of what was ailing them.

> *…You can't know on your own that you have malaria ... but when you go to the hospital and get your blood tested ... it's when you are told that you have ... malaria.* (FGD, female elders, Chitipa District)

> *…When it comes to illness there is nothing else they can do apart from going to the hospital because for young children it's difficult to know what the child is suffering from maybe it is a cough maybe its malaria, may be something is wrong in the body so there is nothing else they can do apart from going to the hospital because at the hospital the doctors are the ones that end the whole story.* (HSA, Phalombe District)

Children having a high fever, fainting or suspected of having malaria[8] were the most often cited reasons people went to the health facility. Most respondents said they would rush immediately to the clinic when an under-five child was sick, especially if there was a high fever or the illness was thought to be malaria.

Other illnesses and symptoms that brought people to the clinic included diarrhea, cholera, TB, "coughing", mtchofu (Sena[9]), weakness of the body, flu and dental problems. One group of respondents mentioned that wealthy people went to the clinic more for chronic diseases such as high blood pressure and heart-related problems from the "fatty foods they eat."

> *"Lack of hygiene", sanitation and "dirty water" were also mentioned as reasons for going to the clinic – these conditions were seen as leading to various illnesses such diarrhea, cholera and at times malaria.*

> *… Like eating food without cleaning your hands you can also get these diseases.*(FGD, single men, Salima District)

> *… Cholera because of not sweeping outside and in the house. Therefore the kids can get cholera.* (FGD, single women, Phalombe District)

[7]For the overall discussion, the term "Health Facility" will be used to refer to local health clinics or hospitals, unless otherwise noted.
[8]Malaria was also a specific topic of the FGDs and SSI's so it is possible this influenced the outcome.
[9]Language spoken in Nsanje District

Other reasons for going to the clinic included: Antenatal visits and "scale" (weighing women during ANC, and children to screen for stunting and/or wasting); to deliver babies, to get tested for HIV and to obtain medicines (e.g. panadol, aspirin, ARVs, LA) and products (e.g. contraceptives, condoms and mosquito nets. While nets are now distributed free through donor and government programs, in the past they were only available at the clinic).

> *…There are some in the villages who do not care about health clinics but maybe they will get mosquito nets there because mosquito nets are received at the health clinics… But in the past days people used to receive mosquito nets at health clinics and therefore if they do not go to health clinics they will not receive nets.* (FGD, new fathers, Nsanje District)

Reasons for going to the health facility that are not because of illness included injuries, which could be related to farming, or being in an accident, either on a bicycle or, less often, being hit by a car.

Although respondents did not usually say they went to a facility for information, they acknowledged that it was part of the services available to them at the clinic. When asked, "Where do you get health messages?" many responded, "At the health facility" (see Chapter 6) Others expressed their appreciation for the advice and counseling provided at the clinic.

> *…Pregnant women should go for antenatal care to receive advice…Advice on how they should prevent malaria.* (FGD, new fathers, Nsanje District)

> *… For a person who is infected with HIV/AIDS for example, they must go to the hospital. At the hospital they give them some effective advice to let them live their daily life comfortably.* (FGD, single men, Chitipa District)

5.1 Who goes to the health facility?

While children were most often cited as the ones in the family needing care at the health facility - "women and children" were the ones who most often went to the facility. While women went for their own needs (ANC, to be weighed, FP, delivery, etc.), it was seen as their role as the family caretaker to bring the children as well.

> *….The mother is also taking the child to the hospital because 'nthumbidwa' . . . total care is from the mother so everything goes there.* (FGD, new mothers, Chitipa District)

> *…Because whenever an illness comes in the family, the woman is the one who takes the responsibility of caring for the patient. While the husband maybe goes to work or just takes a walk… when a child gets sick you (the lady) are the one who goes with the child to hospital… or even when the husband gets sick, you are the one who care for him and that's why the woman is always found at the hospital.* (FGD, female elders, Nsanje District)

In one community, respondents mentioned that things were slowly starting to change and that men were starting to become more involved with caretaking and visits to hospitals due to the intervention of Chiefs and complaints from the women. Others note that in a "healthy family" where there is love, men are more likely to accompany women to the hospital.

> *… But in this family when the woman is sick they go together with the man to the health clinic because there is love, even if they are going for antenatal clinic, the man goes with her when a child is sick. Both the man and the woman go together with the child to the health clinic. (*FGD, women with 2-3 children, Nsanje District)

Men also go to the health facility, although less often than women. Reasons include injuries, accidents, malaria and getting tested for HIV. Some men said they went with their wives for antenatal care and others that they needed to keep healthy for the sake of their families, although neither was a widely held response.
Interestingly, one group of respondents said that wealthy men went to the hospital more often than poor men because of their high-risk sexual behavior (which was also mentioned in Chapter 2 on healthy and unhealthy practices).

> *… In this household, it is not the woman who goes to the hospital often. The one aware of the problem because he is anxious of his status due to what he did behind his spouse. He thinks that things will go bad if he tells her, so he just lies to her "I am going just across the river." Then he cycles all the way up to the district hospital. He just keeps quiet when he learns the results and realizes. "Ooh, I have done wrong."* (FGD, men with 2-3 children, Nsanje District)

Others stated that healthy and unhealthy people sought out services for different reasons. Some respondents mentioned that wealthy people go more often to the clinic because they can afford to in order to maintain their health while poorer people only go when they are ill. Others mentioned that because of jealousy wealthy people may have to go more often.

> *…In short we can say that this family goes to the hospital so often because whenever they have fever or just a simple cough they go to the hospital since they have money. But for a poor family, they do not have the money; they may keep a sick child at home for a week due to lack of money.* (FGD, women with 2-3 children, Salima District)

> *…Sir, these well-to-do people are very sensitive. With just a slight headache, they contemplate "Do I have to let myself die and leave all this wealth I have? No, let me rush to hospital."* (FGD, men with 2-3 children, Nsanje District)

a. Women and children's vulnerability

Children were seen as more vulnerable to illness for a variety of reasons, such as their bodies are still developing, they are too young to know how to avoid disease and they may be malnourished. "Healthy children" were also seen as susceptible to getting diseases from children who were "not healthy."

> *F: What do you think are the reasons that bring children to hospital? What kind of diseases do they usually go with?*
> *P11: Sometimes it may be swimming in water that is being contaminated by bilharzia (likozo), and because of being childish, they can drink the contaminated water, eventually they get sick.*(FGD, female elders, Phalombe District)

> *P8: It is the children because they go and play with children from poor families.*
> *P6: Because it is possible that they drink the water that poor family drinks, using a cup that is not clean.* (FGD, women with 2-3 children, Salima District)

Women were seen as more vulnerable because of the toll that frequent births take on their health. Many respondents made the link between women not using family planning and their numerous visits to the health facility.

> *…Who is likely to go to the hospital? Often times it can be this mother because the way she has borne children, her body can be weak indeed without health so this woman, most of times, can be going to the hospital because at the time that they are conceiving often she loses water from the body and blood from her body. In so doing her body is unwell indeed till it gets indeed to the stage of getting sick often and be going to the hospital time and again.* (FGD, single men, Salima District)

> *…The wife can go to hospital most of the time because she is the one who gave birth unlike the husband . . . So by giving birth to children the body of a woman becomes weak. Unlike a woman who follow methods of child spacing.* (FGD, single women, Salima District)

5.2 Barriers to visiting a health facility

Several barriers were mentioned that prevent people from going to the clinic. These barriers are related to structural issues (distance from the facility), poverty, and belief systems and, to some extent, individual agency.

b. Lack of money

While public facilities offer free care, they are not in every community and often do not have the supplies or staff to attend to patients. When the facilities are out of basic supplies, these often have to be bought at the market[10]. Private facilities, while said to provide better services, made quite high charges. Lack of money was cited time and again as a reason why people would not seek out care. Lack of finances is also related to the structural issue of health facilities being far away from the communities. In order to get to the facilities, people need money for transport and then have to pay for care once they get there. If they have an urgent care case and need to be referred to a hospital, the issue of finances and distance is compounded.

> … *Money!! They have no money; they cannot go to the hospital without money.* (FGD, female elders, Phalombe District)

> *…Aaah mostly ... it is also about money. It could be that they stay near a paying hospital and they have to pay for any service, this can stop them from going to such a hospital. The other thing can be that the hospital could be far from where they stay and they can't walk long distances due to their condition, since they also do not have money for transport, it means they can't go to the hospital. Another thing is if there is no one to encourage them and persuade them to go to the hospital, then they can't make an effort to go.* (Nurse, Phalombe District)

People will try to find the money by borrowing from others – especially if it involves a young child - or they may find other ways of getting medicines based on their diagnosis of the illness.

> *P1-Others don't have money to take them to the health clinic, you just buy them panado and them a piece of it.*
> *F-So, what measure of panado do you give them?*

[10]It was not always clear if the services and commodities at the public facility were free or just the care was free. Need to verify this.

P1- When we go to the clinic we see the size that the doctor is showing us and after we buy the drug we use the same measurement that the doctor showed us at the clinic and depending on how the child is and how sick he is we know that he needs this size of the drug. (FGD, new mothers, Salima District)

…For malaria you tremble so you just go to someone and ask, Do you have LA? So he/she says I went the day before yesterday to such-such a person and they gave me LA so you just say; share me some two tablets of LA and when you get better with those two tablets of LA you start doing your work in the farm. (FGD, women with 2-3 children, Phalombe District)
… Hey!!! We don't let much time pass, if you noticed her/him in the morning or at night, you instantly go to your friend and ask for help (money), Sometimes a friend can decide to give you somewhere to dig(kulima) after helping, so that you can take your child to the hospital. After a child recovered it's when you go to fulfill the promise to dig for them (kukalima). (FGD, female elders, Phalombe District)

Sometimes people will go to the nearby facility only to find out they have to go to a clinic that is far away to get the services they need. This can have fatal consequences.

P3: Some pregnant women when they go there to wait for child delivery, they are told sometimes to go to Phalombe. There are not adequate materials at this health center, so it happens that they have already lost a lot of energy and they are due to deliver. The end result is that you lose both the child and the mother. (FGD, women with 2-3 children, Phalombe)

c. Religion, belief systems and traditional healers

Respondents indicated that some religions did not allow people to access health facilities, although they said this was beginning to change due to "sensitization" and education.

P1: …Yes, these are the people who do not go the hospital whether a child or an adult gets sick. You can get there and advise them well but it doesn't work at all. They do harden their hearts that the people do die while in the house.
P2: But now according to the organizations' encouragements, yes, chiefs what-what, now this practice is coming to an end, if they get ill they do go to the hospital. (VDC, Nsanje District)

The role of traditional healers[11] was more complicated; people sought them out due to their belief systems concerning the origin of an illness (maybe witchcraft) but also because of distance and cost of the health facility. Sometimes the treatment from the healer dealt sufficiently with their (or their children's) illness; other times they would eventually have to go to the facility when the condition worsened.

P2: (referring to malaria) Going to traditional healers is a cultural practice. Others believe in them, that they will get cured. However, the disease needs real treatment. People do not get enough help; they just go there as a result of belief. Nevertheless it is a method that we use to get treatment. (FGD, new fathers, Nsanje District)

[11]In the transcripts the terms "witch doctors" and "traditional healers" both appear. It would be useful to explore the differences in the vernacular to understand the implications for the use of the two terms.

R: …. Some chose not to come here because they chose to go to the herbalist, … they fail to come here because of the long walking distance and also they see that the herbalist is not very far from them (shortest solution), when it gets worse then it's when they think of coming to the hospital. But the main reason that makes people not to come here is the long walking distance.(Nurse, Chitipa District)

P5: They cannot go to health clinic because they do not do what they are supposed to do due to lack of money. Some of them they just look for traditional medicine themselves. Like some can get sick and ask others to look for such-such traditional medicine since they do not have money to go to the hospital. So you go and look for that thing. (FGD, women with 2-3 children, Phalombe District)

Based on interviews with traditional healers, it appears that efforts have been made to work with them, acknowledging that both traditional and modern healing have a role to play in people's lives.

P: We do see the breathing rate of the child the way it is. If they have just fainted by surprise we do blow air into them then they begin to breathe again. Then we say Let's go to the hospital with them because at the hospital they have test machines, they will check them.
F: What about a kid who faints? Have you ever sent him to the hospital?
P: Such people that just faint and go to the hospital I have been sending them, and there are some who faint all the time as njirinjiri as I said, those people if we send them to the hospital they do send them back to us. Then you have to try to do your best on your part. Because we always work hand in hand with the health workers, they advise us that when we fail we should send to the hospital, and them too what fails them must be sent to us so that we assist them. (Traditional Healer, Nsanje District)

d. Concerns about stigma

In a few cases, respondents mentioned concerns about stigma or being made fun of as reasons to not go to the healthy facility. These had to do with HIV and family planning. In some cases, clinics offered FP services only one day a week so it was obvious to everyone why someone would be there. This was seen as problematic for women whose husbands did not know – and would not approve of them – using FP methods.

P1: Shyness, they don't want other people to know that they are HIV positive, but when people discover through loss of weight so that was the time to go to the hospital. (FGD, single women, Salima District)

P12: There are some people who are on family planning methods but do not want to be seen by other people that they are on family planning methods when they go to the health center. However this is unavoidable because of the number of people that goes to the health center on this particular day.
P3: There are some women whose husbands refuse to let them use family planning methods and these women use the family planning methods secretly.
P5: The people who see the woman going for the family planning methods take the issue to their husbands and the end result is the couples get a divorce. (FGD, women with 2-3 children, Nsanje District)

e. Lack of personal agency

Somewhat surprisingly, the issue of women not being able to make independent decisions to go to the clinic was not raised in any of the group discussions as a barrier to accessing services. One respondent mentioned that women could take action while their husbands were away. Only one nurse in Chitipa mentioned the lack of women's agency to get to the clinic.

Some people fail to come to the hospital earlier because of – maybe – in the villages … we can say that for those who come here at hospital most of them are ladies, are not making their own decisions to come here at the hospital. They wait for their husbands to agree to let them to go to the hospital, they cannot come on their own without telling their relatives. (Nurse, Chitipa District)

If a man is aware of the baby's sickness and he is doing nothing, you as a mother you can take some of the family property and sell it to save the baby's life and you can discuss later after the baby is fine. (FGD, female elders, Phalombe District)

f. Perceptions of the nearest facility

The nearest facility differed by community - of the four health facilities that were visited in the study, two are government-owned (in Nsanje and Chitipa) while the other two belong to CHAM (in Phalombe and Salima).

Most respondents felt private facilities were better than public but were very costly. For some it was worth it; for others the advantage of the public hospital being closer was a more important factor. Others complained that public facilities lacked sufficient staff, basic amenities and medicines.

> *P5: What makes us happy is that this is a nearest hospital and when we are sick in the midst of the night you go there and they help but now when it comes to paying the bills that's when you cry as you pay almost K1000.(*FGD, male elders, Salima District)

> *P7: If you get really sick, you go to the private one that has all the important things.*
> *P7: At Ruwo, there is a clinic but if you are suffering from malaria, when they give you the malaria medicine, you don't get well, but if you go to Likanani you get well. The medicine at Ruwo doesn't work, while the one at Likanani works.*
> *F: Why do you think the medicine doesn't work?*
> *P3: Because it's free, while at the other one you have to pay, so the medicine works at the private one.* (FGD, single women, Phalombe District)

> *F: What pleases you at this hospital?*
> *P3: Nothing, it's so expensive, it's better to go to rural government hospital where everything is for free.*
> *P13: The way I see it, when you go there they really help and they give you good medication, for example when my child is suffering from malaria, they take very good care of him.* (FGD, men with 2-3 children, Phalombe District)

When asked what they liked and disliked about their local facilities, the answers were fairly consistent among the respondents. And in most cases the opposite held true. In other words, the things people said they liked about the health facility – its proximity, they received services they needed, it was clean,

there was water, they received injections, there was a NRU (Nutrition Rehabilitation Unit) – were largely the same reasons why others found their facilities lacking – they were not clean, no electricity, lack of medicines, no toilets, not enough space or beds, no water.

> *P3: What I like about this health center, it is near to us, and also availability of medicine because if we people we don't struggle to get medicine assistance in time we are not feeling well in our bodies. That's what made us to be happy in our body, we are well in our bodies.* (FGD, single men, Salima District)

> *P11: People have stopped delivering children at this hospital because of this problem. They tell a woman who has just delivered a child to go to the river and wash the linen she used in the labor ward.* (FGD, female elders, Chitipa District)

> *P11: Or when you go with two children, he says he will only give medication to one child, because there's no way both children from the same house can fall sick at the same time, you should choose one child to be given the medicine. Now a parent of two children, how do you choose one child to be helped.....what's that?* (FGD, female elders, Chitipa District)

Positive feedback was received regarding HIV and AIDS and nutrition services.

> *…..sometimes malnourished children receive cooking oil and soya from the health center…..HIV/AIDs patients receive ARVs as well, they receive peanut butter (chiponde)…* - (FGD, mothers with 2-3 children, Nsanje District)

In Chitipa and Nsanje, some participants applauded the work done by health surveillance assistants (HSAs) in the communities, especially with regard to water treatment, hygiene and sanitation training, treatment of childhood illnesses through the village clinics and general community mobilization activities. They said this was assisting in improving their health as more people were accessing the services and children were getting treated before their illnesses become worse.

> *…they (the HSAs) visit villages and households teaching us the hygienic methods…* (FGD, women with 2-3 children, Chitipa District)

In both the public and private health facilities, people complained that staff could be rude to them, not provide them with adequate care and blame them for their condition. This was mentioned particularly but not exclusively in terms of women giving birth and was seen as a reason why some might choose to deliver at home or go to a traditional healer.

> *P3: Some of them complain giving their reasons that aah, I didn't go for antenatal so the doctor will insult me there, what-what, so in spite of that they do go, they do go to the traditional healers to be assisted there.* (VDC, Nsanje District)

> *P3: Like maybe by assuming that you went to that place, you … those suffering from cholera, so they do shout at you indeed there saying that, what – what, you don't take care of yourself at your home, we don't want that, we are busy, we doing another work here we are going to assist if we wish. Things like this are very worrisome because them, it's their profession, they are supposed to give him/her counseling so that he/she will be a changed person in life of his/her own* .(FGD, single men, Salima District)

From the perspective of at least one nurse, patients who come to the health facility do not heed their teachings or understand their sacrifice. It seems that their expectations of their patients may be at times unrealistic, as in the case below, since many people may not be able to reasonably afford to come to the clinic a month in advance.

> *R: Aaah for me …we…we sacrifice ourselves to-to help…to give help… to give help/medication to the patients. To add on that we teach people about how they can prevent diseases, we teach them about food, about safety, about having toilets, they should use toilet, prevention from sexual transmitted diseases. With these some people start to change. Still some people do forget but we try to repeat teaching them those lessons. We encourage pregnant women to deliver at hospital… we tell them to come here at hospital before 9 months, at least when they reach at the middle of 8 months, so that they can be waiting here at hospital. We also encourage this. Previously most pregnant woman could deliver on their way to hospital sometimes at home because they actually don't know when they will deliver. We visit them, we visit them and teach them to start coming to the hospital while they are 8 months [pregnant].* (Nurse, Chitipa District)

It was also sometimes noted that medical staff would not always take the time for proper diagnosis or bother to come to the clinic if they had other things to do. In fairness, some respondents noted that they just had too many people to take care of, with many different medical issues. In some cases, doctors and medical assistants were seen as untrustworthy and were even accused of selling medication, which led to stock-outs at the clinic.

> *P8:They want people to be getting sick, not to be healthy, that means their business is making profits.* (FGD, new mothers, Salima)
> *P5: Sometimes they give you medicine that is not relevant to diseases that you are suffering from. You may have malaria and instead of LA, they give you medicine for headache because they sold the LA.*
> *F: Who sells the medicine?*
> *P1: The doctors* (FGD, single men, Nsanje District)

> *P4: Sometimes we feel like the doctor/clinician/medical assistant doesn't care about patients because it takes time before you are attended to, but after careful consideration we discovered that the doctor/clinician/medical assistant is always willing to help, it's just that he has to attend to so many people every day as this hospital serves a lot of people. Sometimes people lose their lives before being attended to or whilst waiting for treatment.* (FGD, men with 2-3 children, Nsanje District)

As mentioned earlier, the issue of distance to the health facility, as well as to the referral hospital was problematic for many respondents. All four facilities in whose catchment areas the study was conducted provide primary health care. As such, they refer all complicated cases to the District Hospitals (DH). However, FGD and KII participants had reservations about the referral system because telephones rarely work, and when contacted, the ambulances take time to get to the health centers. This was particularly raised in the Misuku catchment area in Chitipa where the DH is approximately 70km away and the road is almost impassable during the rainy season. According to some FGD participants, some patients die while waiting for the ambulance or while in transit because the roads are not good.

> *P11: Chitipa boma ... Chitipa boma ... when they just see that there's no help here, they send the patient to Chitipa boma. Now going to Chitipa boma you find that there's no transport, no ambulance, you should look for your own transport to go, a person is suffering from malaria .. you*

have malaria and yet when you go and look for transport, where will you get it? You will also need food when you go to Chitipa, so you can even die there. (FGD, female elders, Chitipa District)

Another issue raised was that of staff housing and medical assistants not being available when patients arrive late in the evening. Staff housing was mentioned particularly in
Chitipa and Nsanje where KII and FGD participants said health workers at their nearest HC have no houses at the facility. This means that they have to rent houses in the villages, sometimes very far from the HC and this creates problems when people bring patients at night. Also, the staff report for duties very late and knock off early to travel back home. In other areas, they commended the Medical Assistants for being responsive.

P7: We also want to ask for… when we go to the health center we are told (especially at antenatal clinics) that when a child's body temperature is high, or there is any problem with the child, we should go with the child to the hospital quickly, so what happens at Mbenje Health Center is that when we go with the child to the Health Center (if the child start showing signs of illness at past 7 at night) we don't take long, the same past 7, we will take the child to the Health Center, when we get there they say not this time, you have come very late. When the watchmen goes to wake them up, they do not come. Instead of the child being assisted, he/she dies due to malaria but all because of lack of assistance. (FGD, female elders, Nsanje District)

g. Potential solutions

In terms of solutions, some respondents wanted to see new clinics built or the current ones expanded to be able to handle the in-coming volume. This request was made of the government. Others suggested that health committees, which they said had been functional in the past, should be reconstituted or, if still extant, strengthened. That way, there would be an improvement in quality and transparency, and help ensure that health facilities were more responsive to patients' needs. They also said that those serving on the health committee would need to have some power and authority to see that changes are made.

P2: I would be much happier if government could construct a free health center nearby this community because we are having tough time travelling long distance and as I have already said that the facility that we have here we have to pay something. People still go and pay, others receive the treatment on credit. It takes time for them to clear those credits because they are usually big. (Chief, Phalombe District)

P2: And also in this community there used to be a committee at the health center some time back. If perhaps there was a medical assistant/health worker not doing their job properly they were calling them for disciplinary or even saying the staff should be changed. I don't know if the small committee still exists but it used to be there to ensure patients got the right medication and that health workers were doing their jobs properly.
(FGD, new fathers, Nsanje District)

P3: They are supposed to be there to ensure that medicines have indeed been delivered, nowadays these committees are no longer being used at the hospitals and they are no longer in existence. I would have loved if the committees did take part for transparency. (FGD, male elders, Nsanje District)

Chapter 6: Information Sources

One aim of the formative research was to understand how people access information about health. The research asked questions about where people access this information and what they regard as the best ways to access it.

Participants mentioned a number of information sources, including the health center, church, HSA, school, initiation sessions and meetings initiated by village heads. The sources could be classified as cultural (e.g. initiation sessions), religious (e.g. church or mosque), or social (e.g. radio, dramas and school). However, respondents across all the life stages mentioned the health center most often as the information source. In particular, new mothers and mothers with two or more children cited the health center as their major information source, specifically the antenatal clinics. It seems logical for the younger mothers to access such information from the health centers, since they are among the most frequent visitors. This fact was confirmed by older women who regarded young women as their source of information.

> *Young women are better off because they walk around and go to antenatal clinics but for us we just stay home…they explain to us what they have seen…* (FGD, female elders, Salima District)

Yet some mothers with 2-3 children reported that they stop going to the clinic once their children reach their first birthday; this leaves them out of touch with information on health.

> *It's just that we have the under-five children yes, but once they have reached one year old, we say they are grown up so we do not go with them to under-five clinics, so some of us we do not hear the messages.* (FGD, women with 2-3 children, Phalombe District)

At the community level, health surveillance assistants are highly regarded as information sources. The HSA organizes meetings through the village chiefs to discuss health-related issues. The NGOs and CBOs also play a critical role as information sources. These organizations establish groups, including Home Based Care and youth clubs, where counseling is offered to people living with HIV and young people, respectively. Some of the CBOs have trained youth in performing interactive drama, which seem to appeal especially to new fathers. These young men confirmed that they prefer drama performances to the other sources of information.

Radio was mentioned as well as a source for health information, specifically, Zodiak Broadcasting Station (ZBS), Malawi Broadcasting Corporation (MBC) Radios 1 and 2, "Umoyo wabwino" (Healthy Living) program.

The variety of information that is disseminated included malaria issues, water, sanitation and hygiene, HIV, safe motherhood, family planning and child health (immunization). On the interpretation and application of the information provided, there was some evidence that participants used a gender lens to assign responsibility for health-related actions.

> *You should just say that my husband didn't do it, … you would have said I am married, because the mopping is mine, pots are mine so the other ones like digging a pit is the husband's* (FGD, new mothers, Phalombe District)

In sum, there are three key levels of information sources – health centers at the service level, HSAs, chiefs and community dramas at the community level, and radio to echo and amplify key messages as part of the greater effort to not only convey key messages, but also to motivate positive health practices.

Chapter 7: Conclusions & Recommendations

This study provided extensive information about how men and women from selected districts in Malawi understand the factors associated with "healthy" and "unhealthy" families. While these qualitative findings can neither be generalized to all men and women in those districts nor to Malawians in general, the results of the study do provide important insights for health communication programs. Although there were many references to structural factors that can, and often do, impede positive health practices, the general tenor of the participants' discourse was positive and focused on actions that could be taken at the community, family and individual levels.

Most strikingly, the findings reveal a widespread belief that small families are healthier, better educated and happier, in general, than is true of large families. Importantly, "small" families were defined as those with two or three children. There was also a good deal of emphasis on self-help through hard work, staying in school for a better future and maintaining a hygienic environment.

7.1 Recommendations

SSDI can make important contributions to the health and wellbeing of Malawians through the design, implementation and evaluation of programs that address key factors associated with healthy living. The recommendations below are presented by social ecological level.

a. Structural Level

- Advocate for better standards in health services.
- Advocate for increased suppliers and supply of nets to overcome the scarcity of nets identified by participants.
- Advocate for constant supply of family planning methods, including condoms, so that those desiring to use them have access.

b. Services

- Train additional staff to fill clinic posts.
- As a short-term measure, advocate for placement of health workers in health facilities were there are staffing gaps (e.g., placing a medical assistant from a district hospital in a remote facility where there is currently no service provider).
- Conduct pre-service and in-service training in Infection, Prevention & Control (IPC) .
- Reconstitute the Health Center Committees where there are no longer active, or orient those that are there to ensure a better relationship between facility and surrounding community.
- Work with Chiefs and others to ensure that clinics are clean, and that there is someone at the clinic who can get water for pregnant women and other patients in need.
- Be realistic about available services – find out when the clinics are open, what services and goods they provide, and inform people in each catchment area so they don't go to a clinic that is not open or doesn't have the services sought for.
- Advocate with the MoH and CHAM to provide mechanisms to support patients in CHAM areas who cannot afford to pay for services.

c. Community Level

- Prevention
  - Continue to promote the social norms of net use, family planning, HIV testing and condom use.
  - Address misconceptions regarding bed net use.
- Family planning
  - Promote contraceptives that are available at clinics and at the community level.
- Water and sanitation
  - Encourage communities to work together to build and maintain boreholes.
  - Encourage communities to adopt an "Elimination of open defecation policy".
- Capitalize on the positive attitude about group membership; encourage group membership; assess information needs and provide groups with that information.
- Clinic access and use
  - Encourage communities to come up with joint solutions to access clinics that are not within walking distance.
  - Continue to encourage the norm of going to the hospital when children have high fever.
- Information sources
  - Use Village Heads, Chiefs and HSAs as primary channels for health information, including malaria transmission and prevention.
  - Reinforce messages through the use of community drama, and amplify messages with radio programming, particularly on Zodiak and MBC Radio 1.

d. Family/Individual Level (via communication programs, including radio programs)

- Focus greater efforts on prevention – using nets, FP, better hygiene and sanitation so people have less need to go to clinics.
- Family planning
  - Continue to emphasize the advantages of the small family.
  - Make contraceptives available to households, possibly through HSAs.
- Hygiene
  - Work with families to encourage them to make small changes in their immediate environment to make it more hygienic.
  - Continue to emphasize the importance of hand washing with soap or ash after using the toilet, changing a baby's nappy, before eating, etc.
- Clean water
  - Explore the option of promoting solar disinfection, which is free and easy to use.
  - Continue the promotion of chlorine and waterguard to increase access to clean water.
- Nutrition
  - Work with families to teach them how to access the six food groups, particularly in light of the limited resources available in the village.
  - Inform families that pregnant women need an extra meal per day and breastfeeding women need two extra meals.
- Malaria
  - Increase knowledge around the importance of getting to the clinic without delay with small children who have fever, while ensuring at the service level that staff members are available to see them.
  - In the event of insufficient nets, encourage parents to communicate and decide together which family members should be sleeping under the net when there are not enough nets in the household.

  - Reiterate relevant information regarding the role of the mosquito in infection; address myths regarding transmission sources.
  - Continue to stress the importance of seeking medical advice to test for the presence of malaria.
  - Highlight the increased susceptibility and severity of malaria in pregnant women and children under 5.

- Men's involvement
  - Encourage men to become more engaged where feasible with family wellbeing – so the burden is not all on women to be the caretakers.

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Appendix I: Complete list of attributes of healthy families

Table I.1: Attributes of healthy families as cited and discussed by FGD participants and Key Informants

		Women's FGDs				Men's FGDs				FGDs (n=32)	Key Informants (n=49)
		# of children				# of children					
Major attribute		0	1	2-3	>3	0	1	2-3	>3	Total	Total
Food/diet	Diversification & adequacy	4	4	4	4	4	4	4	4	32	21
	Food secure throughout	3	4	2	2	4	2	1	4	22	32
Hygiene & Sanitation	Possessing sanitary facilities	4	4	4	4	4	4	4	4	32	32
	Good clothing/personal hygiene	3	2	1	0	1	2	2	3	14	9
Peace, love & trust	Peace in Household/no violence	2	4	3	3	3	3	3	4	25	17
	Prayers in family	0	2	1	0	0	0	1	1	5	8
	Faithfulness in the family	1	3	1	4	2	2	3	4	20	22
	Educated members/children	4	3	4	4	2	3	3	4	27	18
Accessing social services	Access to electricity/solar	1	2	2	1	3	2	2	1	14	2
	Access to portable water	4	3	3	4	1	2	4	1	22	11
	Good (feeder) roads	0	0	1	0	0	1	1	3	6	1
Better housing	Good looking/strong house	4	3	4	4	2	4	2	4	27	17
	Clean house/surroundings	2	2	1	1	2	3	3	4	18	12
	Fence around house (security)	1	3	3	3	1	2	4	4	21	2

Table I.1: Attributes of healthy families as cited and discussed by FGD participants and Key Informants (continued)

		Women's FGDs				Men's FGDs				FGDs (n=32)	Key Informants (n=49)
		# of children				# of children					
Owning assets & livestock	Owning livestock	3	1	2	1	4	3	2	2	18	13
	Owning Car	1	1	0	0	2	3	1	0	8	1
	Having chairs/sofa	2	1	3	2	2	1	2	2	15	0
	Owning TV	1	0	0	1	1	0	1	0	4	2
	Owning bicycle	3	4	2	3	2	0	1	0	15	12
Profitable farming	Practicing intensification	3	1	2	2	2	3	4	4	21	2
	Possessing land	0	0	0	0	1	2	0	1	4	4
	Fewer children/child spacing	4	4	4	3	4	4	3	4	30	17
Health & nutrition	Healthy bodies/non-malnourished	3	2	2	3	2	2	3	1	18	23
	Fewer or no illnesses in family	4	4	4	4	4	4	4	4	32	16
	Hospital nearby	2	3	2	4	3	4	4	2	24	3
	Knowing HIV status	0	0	1	0	0	0	0	1	2	0
	Having children	0	0	1	2	0	0	1	0	4	0
Regular income & cash	Having good cash/regular income	4	3	2	2	4	3	3	3	24	9
	Doing business	2	1	3	1	2	1	1	1	12	7

Appendix II: Complete list of external support

Table II.1. List of external support that would enable families to achieve, maintain or regain status of wellness or healthy living as cited by FGD and KII participants

Field	Type of support	KII Sessions	FGD Sessions
Agriculture	Fertilizer or other farm inputs	19	16
	Irrigation equipment	13	9
	Seed livestock	9	10
	Farming land	8	4
Health	Public hospital or free medical care	17	19
	Outreach clinic	4	3
	Drugs at the hospital/health center	0	9
	Water at the hospital	0	2
	Ecosan latrines	7	2
	Mosquito nets	11	4
Social services	Improved water sources	22	18
	School	11	16
	Electricity	3	2
	Market	0	3
Income generation	Microloans/Village Savings & Loans (VS&L)	16	21
	Public work program	3	5
Infrastructure	Roads/public transport	3	8
Skills transfer	Vocational skills	0	7
	Adult literacy/community talks	0	6
	Sports facilities	0	3
Social protection	Clothes, blankets	5	9
	School fees (orphans)	0	7
	Cash support	0	4
	Houses	7	6
	Land upland during rainy season	3	2
	Food support	23	18

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