FAMILY HEALTH CARE IN MALAWI: THE SUSTAINABLE COMMUNITY ALTERNATIVE FOR AIDS MANAGEMENT

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ABSTRACT

With Malawi having one of the highest rates of AIDS in the world and prevention programmes visibly continuing to fail, the present study was motivated by the pressing need to identify alternative and sustainable resources. A total of 175 undergraduates at the national University of Malawi rated the credibility, both past and future, of the possible sources of advice regarding the disease. This time perspective revealed just one consistently prominent resource: the community alternative of the family. We discuss the applications of this particular finding within the real context of changes occuring in Malawi's political and economic situation, concluding that the family has the potential to make a truly significant contribution to the management of AIDS in the country, and very possibly in the region as a whole.

Introduction

In a previous paper, Carr (1993) briefly outlined the preliminary findings of a survey assessing who Malawi's undergraduates would trust with regard

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to taking advice about HIV/AIDS prevention and management. Malawi is currently among the 'leaders' in the world in prevalence (World Health Organization, 1993), with estimates ranging from twenty per cent (Kool, Bloemkolk, Reeve, and Danner, 1990) to thirty-seven percent of sexually active adults infected (Daily Telegraph, 1993). Within the 'sexually active' spectrum, students may be argued to represent both a high-risk group and the future of this 'developing' nation. Our previous research revealed that the family may be a highly credible but perhaps underutilised and undervalued (by planners) community resource for combating the spread of AIDS among students in Malawi. The objectives in the present study are to clarify and to substantiate this potential role. To do so, we report the original findings more fully, and in addition bring new evidence to bear, on the key issue of sustainability (MacLachlan, 1993).

By 'sustainability' here, we mean the extent to which the family is likely to remain a credible source of persuasion long enough to justify any time and resources seriously invested in it as a vehicle for promoting health in the local community. Within the health area generally in Malawi, such sustainability is often a critical issue (MacLachlan, 1993). With specific regard to AIDS, during the short time-frame from 1991 to 1992 the media have suffered a drastic drop in credibility with students (Tembo, 1991, Carr, 1993, Bandawe, 1993). Yet most AIDS prevention effort ironically continues to be invested in these very same media, and programmes visibly continue to fail (Carr and MacLachlan, 1993). Malawi can ill-afford wasted resources: its health and welfare systems are desperately poor in both material and human resources (House and Zimalirana, 1992, Southern African Economist, 1993).

The fact that Malawi has been dramatically losing its struggle against AIDS arguably makes relatively 'niceties' of the wider debate over health beliefs and their precise relationships to health behavior (Ager and Collins, 1992). The alarmingly high rate of AIDS in Malawi implies the presence of a problem even more fundamental than translating healthy beliefs into healthy behavior. Students at the University of Malawi appear not to have received sound advice on effective prevention, and we would argue that *holding correct* beliefs with regard to any infectious disease is a basic, *necessary* prerequisite for ever adopting low-risk behaviors regarding the contraction of that disease (see also Carney, Baroway, Perkins, Pousson, and Whipple, 1991, Siegal aad

Gibson, 1988). In our study, we therefore sought to identify who students might trust with regard to receiving advice about HIV/AIDS.

This 'credibility' question has been posed in AIDS research conducted in the west (for example, Welch-Cline and Engel, 1991), but only once before in Malawi (Tembo, 1991). On the basis of a substantial sample of 391 undergraduates from the national university, Tembo found that medical doctors and nurses were rated on average the most credible sources of information about HIV/AIDS, with traditional healers emerging as lacking credibility. In-between, in descending order of credibility, were the media ("radio", "newspaper", and "posters"), which were perceived to be credible; followed by "priest" and "friend", who were perceived as less than credible. Unfortunately however, although the study was informative and innovative in the Malawian context, it suffered from several methodological flaws. Chief among these perhaps was the omission of the African *family*, an omission which the present study would rectify. Similarly, and since the behavioral scientist is capable of making significant contributions to human health and welfare, the psychologist too would be included.

If the family and the behavioral scientist are indeed perceived by the typical undergraduate to be almost as credible as medical doctors and nurses, then these two occupational groups could shoulder some of the advice-giving workload. We have already seen how Malawi is extremely short of medical personnel. It would simply be unrealistic to expect these personnel to give lectures, and generally disseminate information concerning diseases such as AIDS. In this sense, the present study can be construed as an attempt to newly identify human resources which are at present not being employed to their full potential.

A further shortfall in the original study was that no distinction was drawn between (1) taking advice with regard to prevention of AIDS, and (2) taking advice with regard to coping with the disease if it was contacted. Such a division is of course widely applied in the health field today (Ebrahim and Ranken, 1988). Given the probable rate of HIV among Malawi's undergraduate population, information on the latter question would be germane. Indeed, the need for the distinction was pointed out by the students themselves during piloting for the present investigation.

Any number scale, and its corresponding verbal translation should be

absolutely unambiguous (Sheatsley, 1983). This is not the case in the Tembo questionnaire (Tembo, 1991), on which the scale was translated as follows.

1 = most credible. 2 = more credible. 3 = credible. 4 = not credible.

The scale is also biased, in the sense that only one rather than two of the options refers to lack of credibility. As such, the respondents could be 'led' to respond on the 'credible' rather than the 'not credible' side of the question. It is a basic design principle that items such as these should be balanced in order to avoid such a problem (for example, Crano and Brewer, 1973). The scale was thus redesigned as follows and piloted for clarity.

1 = not at all credible. 2 = not really credible.

3 = reasonably credible. 4 = highly credible.

A further criticism is that the sources listed on the original questionnaire are not wholly clear in meaning. Thus, both "radio" and "newspaper" could be interpreted as national or from overseas; "posters" could be locally-produced or imported; and "priest" could have various different meanings to a Catholic, a Moslem, and a Protestant (all three are to be found at the University of Malawi). The questionnaire would thus be improved, by specifying: radio M.B.C. (the one and only Malawian station); *Malawi* newspaper; and *government* posters (the three being the media through which HIV/AIDS-related messages are channelled in Malawi); and by changing "priest" to "an advisor within your religion (Catholic priest, Moslem priest, Protestant reverend)", thus focussing the question unequivocally on the specific advisor who would actually be sending any message.

Finally, no attempt has ever been made in Malawi to establish the sustainability of any of these sources of advice about health matters in general, or AIDS in particular. The present study sought to rectify this lack of a 'time and investment' perspective. To do so, we decided to examine not only who students *would* trust concerning AIDS, but also who they reported they *had already* taken advice from. In this way, we would be measuring credibility at two points in time: in the past; and in the future; thereby gaining a longitudinal angle on the problem. The question of the sustainability of each possible source will therefore be addressed empirically. Is there continuity between one point and the next?

METHOD

Subjects

We sampled 175 male and female undergraduates at the University of malawi, Chancellor College, who were studying psychology in first and second year. Their ages ranged from 17 to 23 years, with a mean of approximately 20. They were enrolled in a variety of faculties, thus ensuring that the sample was not unrepresentative of the undergraduate population generally. Although the proportion of males:females was almost 4:1, this ratio is a true reflection of the gender stratification in Malawi's undergraduate population as a whole.

Materials

The questions below formed part of an extensive questionnaire on a wide range of student issues related to student health and welfare.

The first question was prospective, and asked: "With regard to giving you advice about how to prevent HIV/AIDS, please indicate how credible (that is, believable) you would find each of the following". This was followed by the rating scale and the various sources listed in Table 1.

The second question, again prospective, simply replaced the word "prevent" with "manage if you already had". This distinction was included on the basis of suggestions made by students at the piloting stage.

The third and final question was retrospective, asking: "There are a number of different ways that you might have heard about AIDS. Which of the following have you found most useful?" This was followed by the rating scale and the various sources listed in Table 2.

Procedure

The questionnaire was completed at one group sitting, during a psychology class. Beforehand, the students were given the broad purpose of the study; assured of confidentiality; and informed very clearly that their participation was voluntary.

Results

Given our emphasis on credibility through time, Tables 1 and 2 is that the traditional healer is most negatively evaluated. In sharp contrast however

is the family, which is consistently rated highly. In fact, the family is the one and only source of advice which is consistently placed near the top.

Table 1: Prospective Utility

Prevention		Management	
Source	Mean	Source	Mean
Medical doctor	3.5	Medical doctor	3.3
Family	3.2	Religious advisor	3.2
Religious advisor	3.1	Family	3.1
Psychologist	3.1	Psychologist	3.1
Nurse	3.1	Nurse	3.1
Radio (MBC)	2.8	Friend	2.6
Malawi newspaper	2.8	Malawi newspaper	2.5
Government posters	2.8	Government posters	2.4
Friend	2.6	Radio (MBC)	2.4
Traditional healer	1.6	Traditional healer	1.6

Note:

1 = Not at all credible; 2 = Not really credible;

3 = Reasonably credible; 4 = highly credible.

A source scoring less than 3 is less than reasonably credible.

Table 2

Retrospective Utility

Source	Mean Rating
Newspapers/magazines	6.0
Parents	5.7
Medical doctors	5.2
Brothers/sisters	4.9
Friends own age	4.6
Teachers/lecturers	4.1
Traditional healers	2.1

Note: Scale ranged from 1 (not at all useful) to 7 (most useful)
A source scoring below 4 has been less than useful.

The media, for example, are reported to have been useful in the past, but they are rated less than reasonably credible with an eye on the future. Friends, too, are perceived to be less than reasonably credible sources of advice with regard to the future. The psychologist in Table 1, and teachers/lecturers in table 2, are each relatively well-placed, but they are clearly not 'one-and-the same' source of information. Nevertheless, the data contain the suggestion that the psychologist is potentially useful.

Discussion

There is a discrepancy in rank between past and future regarding the medical doctor. The students tell us that doctors would be useful; but that they have not actually been so. It is a fact that doctors are extremely scarce in Malawi's communities (for example, Southern African Economist), and will probably remain so for the foreseeable future (for example, House and Zimalirana, 1992). Thus, medical doctors are not really a practical option for combating AIDS.

The clearest discrepancy of all, however, concerns the present and past credibility of the media. This discrepancy is probably due in large part to the actions of the Catholic Church in Malawi, a community force for whom, as suggested in Table 1, there is a clear future role in managing AIDS. This interrelationship between Church and media obviously needs fully explaining, especially as it has a bearing on the role of the family in AIDS management. Such an explanation involves the wider reality of Malawi's current political and economic situation.

Like much of the region generally, the country is in a state of flux, and is liable to remain so for some time to come. The nub of the matter is the pro-democracy movement that is currently sweeping over the whole of sub-Saharan Africa. In the case of Malawi, this has meant the beginning of a painful transition process away from the autocratic dictatorship of the past three decades. Prior to the recent referendum, forty people were shot dead following anti-government riots in the commercial capital Blantyre (Carr and MacLachlan, 1993). Following the results of the referendum on multi-party democracy, the Life President Dr. H. Kamuzu Banda announced that elections could be held within the year. The west's policy of 'coercive democracy' in this affair, following on the heels of the pervasive drought in southern Africa during 1992, has certainly hurt the Malawi economy.

It is reality in sub-Saharan Africa that political and economic changes will intrude into the field of health care (for example, Ebrahim and Ranken, 1988), and Malawi's AIDS problem is no exception: during Lent 1992, the Catholic Church launched from its pulpits a pastoral letter calling on the Life President for Humanitarian reform (Chiona, Mkhori, Chimole, Assolari, Chamgwera, Chisendera, and Roche, 1992). This one event undoubtedly initiated the current wave of change within Malawian communities and

throughout the country. But it also damaged the credibility of the previously unchallenged government, and its offices. Among these offices are the media, which have been and still are the predominant channels for health messages. This interrelationship between Church and media is probably why we have seen such inconsistency in the credibility fortunes of these two sources (see also Tembo, 1991, Bandawe, 1993).

Our point, however, is a broader and very pragmatic one: as the change process continues, it becomes a priority to identify a sustainable source of information. And, as our data shows, the one source which thus far appears unaffected by these wider changes is the family. It is in fact a long-standing tradition all over the African continent to place great trust and respect in the (extended) family system (Siann and Ugwuegbu, 1988). Here then is a likely touchstone for replanning the management of the AIDS crisis in Malawi. Actually, many African health services are already showing increasing commitment to community care, and this commitment – in relation to nutrition for example – has begun in Malawi (Wilkinson, 1991).

Finally, we should not forget that undergraduates, although an important group, represent a very small proportion of the nation's youth. With their special abilities and vested interests, they may not be typical of the wider youth population in terms of who they trust about AIDS. The rest of the country's youth, for example, may find the traditional healer more accessible or approachable. As the present study has demonstrated however, important health-related questions like these can only be answered by empirical means.

Within a matrix of social change in a developing country, the present study suggests that the family is a highly rated source of advice by university students. Furthermore, Malawi's secondary school pupils also rate the family highly (Bandawe, 1993). To the extent that (1) the changes in Malawi are merely a microcosm of those occurring in sub-Saharan Africa as a whole, and (2) the institution of the family is widely respected and trusted in the region as a whole, then the potential for this particular African institution in the field of health promotion and illness prevention is wide indeed.

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