University of Alberta

The Meaning of a Healthy Family in Sub-Saharan Africa: Perspectives of Two-Parent Families in Urban Malawi

by

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Dedication

In memory of my mother, the late Stella Chinseu;

the woman who inspired me to love,

and to be kind

Abstract

To explore how healthy family functioning is conceptualized by families in sub-Saharan Africa, 10 mothers and 9 fathers participated in in-depth interviews and discussed the meaning of a healthy family for them, and described the practices they engage in to support having a healthy family. Analyses revealed that participants described a healthy family holistically, captured under four major themes: physical health, relationship health, spiritual health, and mental health. Participants described a range of practices or family processes that they intentionally engaged in to ensure that the physical, relationship, spiritual, and mental health needs of their family were met. Participants' conceptualizations of what it means to have a healthy family were compared to North American scholarly models of family functioning highlighting the need to consider culture when conceptualizing or measuring family functioning. Implications of the findings for policy, programming and services for families in sub-Saharan Africa are discussed.

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CHAPTER 1: INTRODUCTION

Family is "a universal social institution– all cultures at all times have had some form of family system" (Lee, 1988, p. 59). How family is defined is important not only to individuals and family groups but also to those who make decisions that affect them. The meaning of family has social, political, economic, and legal implications that ultimately affect people's everyday lives (Weigel, 2008). For instance, policies such as those on housing, health insurance, family planning, and social support, largely depend on how family is defined (Weigel, 2008). Notably, what it means by the term "family" remains an issue of great debate. Currently, there is no universal/standard definition of family (Baker, 1996; McDaniel & Tepperman, 2000; Olson & DeFrain, 1994; Skolnick & Skolnick, 2009), largely because it depends on many things such as culture, worldview, and professional orientation.

Family is commonly defined within three major perspectives (Koerner & Fitzpatrick, 2004; Weigel, 2008). Firstly, family may be defined based on *structural* components of the family system. Definitions of family under this focus on "the presence or absence of certain family members related through blood or marriage such as parents, children, and extended family members" (Koerner & Fitzpatrick, 2004, quoted in Weigel, 2008, p.1427). Family may also be viewed based on *functional* definitions of family (Koerner & Fitzpatrick, 2004; Weigel, 2008). This perspective looks at the family as an institution in which psychosocial functions and tasks are performed and fulfilled (Weigel, 2008). Such roles include maintaining household, socializing children, providing emotional

and material support for family members, and fulfilling family roles (Weigel, 2008). The focus of this perspective is on how functions and tasks that family members perform contribute to the wellbeing of other family members and the betterment of the society.

Lastly, family may be defined based on *transactional* definitions. In this perspective, the focus is on the degree of emotional bondedness and "we-ness" between and among members of the family (Weigel, 2008, p. 1428). Therefore, socioemotional issues like love, support, caring, connectedness, and commitment are paramount to how the family is defined (Weigel, 2008). Weigel (2008) observed that within these perspectives of defining a family there are some overlaps and that definitions of family in one perspective may include elements from the other.

Even though there is no consensus on the definition of family, researchers and scholars agree that families are the hub of any society, and the basis for its survival because of the many important activities that they perform within the family system and to the larger society (McDaniel & Tepperman, 2000; Olson & DeFrain, 1994; Skolnick & Skolnick, 2009). Families provide an environment where family members' protection, economic, and emotional needs are met (McDaniel & Tepperman, 2000; Nkosi & Daniels, 2007). In the family environment children are socialized and prepared for the world (Olson & DeFrain, 1994) and adults develop and nurture their careers. Further, families are also economic institutions that provide economic services to the society through labor participation, and production and consumption of goods and services (Skolnick &

Skolnick, 2009; McDaniel & Tepperman, 2000). Furthermore, the family regulates sexual relationships and serves as a sustaining system for the society through procreation and adoption (Lee, 1988; McDaniel & Tepperman, 2000).

Importantly, the likelihood that families can accomplish these critical functions and tasks largely depends on how family systems function in their everyday life at both individual and family level. Thus, families that work and live well are likely to accomplish these functions and tasks, positively contribute to the wellbeing of their members, and make a significant contribution to the welfare of the society. It is for these reasons that family functioning is an area of interest that has received tremendous attention from scholars in the social sciences and related disciplines as well as healthcare professionals, family therapists, social workers, and other practitioners interested in family health and wellness.

There is a plethora of literature specifically highlighting benefits associated with healthy functioning families for children and adolescents. For instance, healthy functioning families are associated with healthy growth and development of children (Repetti, Taylor, & Seeman, 2002), development of positive self-esteem in adolescents and youths (Baldwin & Hoffmann, 2002; Gorbett & Kruczek, 2008; Lian & Yusooff, 2009; Mandara & Murray, 2000), positive adjustment in children and adolescents (Richmond & Stocker, 2006), positive parenting styles (Hernandez, 2009), less perceived stress, positive problem-solving, and coping behaviors among college students (Gefen, 2010), and positive academic achievement (Wentzel, 1994).

On the flip side, families that do not work and live well are associated with several negative outcomes such as children's maladjustment (Low & Stocker, 2005) and poor development (Walker & Shepherd, 2008), and family conflicts and breakdown. Further, families that do not function well negatively impact adults in several ways. For instance, studies have found that adults who come from these families are likely to bring negative moods into the workplace (which may be portrayed through poor interpersonal behaviors), and experience unwanted pressures and stresses on the job (Weinberg & Mauksch, 1991) which may negatively affect productivity (Robinson & Post, 1995). Understanding how families function in everyday life is central to the wellbeing of family members as well as the welfare of the society. Thus, understanding healthy family functioning holds the potential for developing programs and services that are tailored towards helping the families meet their needs in everyday life.

Currently, most of research on the concept of healthy family functioning has been conducted in Western countries, especially in North America. Popular models that are used to conceptualize and assess family functioning include: the Circumplex Model of Marital and Family Systems (Olson & Gorall, 2003); the Beavers Systems Model (Beavers & Hampson, 2000; Beavers & Hampson, 2003); and the McMaster Model of Family Functioning (Epstein et al., 2003). All these models were developed based on a Western view of a healthy family and reflect Western cultural values.

While these models of family functioning offer important ways of understanding healthy family functioning in Western societies, it is not yet clear

whether these models can be transferred to other cultures (e.g., African culture) and capture the realities and meanings of a healthy family (Shek, 2001). Even though family is "a universal social institution" (Lee, 1988, p. 59), cultural differences may affect how family is defined (Weigel, 2008) and also how healthy functioning family is perceived (Walsh, 2003). For instance, studies in collectivist cultures that differ in important ways from the individualistic North American culture have found that some dimensions of family functioning highlighted in North American scholarly models do not have the same meaning in other cultures. For example, what constitutes enmeshment in some cultures (i.e., mainstream North American cultures) and is associated with unhealthy outcomes for family members appears to capture normative closeness in other cultures and is associated with positive outcomes for child and adolescent development (Manzi et al., 2006). Such differences raise questions as to whether conceptualizations and assessments of family functioning based on North American perspectives are appropriate and applicable to other cultures.

As a Malawian family scholar, I am particularly interested in the applicability of North American models of family functioning for the African context. Little is known about the conceptualization of a healthy family in Africa, particularly in sub-Saharan Africa (Greef, 2000; Zwane, 2004).

Motivated by the importance of understanding the meaning of a healthy family, concerns that Western-developed family conceptualizations may not be appropriate for African families, and the paucity of research on the topic in this part of the world, I sought to explore the meaning of a healthy family from the

perspective of families in urban Malawi. Such knowledge is important for understanding how similar or different Western conceptualizations are from the Malawian perspectives of a healthy functioning family, and also for developing programs and services that reflect the needs of Malawian families in their everyday life.

In the next chapter of this thesis I describe the well-known North American models of family functioning, review the scant literature on the application of these models to cultures outside North America, raise concerns about the cultural appropriateness of these models outside Western cultures, and provide a rationale for the proposed study of exploring the meaning of healthy family functioning in Malawi. In Chapter 3, I provide some background about Malawi and describe the study methodology. Chapter 4 presents the findings of the study. In Chapter 5, I compare my findings to North American scholarly models of family functioning, consider the implications of these findings for understanding the concept of family functioning across different cultures, discuss the implications of this study's specific findings for the development of policies, programs and services to support Malawian families, and finally, I offer some suggestions for future research.

CHAPTER 2: REVIEW OF LITERATURE

> "A healthy family is neither average nor merely lacking in negative characteristics. Rather, it has described, positive features" (Epstein, Ryan, Bishop, Miller, & Keitner (2003, p. 581).

A review of the literature reveals that scholars and researchers in social sciences and health and health related disciplines use different terms to refer to families that work and live well. Such terms include: balanced families (Olson & Gorall, 2003); effective functioning families (McCreary & Dancy, 2004); happy families (Shek, 2001); healthy families (Epstein, Ryan, Bishop, Miller, & Keitner, 2003; Niska et al., 1999; Denham, 1999b); healthy functioning families (Smith & Stevens, 1992); optimal families (Beavers & Hampson, 2003; Beavers & Hampson, 2000); good functioning families (Walker & Shepherd, 2008); normal families (Walsh, 2003); and strong families or successful families (DeFrain & Stinnett, 1992). Often times the concepts of *family health, familial health, family functioning, and healthy family* are used interchangeably in literature (Anderson & Tomlinson, 1992; Denham, 1999b). Notably, there is no single definition for healthy families (Walker & Shepherd, 2008) because this concept is usually based on subjective worldviews, is socially constructed, and is influenced by theoretical positions, professional values and biases (Walsh, 2003), as well as the larger culture (Denham, 2003).

To understand how a family that works and lives well is conceptualized, two perspectives are reviewed: 1) the perspective of family scholars; and 2) the

perspectives of lay people. The subsequent review of literature expounds on these two points.

Conceptualization of a Healthy Family: Perspectives of Family Scholars

What meaning do family scholars have for a healthy family?

There are several models that are used by scholars, researchers, and clinicians to conceptualize and assess healthy couple and family functioning. These models offer a rich insight on how this group of people conceptualizes a healthy family. The most widely used models of family functioning were developed in North America and include: the McMaster Model of Family Functioning (Epstein & Bishop, 1981; Epstein, Bishop, & Baldwin, 1982; Epstein, Bishop, & Levin, 1978; Epstein et al., 2003); the Circumplex Model of Marital and Family Systems (Olson, Russell, & Sprenkle, 1983; Olson & Gorall, 2003); and the Beavers Systems Model of Family Functioning (Beavers & Hampson, 2000; Beavers & Hampson, 2003). Because of their relevance to the present study as well as the wealth of information they shed on the conceptualization of a healthy family, these three models of family functioning are described in the subsequent sections.

The McMaster Model of Family Functioning

The McMaster Model of Family Functioning (MMFF) (Epstein et al., 2003; Miller et al., 2000) is grounded in systems theory. The model assumes that the family should provide an environment that is favorable for development and maintenance of family members' social, psychological, and biological needs (Epstein et al., 2003). Thus, the MMFF focuses on six dimensions of family

functioning that are considered crucial for emotional and physical health or problems of family members (Epstein et al., 2003). These six dimensions include: family problem-solving, communication, roles, affective responsiveness, affective involvement, and behavior control. Subsequently, the details of each of these dimensions are provided.

Problem-Solving. Problem-solving focuses on the family's ability to resolve problems to a level that maintains effective family functioning, as well as the specific steps they take to do so (Epstein et al, 2003; Miller et al., 1994). Family problems are divided into two: instrumental problems (i.e., those that are related to meeting basis needs in everyday life, such as food, shelter, clothing, healthcare); and affective problems (i.e., those that relate to issues of feeling and emotional experience, such as stress, depression, worry, and also emotional needs such as love) (Epstein et al., 2003; Miller et al., 2000).

The most important issue in problem-solving is not the absence of problems in the family. Rather, it is how families deal with or resolve their problems. Epstein and colleagues (2003) explain that all families face problems and that the problems may be similar, but what differs is how families address their problems. Thus, healthy families approach problem-solving systematically, and if they have unresolved problems, they are relatively few and/or new, and are resolved effectively (Epstein et al., 2003). By contrast, families that are not healthy have difficulties in solving problems because there is less effort to solve the problems and they have a less systematic approach for solving problems (Epstein et al., 2003).

Communication. According to the MMFF, communication refers to the "effectiveness, extent, clarity, and directness of information exchange in the family" (Miller et al., 1994, p. 1). The model focuses on two aspects of communication: 1) clear versus masked communication (i.e., is the content of the message clearly stated or is camouflaged, muddied, or vague); and 2) direct versus indirect communication (i.e., is the message going to the intended people or does it tend to be directed to other people?) (Epstein et al., 2003; Miller et al., 2000). From these two aspects there are four types of communication: clear and direct communication (i.e., the message is clearly stated and goes to the intended person); clear and indirect (i.e., the message is clearly stated but directed to other people); masked and direct (i.e., message goes to the intended person but is camouflaged); and masked and indirect (i.e., message is camouflaged and direct to other people). According to the MMFF, a healthy family is one where family members communicate in a clear and direct manner.

Role Functioning. The MMFF defines family roles as "the efficacy with which family tasks are allocated and accomplished to maintain an effective and healthy system" (Miller et al., 1994, p.1). Family roles include: provision of resources (i.e., tasks and functions aimed at providing for the family's needs in everyday life); nurturance and support (i.e., provision of comfort, warmth, reassurance, and support for family members); adult sexual gratification (i.e., affective issues such as sexual satisfaction between husband and wife); personal development (i.e., physical, emotional, educational, and social development support for family members to develop skills for personal achievement); and

maintenance and management of the family system (e.g., decision-making functions) (Epstein et al., 2003; Miller et al., 2000).

Two key aspects of role functioning are role allocation and role accountability. Role allocation looks at how roles are assigned in the family by taking into account issues like the person's power and skills to perform the roles, appropriateness of the person's age, and whether the family members are satisfied with how the tasks are distributed. Role accountability looks at fulfillment of roles in the family, sense of responsibility, and monitoring of the roles. Based on the type of roles and how they are allocated and accounted for, the MMFF conceptualizes a healthy functioning family as one where "all necessary family functions are fulfilled, roles are allocated reasonably, and accountability is clear" (Epstein et al., 2003, p. 592).

Affective Response. Affective response is the "ability to respond to a given stimulus with appropriate quality and quantity of feelings" (Epstein et al., 2003, p. 594). Qualitatively, the focus is on whether family members are able to respond to emotional feelings in life and whether their response is consistent with the stimulus or situation (Epstein et al., 2003; Miller et al., 2000). Quantitatively, the focus is on whether the degree of response is reasonable, as expected, or overresponsiveness or underresponsiveness (Epstein et al., 2003; Miller et al., 2000).

There are two categories of affective responses: 1) welfare emotions (e.g., affection, warmth, tenderness, support, love, consolation, happiness, and joy); and 2) emergency emotions (e.g., anger, fear, disappointment, depression). From these

emotions and affective responses, a healthy family is conceptualized as one in which members are capable of expressing a full range of emotions, and experience emotions that are situationally appropriate with an intensity and duration that are reasonable (Epstein et al., 2003; Miller et al., 2000).

Affective Involvement. The MMFF defines affective involvement as "the quality of interest, concern, and investment that family members have for each other" (Miller et al., 2000, p. 1). The focus is on the amount and manner of interest family members show in one another. According to Epstein and colleagues (2003), there are six types of affective involvement: 1) lack of involvement (i.e., showing no interest in one another); 2) involvement devoid of feelings (i.e., there is some interest in one another); 3) narcissistic involvement (i.e., there is interest in one another only to the degree that their behavior reflects on the self); 4) empathetic involvement (i.e., interest in one another for the sake of the others); 5) overinvolvement (i.e., excessive interest in one another); and 6) symbiotic involvement (i.e., an extreme and pathological investment in others). Based on these types of involvement, a healthy family is one in which members show one another empathetic involvement (Epstein et al., 2003).

Behavior Control. Behavior control is the pattern a family adopts for handling situations that: are physically dangerous; involve meeting and expressing psychobiological needs and drives; and involve interpersonal socializing behavior between family members and with other people (Epstein et al., 2003; Miller et al., 2000; Miller et al., 1994). There are four styles of behavior control: 1) rigid behavior, which is characterized by a family where standards are narrow and

culture-specific, and there is minimal negotiation or variations across situations; 2) flexible behavior control, which is typical of families where standards are reasonable, and there is opportunity for negotiation; 3) laissez-faire behavior control, which is characterized by a family in which no standards are held, there is much latitude allowed regardless of situation; and 4) chaotic behavior control, which is characterized by unpredictable behaviors and there is a random shifting among the behavior styles (rigid, flexible, laissez-faire) so family members do not know the exact standards that apply at any time or how much negotiation is possible. From these behavior styles, a healthy family is conceptualized as one where family members engage in flexible behavior control (Epstein et al., 2003).

As a whole, the McMaster Model of Family Functioning conceptualizes a healthy family as one where members of the family are able to solve problems effectively and easily, communicate clearly and directly, fulfill all necessary functions that support their everyday life, express and experience appropriate emotions of reasonable intensity and duration, show empathy for each other, and also exercise flexible behavior control (Epstein et al., 2003; Miller et al., 2000).

The Circumplex Model of Marital and Family Systems

The Circumplex Model of Marital and Family Systems (Olson & Gorall, 2003) is based on systems theory and assesses family functioning at couple and family levels. The model focuses on three main dimensions of family functioning: cohesion; flexibility; and communication (Olson, 2000; Olson & Gorall, 2003).

Cohesion (Bonding). Cohesion refers to the emotional bonding that couple and family members have towards each other (Olson 2000; Olson et al.,

2003). There are five levels of cohesion that represent a continuum from separateness to togetherness of family members. According to this model, family cohesion ranges from *disengaged/disconnected* (i.e., extremely low level of bonding), to *somewhat connected* (i.e., low to moderate bonding), to *connected* (moderate bonding), to *very connected* (moderate to high bonding), to *enmeshed/overly connected* (extremely high bonding) (Olson & Gorall, 2003). Thus, cohesion focuses on how family members as a system balance separateness and togetherness (Olson & Gorall, 2003). A healthy family is the one that falls on the three central/midrange/balanced levels of cohesion (i.e., somewhat connected, connected, and very connected). Conversely, unhealthy family is the one that falls in either of the two extreme/unbalanced levels of cohesion (i.e., disengaged or enmeshed) (Olson, 2000; Olson & Gorall, 2003).

Flexibility (Change). Flexibility is defined as "the quality and expression of leadership and organization, role relationship, and relationship rules and negotiations" (Olson, 2011, p. 65). Family flexibility (change) ranges from *rigid/inflexible* (i.e., extremely low), to *somewhat flexible* (i.e., low to moderate), to *flexible* (moderate), to *very flexible* (moderate to high), to *chaotic/overly flexible* (extremely high) (Olson, 2000; Olson, 2011; Olson & Gorall, 2003). The focus of this dimension of the model is on how family members as a system balance stability and change. Thus, a healthy family is the one that falls on the three central/midrange/balanced levels of flexibility (i.e., somewhat flexible, flexible, and very flexible) (Olson, 2000; Olson & Gorall, 2003). Conversely,

unhealthy family is the one that falls in either of the two extreme/unbalanced levels of cohesion (i.e., rigid or chaotic) (Olson, 2000; Olson & Gorall, 2003).

Communication. Communication refers to the positive exchange of information between and among family members (Olson & Gorall, 2003). Communication is measured by focusing on the family unit, specifically on their listening skills, speaking skills, self-disclosure, clarity, continuity tracking, and respect and regard (Olson, 2000; Olson & Gorall, 2003). According to the model, a healthy family is the one that communicates positively (i.e., family members show empathy and attentive listening, speak for oneself and not for others, share feelings about oneself and their relationships in the family, and stay on topic when talking to one another) (Olson & Gorall, 2003). Importantly, communication plays a crucial role of facilitating how couples and families alter their levels of cohesion and flexibility (Olson, 2000; Olson, 2011; Olson & Gorall, 2003).

Taken together, the Circumplex Model of Marital and Family Systems conceptualizes a healthy family as one that has balanced (midrange) levels of both cohesion (emotional bonding) and flexibility (change), and where members communicate positively (Olson, 2000; Olson, & Gorall, 2003). According to this model, families that are too cohesive (enmeshed) or too distant (disengaged) on the cohesion scale, and show too much change (chaotic) or too little change (rigid) on the flexibility scale, and exhibit negative communication patterns (e.g., family members show poor listening skills, go off topic when talking to one another, hide their feelings about oneself or other family members, and lack respect and regard when talking to one another) are considered less functional or

problematic (Franklin, Streeter, & Springer, 2001; Olson, 2000; Olson, 2011; Olson & Gorall, 2003; Perosa & Perosa, 2001).

The Beavers Systems Model of Family Functioning

Like the MMFF and Circumplex Model of Marital and Family Systems, the Beavers Systems Model of Family Functioning (Beavers & Hampson, 2000; Beavers & Hampson, 2003) is based on systems theory. The model has two main dimensions of family functioning: family competence and family style.

Family Competence. According to Beavers and Hampson (2003), family competence refers to "how well a family as an interaction unit performs the necessary and nurturing tasks of organizing and managing itself in everyday life" (p. 551). More specifically, it describes levels of family competence ranging from optimal to severely dysfunctional. The level of family competence "relates to the structure, available information and adaptive flexibility" (Beavers & Hampson, 2000, p. 128).

According to this model, healthy families are characterized by the following: adults in the family are able to negotiate and share leadership; there are strong and clear generational boundaries in the family; communication is clear and direct, and family members are able to resolve conflict and accept differences; and are spontaneous, show a wide range of feelings, and are optimistic (Beavers & Hampson, 2000; Beavers & Hampson, 2003). Families that are not healthy are characterized by: weak adult coalitions; ineffective leadership; limited ranges of feelings and more pessimism; poor communication; and limited negotiation and adaptive capacity (Beavers & Hampson, 2000; Beavers & Hampson, 2003).

Family Style. Family style refers to a family's functional and behavioral way of relating and interacting within and outside the family and ranges from centripetal (CP) to centrifugal (CF) (Beavers & Hampson, 2000; Beavers & Hampson, 2003). According to this model, centripetal family members are those that often times look for relationship satisfaction from within the family rather than from outside because they are less trustful of the world outside (Beavers & Hampson, 2000; 2003). Centripetal family members repress, suppress, or deny negative or hostile feelings and show much affection for each other, and pretend everything is fine and that they are always there for each other (Beavers & Hampson, 2003). Quite differently from centripetal families, centrifugal families see the family as holding the least promise of satisfaction and therefore seek satisfaction from the outside world (Beavers & Hampson, 2000; Beavers & Hampson, 2003). Centrifugal family members do not like affectionate messages, rather, they are more comfortable with negative or angry feelings (Beavers & Hampson, 2003).

Thus, the model focuses on the closeness of family members, and also on how rigid or flexible the family is in terms of looking for satisfaction outside the family. Taken together, healthy families are those that have a system's approach to the relationships (i.e., members realize that their interactions produce a given result and that causes and effects are interchangeable) (Beavers & Hampson, 2003), are able to manage the affairs of their family, and are able to change and adapt to meet individual members' needs (Beavers & Hampson, 2000). Families that are not healthy exhibit less of the above qualities, and have also excessive or

extreme centripetal and centrifugal family styles (Beavers & Hampson, 2000; Beavers & Hampson, 2003).

Walsh's Normal Family Process Perspective

Other scholars and researchers have also provided views of a healthy family. For instance, Walsh (2003) suggests four perspectives for considering a normal or healthy family. One of these four perspectives is called "normal family processes". It is grounded in systems theory and focuses on the ongoing processes happening in the family's developmental and cultural contexts and how they shape the health of family members. According to this perspective, a normal family is the one which has "basic patterns of interaction processes that support the integration and maintenance of the family unit and its ability to carry out essential tasks for the growth and well-being of its members" (p. 7).

The review of literature on the McMaster Model of Family Functioning, the Circumplex Model of Marital and Family Systems, and the Beavers Systems Model of Family Functioning shows that these models of family functioning are similar and assess family functioning in similar areas. Commonalities among these models are their system's approach to conceptualization and assessment of family functioning. This involves a recognition that a family is a system made of individuals who affect one another as they undergo their everyday life and that the family system is affected by factors or forces outside the family. In addition, all three models focus on many of the same themes of family functioning (e.g., communication, emotional bonding, role-performance and fulfillment, boundaries). For instance, family style (Beavers Model), affective involvement

(McMaster Model), and cohesion (Circumplex Model) are similar in that they all focus on emotional bonding of family members. Further, in all the three models (e.g., flexibility in the Circumplex Model, affective involvement and behavior control in McMaster Model, and style in Beavers Model) there is also a focus on how family members change their behavior to respond to specific demands or situations (e.g., family rules, crises, and emotional needs), and how that affects individual members and also the family as a system.

Based on the McMaster Model of Family Functioning, the Circumplex Model of Marital and Family Systems, and the Beavers Systems Model of Family Functioning (Epstein et al., 2003; Olson 2011; Olson & Gorall, 2003; Beavers & Hampton, 2003) and the Walsh's "normal family process" perspective (Walsh, 1994; 2003), scholars in North American conceptualize a healthy functioning family as one where there is leadership in the family, members communicate effectively, they effectively manage crises and solve problems, they have strong, but not overly involved emotional bonding, they show support for each other, and they effectively perform and fulfill roles to support wellbeing of members in everyday life. According to these models, these family processes should support healthy development and growth of family members in all important aspects of their everyday life (e.g., social, physical, mental, and emotional), and that these family processes allow for a balance between meeting individual and family needs.

Although the developers of all three models assert that the measures based on these models have been tested and validated, and used across various groups

(e.g., ethnicity/race, social class, educational levels) and in diverse marital systems (e.g., single-parent, and step families) (Beavers & Hampson, 2003; Epstein at al., 2003; Olson and Gorall, 2003), none of the models had adequately addressed the issue of culture. For instance, in spite of acknowledging that conceptualization of the dimensions of these models should take into account the culture in which the couple or family belongs, the models do not offer insights on how this could be addressed. Furthermore, none of the measures associated with these models appear to be sensitive to cultural differences. These are serious limitations of these models which warrant further research to explore diverse cultural conceptualizations of healthy family functioning and to investigate the validity of the tools associated with these models for use outside mainstream North American populations.

Meaning of a Healthy Family: Perspectives of Lay People

What meaning do lay people have for a healthy family?

Besides the conceptualization of a healthy family presented in the models discussed above, there are other studies which investigated lay people's views of a healthy family. Notably, these studies are few and are mostly from North America.

McCreary and Dancy (2004) investigated the dimensions of family functioning from the perspectives of low-income African American single-parent families. The study explored how participants defined their families, the essential dimensions of family functioning, and the specific activities and interactions that exemplified effective and ineffective family functioning within each identified

dimension (McCreary and Dancy, 2004). The findings revealed five major themes essential for effective family functioning: emotional nurturing (sharing affection and emotional closeness); communication (sharing thoughts, information, advice, and encouragement to one another); doing things together (spending time together); helping each other to meet family and individual needs; and parenting children appropriately (McCreary and Dancy, 2004). The study also reported that function ineffectively family members are uncaring, hostile or violent toward each other, fail to communicate positively, avoid being together, refuse to help each other, and neglect parental responsibilities (McCreary and Dancy, 2004).

Niska and colleagues (1999) examined the meaning of family health from the perspective of Mexican American first-time parents. Niska and colleagues (1999) reported that participants' meaning encompassed physical, emotional, social interactional, and spiritual aspects of their family. Participants' emphasis on the importance of family unity (being united/being together) and joint parenting confirmed the findings of Chan et al (2011) and McCreary and Dancy (2004).

Denham (1999b) investigated how family health was defined and practiced within family households of rural Appalachian families. In this study, parents and children described family health in terms of the absence of illness or disease, the ability to actively engage in life, a balance among multiple family life dimensions, and as a holistic phenomenon with physical, emotional, social, spiritual, and ecological dimensions. Thus, a healthy family was one whose members enjoyed good physical, emotional, social, and spiritual wellbeing.

Evidently, the meaning of a healthy family among lay people and families is similar across different countries and subgroups. The studies reviewed above found that participants viewed a healthy family as one where members have good physical (i.e., enjoy good physical wellness), social (have healthy relationships with other people outside), spiritual (e.g., believe in and depend on divine power), and mental and emotional wellbeing (e.g., deal with stress and depression positively). Importantly, even though the review showed that lay people's perspectives also emphasized family unity, a comparison of scholarly conceptualizations of a healthy family and lay perspectives shows that there is much consistency in how these two groups conceive of a healthy family. The perspectives of lay people explicitly isolate major dimensions of health (e.g., physical, social, spiritual, mental and emotional health). For instance, a healthy family is perceived as one whose members have good physical wellbeing. Scholar's conceptualizations focus on dimensions of family function that impact different aspects of health. The scholars assert that effective/good/healthy functioning in specific dimensions of family functioning will lead to better outcomes in physical, social, spiritual, mental and emotional health of family members. In short, lay perspectives tend to focus more on the outcomes of healthy family functioning whereas the scholars focus on the specific family processes associated with family functioning. Yet there is much overlap in lay and scholarly perspectives of what is a healthy family. For instance, both scholars and lay people view a healthy family as one where there is good communication,

problem-solving, and also strong emotional bonding (e.g., characterized by sense of togetherness) between and among family members.

The difference between the perspectives of lay people and conceptualizations of scholars is mainly on two issues: family unity, and spirituality. Among lay people there seem to be more emphasis on family unity than do scholars. Further, while issues of spirituality are subtle in the scholars conceptualizations, lay people's view of a healthy family incorporate spirituality in their view of what a healthy family is.

Culture and Conceptualization of a Healthy Family

Is the meaning of a healthy family the same for people of different cultures?

The models of family functioning presented above were developed based on studies that involved North American families. As such they reflect "a healthy family" or "healthy family functioning" from the perspectives of North American families, scholars, and clinicians. While the above conceptualizations of healthy family functioning provide useful and meaningful understanding of families and their health, it is not yet known whether such conceptualizations are applicable to cultures that are different from North American mainstream culture. For example, North American culture is less collective and more individualistic compared to many other cultures (e.g., the African culture and the Chinese culture). Family functioning in individualistic cultures may be different from that in collective cultures. For instance, families in collective culture may emphasize on socializing children to be more dependent on their family members while individualistic culture may encourage independence.

Another way culture may affect notions of healthy family functioning could be around the nature of roles—specifically, the degree of role flexibility and rigidity that is normative and considered healthy. Highly gendered cultures (e.g., African culture) may have clearly defined roles that are gender specific and there may be less flexibility in how roles and tasks are assigned to family members. By contrasts, in less gendered cultures (e.g., North American culture) there may be more flexibility in how roles and tasks are assigned. Thus, family processes may be different and consequently the meaning of a healthy family or healthy functioning family may also be different.

Family life in other cultures, such as the African culture, may be characterized by male dominance in decision making, strong relationships with extended families, less child freedom in terms of choices and decisions about his/her life (e.g., career, marriage), and these culturally-oriented characteristics are reflected in everyday functioning of the family. All these characteristics are not typically found in North American families. Thus, healthy family functioning may be different.

Further, researchers have observed that current scholarly conceptualizations of family functioning are mostly reflective of two-parent middle-class Caucasian families (Fine, 2001) and often times are evaluated from the perspective of Western scientific discourse, which emphasizes individualism. For example, Chen et al., (2003) argued that "the meaning of family functioning and the definition of healthy functioning may be different in Western and Eastern cultures" (p. 42). Thus, Western-based conceptualizations may not capture the

same conceptual meaning if employed in collective cultures (Chen et al., 2003; Shek, 2001, 2005).

Examining studies that have investigated family functioning in countries outside North America may reveal important differences between the North American view of a healthy family and that of other cultures. For example, Manzi and colleagues (2006) conducted a study in Italy and the United Kingdom in which they examined the relationship between family cohesion and enmeshment and their implications for identity and psychological well-being among adolescents approaching a major life transition (i.e., the end of secondary school). The researchers used instruments adapted from the United States. Generally, they found that family enmeshment was associated with poorer psychological well-being among adolescents in the United Kingdom but not among Italian adolescents. Specifically, Manzi and colleagues (2006) found that among adolescents from the United Kingdom, enmeshment was associated with higher anxiety and depressive symptoms. In contrast, Italian adolescents who reported greater family enmeshment did not experience more depressive symptoms or anxiety as they approached the transition from secondary school. Manzi and colleagues (2006) concluded that "family enmeshment simply does not appear to be maladaptive in a traditional cultural context that emphasizes family connectedness" (p. 686). This suggests that family enmeshment (too much bonding) may not be considered as unhealthy in some cultures (e.g., in Italian families) where strong family bonding is viewed as an important component of everyday life in a healthy family.

Chen et al., (2003) investigated family functioning for a sample of Chinese families with a hospitalized child compared to a sample of families with healthy children in Hong Kong and Chinese Mainland. They used a version of the McMaster Model's Family Assessment Device (FAD) translated into Chinese. Chen and colleagues (2003) reported that even though there were adequate reliability and moderate subscale correlations of the FAD in measuring family functioning, they also observed important differences between how family functioning was perceived in Chinese and North American cultures. For instance, the subscale of Behavior Control revealed differences between family functioning in North American and Chinese families, which reflected different parenting styles between Western and Chinese parents. Chen et al (2003) commented that "what is considered overcontrolling parental behavior in Western culture may be viewed as appropriate socialization in Chinese families" (p. 57). This suggests that behavior control may be conceptualized differently in different cultures. As such, conceptualizations and operationalization of constructs that do not reflect the cultural meanings may wrongly assess family functioning.

Chan and colleagues (2011) conducted a study in Hong Kong in which they investigated the meaning of family health, happiness, and harmony from the perspectives of community leaders and advocacy groups. In this study, participants defined a healthy family in terms of family unity and psychological well-being. The participants placed much importance on everyday family functioning processes that facilitated and promoted family unity.

The above studies raise the concern that the conceptualization of a healthy family may be different across different cultures. Given the findings from the few studies outside a North American context, there appears to be a need to develop culturally appropriate conceptualizations and assessments of family functioning that are representative of the realities of family dynamics and processes in everyday life of families in different cultural contexts. Scholars have cautioned that conceptualizations and assessments of family functioning and subsequent judgments about whether the family is healthy or not should take into account the cultural values to which the family belongs (Epstein et al., 2003; Walsh, 2003). Characteristics of family functioning that may be considered unhealthy in one culture may, in fact, be viewed as healthy in another culture. Epstein and colleagues (2003) explain, for example, that judgment of appropriateness of emotions such as sadness "is not clear-cut and varies among cultures" (p. 584). They conclude by taking the position that "knowledge of the culture to which a family belongs is necessary to understand a family, and the judgments of health or normality are relative to the culture of the family" (p. 584).

Given the cultural differences between North America and countries in Africa, one wonders whether Western-based conceptualizations of a healthy family reflect the true meanings of a healthy family embedded in the African collective culture system. Siqwana-Ndulo (1998) noted that the value system of Africans is based on a cultural heritage that is different from that of the West. The problem, however, is that currently there is lack of research on the conceptualization of a healthy family in Africa. Thus, it is difficult to ascertain

whether Western-developed conceptualizations of a healthy family may accurately capture the realities in African families.

While there is research on the meaning of a healthy family functioning in North America, Chinese, and some European populations (e.g., Chan et al., 2011; Chen et al., 2003; Epstein et al., 2003; Walsh, 2003; Olson & Gorall, 2003; Beavers & Hampson, 2003; Beavers & Hampson, 2000; Denham, 1999b; Niska et al., 1999; Manzi et al., 2006; McCreary and Dancy; 2004), there is a paucity of studies on the topic in developing countries, especially in Africa. Researchers in Africa (Greef, 2000; Zwane, 2004) have noted that research on family functioning in Africa is lacking. I found only two studies on healthy family functioning in Africa (Greef, 2000; Zwane, 2004) and both of these studies were conducted in South Africa, a country that has had more White European influence than most African countries. A brief review of these studies is provided subsequently.

Greef (2000) was interested in identifying variables that could explain variations in family functioning across four family developmental stages for South African families: married couples without children; families with the oldest child not yet in school; families with oldest adolescent still living at home; and families with the oldest child having left home. The goal was to identify characteristics of families that function well. The focus was to check whether the findings from South Africa were different from the North American findings. Husbands and wives, from 101 White families and 18 families of color, completed the following self-report measures: the Family Adaptability and Cohesion Evaluation Scale (FACES II) (Olson, Portner, & Bell, 1989) to evaluate

family functioning; the Family Strengths Scale (Olson, Larsen, & McCubbin, 1985) to measure family resources; the Enriching and Nurturing Relationship Issues, Communications and Happiness Scale (ENRICH) (Olson, Fournier, & Druckman, 1985) to measure marital strengths; the Family Crisis Oriented Personal Evaluation Scale (F-COPES) (McCubbin, Larsen, & Olson, 1985) to measure family coping strategies; the Family Satisfaction Scale (Olson & Wilson, 1985) was used to family satisfaction; and the Quality of Life Scale (Olson & Barnes, 1985) to measure quality of life.

Participants reported that the following were the characteristics that contributed to a well-functioning family: satisfaction with family life; spouse's satisfaction with sexual relationship; satisfaction with general quality of life; good relationship with family and friends; flexibility in spending free time; conflict management and resolution; and positive communication (Greeff, 2000).

The second African study investigated perceptions of Black adults on factors that contribute to healthy family functioning in South Africa (Zwane, 2004). The researcher sought a random sample of participants from three areas in Gauteng Province resulting in a sample of 18 participants ranging in age from 26 to 54 years (including two couples and 14 individuals from different households).

Participants were asked to respond in writing to the following open ended question: "What factors do you think contribute to healthy family functioning?" (Zwane, 2004, p. 6). Following this, semi-structured interviews were conducted with eight participants who the researcher thought had provided rich data on the written question. Zwane (2004) reported that the following were the major factors

participants thought contributed to healthy family functioning: showing respect for each other (e.g., participants expressed that lack of respect for each other can result in family conflict and break the family); loving each other (e.g., accepting who one is despite his/her weaknesses); effective communication between and among family members (e.g., clear and respectful communication, and good listening skills); family times (i.e., spending quality time together relaxing and also discussing issues concerning welfare of the family); trusting each other (especially between husband and wife on issues of fidelity); understanding between and among family members (e.g., participants expressed that understanding was the building-block of a healthy family); discipline in children to maintain good and responsible behavior, being there for each other (e.g., parents for children and vice versa, and spouses for each other); religion (e.g., participants said that a family should be established on the foundation of God's principles); and boundaries within and outside the family (e.g., making sure that extended families are not influencing the family negatively).

Zwane (2004) also reported the following minor themes: personal space (e.g., personal privacy, time, and confidentiality); responsibility (e.g., knowing one's roles in the family and being accountable to other family members); hierarchy (i.e., line and levels of authorities in the family such as viewing the father as the head of the family); family rules (i.e., rules to guide discipline in the family); conflict handling (solving disagreements and arguments amicably, not fighting with each other, and not keeping grudges against each other); morality (e.g., respecting senior citizens); roles (i.e., clearly defined and gender specific

roles where a man should act like a man and a woman like a woman); maturity (i.e., in all aspects of life such as religion, relationship, mental and emotional, and also being responsible for one actions); intelligence (e.g., being intellectually capable to handle the challenges of life); culture (i.e., living a life that is culturally appropriate or acceptable); and forgiveness between and among family members when they wrong each other.

Greef's (2000) and Zwane's (2004) findings showed both similarities and differences about healthy family functioning. Participants in both studies reported similar aspects of everyday life central to healthy family functioning such as effective communication, quality family time, conflict management and resolution, importance of healthy relationships with extended families, and good spousal relationship. But, their findings also revealed important differences. On one hand, participants in Zwane's (2004) study were native South Africans and were asked to respond to an open ended question (provided above) in their own words. They offered their thoughts about healthy family functioning which were reflective of the meanings and interpretation true to family functioning in the African culture. On the other hand, although Greef's (2000) study was conducted in Africa, it may not reflect the meaning embedded in native Africa culture for two reasons: firstly, the majority of Greef's participants (85 percent) were White families and only 15 percent were families of color. Given that family life in White South African families resembles Western culture and is different from the native African family life, it is possible that this study did not capture family functioning characteristic of native African families. Secondly, Greef (2000) used

North American measures that only include items deemed relevant to family functioning in a North American context and then checked to see how similar or different his findings were compared to North American research. While Greef (2000) reported that the findings were similar to North American conceptualizations, it is important to note that the way he went about measuring family functioning may have missed important differences because the measures may not capture aspects or dimensions of functioning important to native African families. For instance, the importance of spirituality and the strong emphasis on healthy relationships with extended family typical in African families may not come out as important when using North American conceptualizations and measures.

Still, there are some commonalities in the conceptualization of healthy family functioning across North American and African studies. Similar to North American conceptualizations of healthy family functioning (Beavers & Hampton, 2003; Epstein et al., 2003; Olson, 2011; Olson & Gorall, 2003), the two African studies (Greef; 2000; Zwane (2004) found that effective communication, problem-solving, and boundaries (e.g., relationship with extended family and friends) were critical aspects of healthy family functioning for South Africans. This suggests that there are aspects of family functioning that are common to families across different cultures– at least by the concepts and/or terms used to refer to some of the dimensions of family functioning (i.e., common terms are used to refer to certain family process in North America and African cultures). However, the meaning of specific dimensions such as communication between

and among family members and how family processes are carried out (e.g., steps in resolving conflict, and decision making in the family), how roles are fulfilled (e.g., disciplining of children, and performance of family tasks), and how these processes affect the family system (e.g., family togetherness or emotional bonding) may not be similar across cultures. An example of how terms can carry different meanings is that of "communication". Different cultures may recognize that communication is important for family functioning but there may be differences in terms of what that "communication" constitutes. For instance, the McMaster Model of Family Functioning (Epstein et al., 2003) asserts that when communication is clear and indirect (i.e., the message is clearly stated but is not directed to the intended person), the family may not be the healthiest. The model goes further to say that a healthiest family exists when, among other things, family members communicate in a clear and direct manner (i.e., the message is clearly stated and is directed to the intended person) (Epstein et al., 2003). This conceptualization may not capture the realities of "good" communication in some African cultures with respect to certain aspects of family functioning. For instance, culturally, traditional Malawian families socialize their children not to communicate their problems directly to the father. The children have to reach the father through the mother. Sometimes when a child goes direct to the father, the father may ask him/her whether he/she talked with the mother and he may not respond to his/her issue until the child takes it to him through the mother– this indirect pattern of communication is culturally prescribed. In other words, communicating directly to the father is against cultural values and is seen as a

sign of dysfunction in the family. Thus, traditional Malawian families may perceive healthy family functioning as one where a child communicates clearly but indirectly (i.e., presenting the message to the mother that is intended for the father). Using a North American conceptualization of effective communication, these traditional Malawian families would be assessed as less healthy.

In spite of using the same terms there may be important differences in meanings associated with a term across cultures. Just because a cultural group identifies the same constructs as important to healthy family functioning as another culture, caution must be that they are referring to the same kinds of family processes. Thus, it cannot be assumed that North American conceptualizations of family functioning and their corresponding measures are appropriate and applicable to other cultures.

As a native Malawian studying Family Science in North America, upon graduation I am interested in applying my graduate training to teaching Family Science at the University of Malawi, researching family wellbeing, and contributing to the development of policies and programs that enhance the wellbeing of Malawian families. The appropriateness of North American models and measures of family functioning to the Malawian context are critical to my long-term goals. Thus, given the paucity of research in Africa and the total lack of research on family functioning in Malawi, and given my insider knowledge of Malawian culture, I sought to contribute to the body of knowledge on family functioning in this region of the world by seeking perspectives of families on what a healthy family means to them, and by comparing Malawian and North American

perspectives of healthy family functioning. Thus, I explored two research questions: 1) How is healthy family functioning conceptualized or described by two-parent urban Malawian families?; and 2) How do Malawians' conceptualizations of healthy family functioning compare to North American scholarly and lay conceptualization?

CHAPTER 3: METHODOLOGICAL DESIGN

Reporting research methodological design, method(s), and instruments thoroughly is an important component of the research process because it allows readers to: familiarize with the context in which the study was conducted; assess and examine the credibility and trustworthiness of the research findings; and examine the relevance of the research findings and their contribution to knowledge (Carlsen & Glenton, 2011; Cohen & Crabtree, 2008; Johnson & Christensen, 2012; O'Leary, 2010). As such, this chapter provides the details of the research methodology.

The chapter is divided into four sections. It begins by providing a brief description of Malawi and the specific study site, Blantyre City to inform the reader of the socioeconomic and sociocultural context in which the study was conducted. This will not only contribute to rigor but also will facilitate transferability of the findings to other settings or groups (Graneheim & Lundman, 2004). Secondly, a research design is provided to elucidate the methodological basis of the study, hence bridging the research questions to the findings. Thirdly, it discusses the methods used in this study and their specifics, and these include: how rigor was employed throughout the whole research process to achieve credibility and trustworthiness of the findings; how participants were recruited for the study and eligibility criteria that were followed; the procedures that were used for data generation, management, and analysis; and how ethical issues were addressed. The last part of the chapter provides an explanation of the limitations of this study.

Brief Description of Malawi

The study was conducted in Malawi, a landlocked country in sub-Saharan Africa. Geographically, the country is located south of the equator, and is bordered by the following countries: the United Republic of Tanzania to the north and northeast; the People's Republic of Mozambique to the east, south, and southwest; and the Republic of Zambia to the west and northwest (National Statistical Office & ICF Macro, 2011; National Statistical Office, 2012b).

Politically, Malawi is a stable country. It adopted multiparty system in 1994 (National Statistical Office & ICF Macro, 2011) and operates under three arms of the government, namely: the executive (consists of the president, vice president(s), and cabinet ministers); the legislative (consists of a unicameral National Assembly of 193 members representing their constituencies); and the independent judicial system (consists of Magistrate Courts, a Constitutional Court, a High Court, and a Supreme Court of Appeal).

Demographically, Malawi is a highly populated country and only 15 percent of the population lives in urban areas (National Statistical Office, 2008; National Statistical Office, 2012c). The country has a total fertility rate (TFR) of approximately 6 births per woman, an average household size of 5 persons, and a total population of 13 million people (Ministry of Development Planning and Cooperation, 2010; National Statistical Office, 2008; National Statistical Office, 2012c; National Statistical Office & ICF Macro, 2011). The high population in the country can be attributed to low education attainment among the people (Bongaarts, 2010; Kimura & Yasui 2007; UNFPA, 2004; Yucesahin, 2009).

According to the official reports, only 5 percent of Malawians have a secondary education qualification equivalent of O'Level Certificate and only 2 percent have acquired a postsecondary qualification (National Statistical Office, 2012c; National Statistical Office & ICF Macro, 2011).

Malawi is a religious country and almost the whole population practices some sort of religion. Of the 13 million people in Malawi, 83 percent are Christians, 13 percent are Muslims, 2 percent belong to other religions (e.g., Buddhism and Hinduism), and 2 percent do not belong to any religion (National Statistical Office, 2008). Thus, religion shapes everyday lives of most Malawians and this is evident in their active engagement in spiritual or religious practices in their everyday life. For instance, most Malawian families have regular family prayer times in the evening and they also regularly go to worship places such as the church or the mosque.

According to the National Statistical Office and ICF Macro (2011), 72 percent of Malawian households are headed by men and 28 percent by women. Importantly, more recent official reports indicate that in Malawian households more women (82 percent) than men (18 percent) are involved in domestic chores such as cooking, cleaning, collecting water, and so forth (National Statistical Office, 2012c). This reflects the strong cultural values Malawians hold that household chores are a responsibility of a woman and a man's job is to provide for the family economically. Nevertheless, in urban Malawian families adherence to traditional values is not as strong as it is in rural Malawian families. Thus, one would find more men in urban areas involved in domestic chores and more

women actively engaged in providing for the family than do their counterparts in rural Malawi.

Economically, Malawi is one of the poorest countries in the world. The country's economy is primarily agro-based with tobacco, tea, sugar, and coffee being the country's main domestic exports (National Statistical Office, 2012b; National Statistical Office & ICF Macro, 2011; World Bank, 2008). Currently, Malawi has a gross domestic product (GDP) per capital of $900 (Ministry of Development Planning and Cooperation, 2010), and is among the Least Developed Countries (United Nations Human Settlements Programme, 2010). Recent estimates indicate that over half of the population of Malawi (50.7 percent) is poor and 25 percent of the total population (i.e., over 3 million of the 13 million people) is ultra-poor such that they, for instance, cannot even afford to meet the minimum basic needs in their everyday life (National Statistical Office, 2012c). Nationally, 17 percent of the population in urban Malawi is living in poverty with 2.7 percent being ultra-poor (National Statistical Office, 2012c).

Using the Classification of Individual Consumption According to Purpose (COICOP), National Statistical Office (2012b) reports that food consumption is higher (representing a share of 56 percent of total per capita consumption) than non-food consumption in Malawian families. The report further states that within the non-food component, 16 percent of the entire consumption is spent on housing and utilities (i.e., water, electricity, and fuels), 6 percent on transport, and only 1 percent is spent on hotels, restaurants, and recreation. Evidently, Malawians use most of their income on basic needs to support their everyday life and survival

instead of using the money on durables and/or recreation. The poor performing economy and the high population growth pose a tremendous challenge for Malawian families in meeting everyday needs in their life.

Actual Study Site: Blantyre City

Currently, the urban population in Malawi has two million people (National Statistical Office, 2008). Participants for the study were sampled from Blantyre, the largest commercial and second most populous city in Malawi. It has a total population of 661,444 people distributed by sex evenly (i.e., 337,665 males and 323,789 or females) (National Statistical Office, 2008).

Blantyre City is home to many private and public education institutions (pre-schools, primary schools, secondary schools, and post-secondary institutions). It has three of the five constituent colleges of the University of Malawi (i.e., the Malawi Polytechnic, College of Medicine, and Kamuzu College of Nursing) and several private higher education institutions. It also has several cultural, heritage, and recreation facilities such as the Chichiri Museum, the Blantyre Youth Centre, and the French Culture Centre.

Blantyre City houses some of the country's best medical facilities such as the Queen Elizabeth Central Hospital (the biggest referral hospital in the country), Mwaiwathu Private Hospital (the best private hospital in the country), Blantyre Adventist Hospital (one of the best mission hospitals in the country), and the Beit CURE International Hospital. Blantyre City is also home to the Supreme Court of Appeal.

Blantyre City was chosen for this study for two major reasons: Firstly, the site was chosen for logistical purposes. Most parts of Malawi, Blantyre inclusive, receive light cold showers (locally known as the Chiperoni) from April/May to late July. During this season most roads in the outskirts of the city are dusty, and become muddy and impassible. In contrast, urban areas have tarmac road network and are accessed all the time. Fieldwork for this study coincided with the time when Blantyre was experiencing the Chiperoni. Therefore, the site was chosen to facilitate easy access to the participants.

Secondly, this study was a partial replication of a study currently being conducted in Canada. The original study is taking place in Edmonton, a large city in Western Canada, and the capital city of the province of Alberta. Since the original study is taking place in the urban area, it was reasonable to conduct a similar study in an urban area to enable future comparisons of the findings between sub-Saharan Africa and North America. Moreover, the researcher had observed that research in the area of family health, for example in North America, had mostly been carried out in urban areas.

Research Design: Qualitative Study

Paying attention to the research methodology, method(s), and tools, all of which must be most appropriate for answering the research question(s), within the researcher's interest and capacity, and practical and doable (O'Leary, 2010) is fundamental to a credible research study. Mindful of these principles, I used qualitative research design to shape and drive the research process of this study. Qualitative studies seek to have an in-depth understanding of the perspectives of

the researched (Cohen & Crabtree, 2008; Gilgun, 2006a; Golafshani, 2003; Johnson & Christensen, 2012; O'Leary, 2010; Polkinghorne, 2005). Walsh (2003) observes that "qualitative methods hold potential for exploring meanings and belief systems, perceptions, and other subjectivities of family experience" (p. 50).

In this study, I sought to have in-depth understanding of the meaning of a healthy family from the perspectives of two-parent families in urban Malawi, and to describe their experiences as they support their family health in everyday life. Therefore, a qualitative research design was determined to be the best fit to address the research problem and achieve the objectives of the research. Specifically, ethnography was the qualitative research approach that was used in this study.

Ethnography

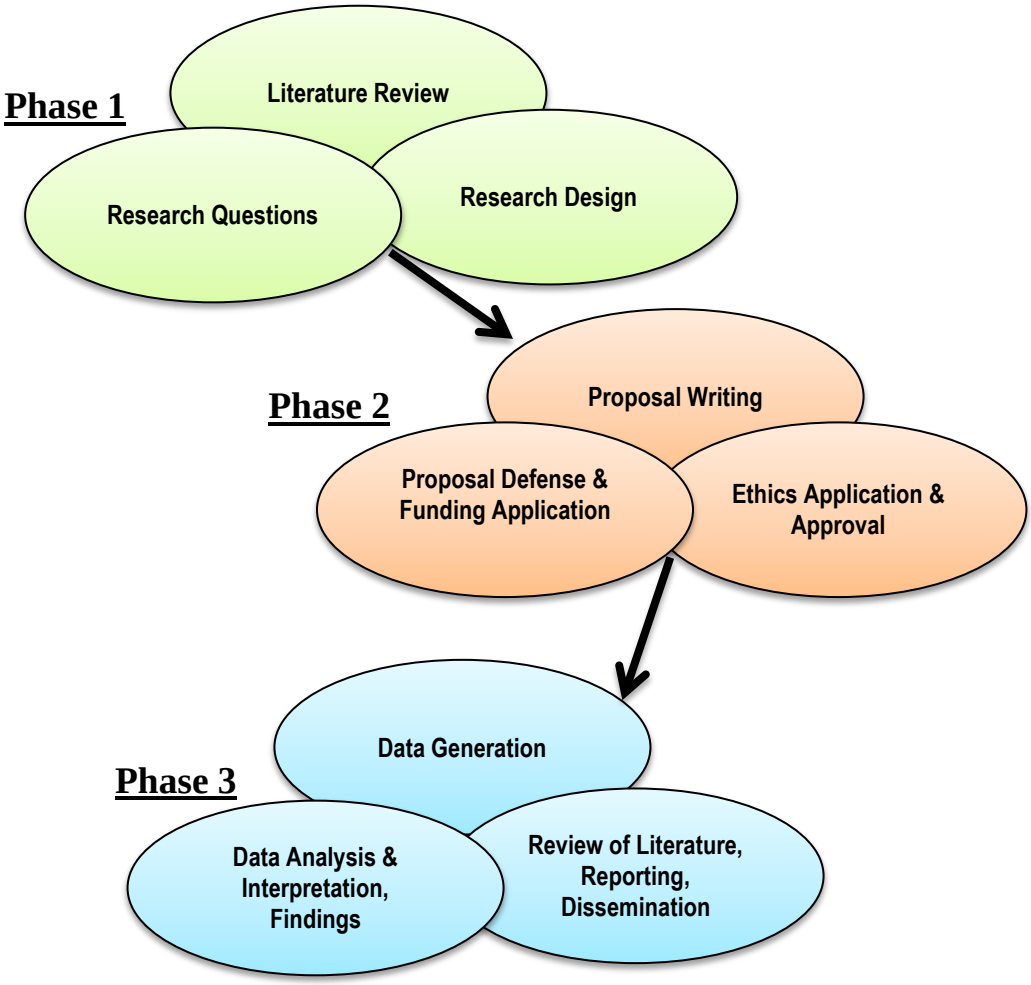
Ethnography involves a strong commitment to discovering, understanding, interpreting a way of life (culture) from the perspectives of the participants and providing rich/thick descriptions of their point of view (Gregory & Ruby, 2011; Johnson & Christensen, 2012; Mantzoukas, 2010; Ochieng, 2010; O'Leary, 2010; Riemer, 2008). Central to ethnographic studies is that data are primarily generated through fieldwork and are viewed holistically (Nuran, 2008; Whitehead, 2005).

Thus, ethnography was used because of its appropriateness to address the research questions. Specifically, ethnography allowed me to explore the meaning of a healthy family from the families' own words, enter their world in ways that otherwise could not have been possible, and learn the subtle meanings embedded

in the participants' culture and everyday life and reflected in their descriptions of what a healthy family meant *to them*. (The whole research process of this study is presented in figure 3.1 below).

Figure 3.1

Overall Research Process for this Study



Data Generation

Entrée into the Field

Data collection was conducted in the months of April through July 2012. Any research study carried out in Malawi requires the researcher to request formal permission from the local authorities to allow him or her to recruit study participants. Thus, I commenced fieldwork by writing formal letters to the Chief Executive Officer (CEO) for Blantyre City and the Commissioner of Police for Southern Region Police Headquarters. I delivered the official letters in person and waited for over one month for their approval. In the meantime, concerned with the limited time the researcher had to spend in Malawi, the CEO of Blantyre City gave me a go-ahead to start recruiting participants but was told not to interview them until they granted me written official permission. After the local authorities formally approved the request to have access to the residents of Blantyre city, I started recruiting the participants and scheduling interviews.

Participants

Ten two-parent families which included nine fathers and ten mothers in urban Malawi participated in this study. They consisted of five families with at least one preschool child and five families with at least one school-age child. All the participants were Malawians and their ages ranged from 22 to 54 years (M = 36.6). Their preschool and school-age children's ages ranged from 2 to 12 years (M = 6.5). All the participants were practicing Christians and belonged to a religious institution.

At the time of data generation, all families were residing in Blantyre City in what could be described as low and middle income residential areas. All but one family were living in rented houses. The sizes of the families varied from 4 to 10 members (M = 6) and were mostly composed of the parents and their children and a maid and/or the father's/mother's relative(s), a typical family composition in urban Malawi.

Of the 19 participants, 10 had a Malawi School Certificate of Education (equivalent of O'Level Certificate in the United Kingdom), two had a Technical/Trade Certificate, six had a College Diploma, and one had a Bachelor's Degree. All the participants in this study were either working in the home or out of home. Men's employment included working in the public or private sector and/or running family businesses. The majority of the fathers (seven fathers) were employed full time in public or private sectors (an average of 7 hours 30 minutes per day from Monday to Friday, and occasionally 4 hours 30 minutes on Saturdays, and off on Sundays), one had retired and was solely running a family business, and one was not employed in the public/private sector but was actively engaged in family business and at the time of the interview he was looking for a job in the public and private sector. Of the seven fathers who were employed full time in public or private sector, three were also actively involved in everyday running of their family business, which in most of the times wives were in-charge in almost all the aspects of the business.

Women's employment included working in the home, running family businesses, and working in the public or private sector. Of the 10 mothers who

participated in this study, the majority (eight mothers) were working in the home and also running a family business full time, and two were employed full time in public or private sectors. The two mothers who were employed full time in public or private sectors were also actively involved in everyday running of their family business.

When reporting about their monthly income the participants were given the option of reporting either individual income or family income. All participants reported their income as family income. All but one family reported the amount of their monthly family income. The participants reported monthly incomes that ranged from $320 Canadian to $1500 Canadian (*M* = $712 Canadian). Even though this income range may appear large, only two families were on the higher end and there were no major variations for the rest of the families. All but one participant family reported that they pool their income. All participant families said as a couple they discuss and decide how they spend their earnings.

Sources of income for these two-parent families included employment, pension, and family business. Notably, it was observed that some of the participants reported a monthly family income which was not reflective of the assets the researcher observed in the family. For instance, two of the participant families reported a very low family income (approximately $375 Canadian per month) yet they owned a vehicle and other valuable assets in their home (e.g., televisions set, home theatre, fridge, cooker) which one would not typically expect to find in a Malawian family of that reported income status.

Most of the participant families had access to medical care through the husband's or wife's medical insurance cover from their employer. None of these participant families was on public welfare support. Overall, these families are different from other families in Malawi in that they were less traditional than most Malawian families, and that most of the participants were educated. Thus, there was greater flexibility in how they did certain things (e.g., men were involved in doing household chores than it would be expected in more traditional Malawian families).

Recruitment

Qualitative researchers usually use criterion-based selection when recruiting participants for the study because participants are recruited based on satisfying prescribed criteria (Johnson & Christensen, 2012; O'Leary, 2010). I used purposive (judgmental) sampling to select participant families for this study. Purposive sampling involves using specific guidelines to recruit participants who meet specific characteristics of interest and who will provide rich data for the study (Johnson & Christensen, 2012; Polkinghorne, 2005). In addition, these families were categorized into two groups, namely families with pre-school children (under 6 years) and families with school-age children (6 to 12 years).

Eligibility criteria. To be included in the study the participant families had to satisfy all of the following conditions: 1) be residing in Blantyre urban at least 6 months prior to the interview; 2) both parents be living in the household at least six months prior to the interview; 3) both husband and wife had to be over 18 years of age (the legal marriage age in Malawi); 4) there should be at least one

preschool and/or one school-age child and be living in the household six months prior to the interview; 5) family members had to be fluent in the local language, Chichewa; and 6) both mothers and fathers had to be willing to be interviewed.

Participant families who did not meet these criteria were not included in the study. For instance, during recruitment I met mothers who showed a strong interest to be in the study, but whose husbands were outside the country and had not been in the family for over six months prior to data generation. While these mothers were willing to be in the study, they did not meet all the inclusion criteria to be in the study. Mindful of the fact that this could have affected the richness of the data, I politely told them that they did not satisfy the conditions for recruitment and, therefore, could not be in the study.

Recruitment strategy. I visited the study site and asked to meet with the local neighborhood authorities. When I met them I first explained the study and the eligibility criteria to them. Then I asked them to help me identify families they thought could meet the eligibility criteria. The local neighborhood authorities made suggestions about the potential participant families and gave me a list of house numbers.

Using this list, I made initial contacts with the potential participant families. At the participants' home, I started by introducing myself to the mothers and the father. Then the study, its purpose, the procedures, the time commitment expected from them should they be recruited for the study, and their freedom to choose interview day, time, and place. After talking about the study, I explained to the prospective participants that I had obtained ethical approval from the

University of Alberta Research Ethics Board in Canada and the Chancellor College Ethical Review Committee at the University of Malawi to conduct the study. I also told the participants that the Chief Executive Officer (CEO) for Blantyre City Assembly and the Commissioner of Police for Southern Region Police Headquarters had granted me permission to look for and recruit participants for the study.

Then I explained to the prospective participants all ethical issues concerning this research study, including the following: benefits of taking part in this study; risks of taking part in this study; voluntary participation and freedom to withdraw from the study; confidentiality and anonymity; and use of information from this study. After all this was explained to them, prospective participants were asked if they had understood what the study was all about and all the ethical issues that had been explained to them, and if they had any questions or concerns. I thoroughly answered all questions and concern they had.

After this, participants were asked if they were willing to be in the study. When they expressed willingness to be in the study they were given the Information Sheet (which covered the same information that I had just explained to the participants and also contact information for me and my thesis supervisor), Consent Form, and Demographic Profile Form (see appendices A, B, and C, respectively). All these documents were in the participants' mother language, *Chichewa*.

I told the participants that the documents would be left with them for at least one week to give them ample time to make their decision, that I would visit

them to follow up on their decision to be or not to be in the study. I asked participants to read the documents carefully before making their final decision. I asked for phone numbers so that I could contact them to arrange a follow-up meeting during which I would ask them about their decision regarding the invitation to be in the study.

Then I made follow up visits after one week and those who had made the decision to be in the study were recruited for the study. During this follow up visit I asked them to complete the Consent Form and the Demographic Profile Form. Importantly, I reminded them about their voluntary participation and that signing the Consent Form did not necessarily bind them to remain in the study against their will, and that they were free to withdraw from the study. I also reminded the participants of the window period for withdrawing their data, that they could do so up to one week after the final interview. Lastly, the interviews were scheduled for both mothers and fathers for at least one week after this follow up visit.

Participant withdrawal. Only one participant (a father) withdrew from the study. He expressed that his time schedule was extremely busy because he had to balance work, school, and family. He was working all day during weekdays and attending classes all day during the weekends. He could not be available in the evening (both during weekdays and weekends) because he said he wanted to spend time with his family, rest, refresh, and prepare for work and/or study. Hence, he could not find time to be interviewed.

Why I Used "Healthy Family" Instead of Other Concepts

As reviewed in the second chapter of this report, there are several terms that are used to refer to families that work and live well, such as balanced families (Olson & Gorall, 2003), effectively functioning families (McCreary & Dancy, 2004), healthy families (Epstein et al., 2003); healthy functioning families (Smith & Stevens, 1992); optimal families (Beavers & Hampson, 2003); good functioning families (Walker & Shepherd, 2008); normal families (Walsh, 2003); and strong families or successful families (DeFrain & Stinnett, 1992). To ensure transferability of the concept of "healthy functioning family", I specifically chose to use the term "healthy family" in this study because it was the one that, when translated into Chichewa, most closely matched with the idea of "families that work and live well in everyday life". What I was interested in studying in Malawi was the same construct that family scholars in North America refer to when they use the term family functioning or healthy family functioning.

Conversations with the Participants (Interviews)

All interviews were conducted by me. Data were collected using a semi-structured interview guide, a demographic questionnaire, and field notes. I began the interviews by extending gratitude to the participant for accepting to be in the research study and be interviewed. Then I reminded the participants about ethical issues (especially the issue of confidentiality), and I walked them through the topics expected to be covered, and also reminded them that they had the freedom to ask me to repeat or paraphrase or rephrase the question they did not understand.

All the interviews were scheduled at a time and place convenient for the participants. Seventeen of the nineteen interviews were conducted in participants' homes either in the morning or in the afternoon. One interview was conducted in the participant's office during lunch hour, and the other was conducted in the car of the participant's employer in the morning while he was about to go to the field. The interviews lasted between 29 minutes and 67 minutes, with the typical interview lasting about 45 minutes.

All the interviews were conducted in Chichewa, the native (mother) language for both the participants and me. However, during the interviews some participants were mixing Chichewa and English especially when they had run out of Chichewa words or when they thought that using Chichewa could not convey exactly what they wanted to communicate.

I sat one-on-one with the participants and sought their understanding of the topics as reflected on the interview guide. The fathers and mothers were interviewed separately and also in the absence of other members of their family or outsiders. Culturally, in the presence of an outsider, wives/children are expected to agree with their husbands/fathers and usually conceal their genuine views. Taking this into account, it was important to interview the mothers and fathers separately to allow the mothers to be free to express their genuine thoughts about their family's health, thereby enriching the quality of the data. With participants' approval, all the interviews were recorded using a digital voice recorder.

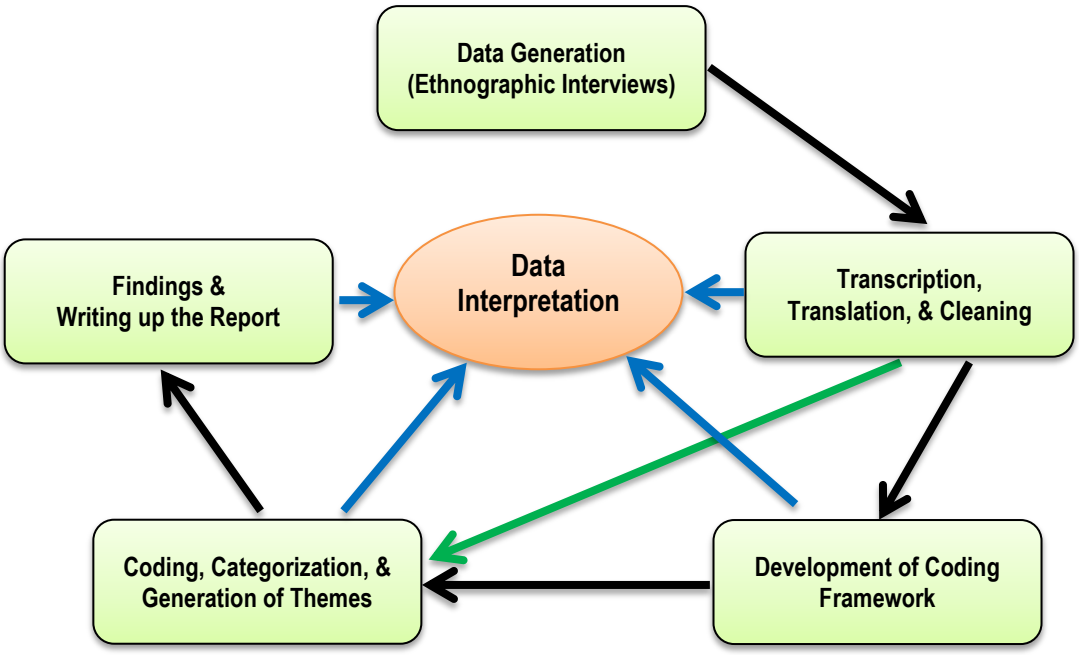
Data Analysis and Interpretation: Making Sense of the Participants' Views

Data analysis and interpretation is an important step in qualitative research. The quality of the findings has the fundamental root in how data are analyzed and interpreted. Green, Willis, Hughes, et al. (2007) stress that "rigorous analysis of interview data is a necessary component of the research endeavour and is critical to the generation of good evidence" (p. 549). As discussed herein, issues of reflexivity (e.g., being culturally sensitive to the meanings participants had on an issue/topic) were central to the analysis of the data, interpretation of the data, reporting of the findings, and the claims that were made about the perspectives of participants on what a healthy family means to them. Thus, I took special effort and commitment to analyze and interpret the data in a professional manner. Details of how I analyzed and interpreted data are provided subsequently.

Data analysis and interpretation followed several steps that involved a process of moving back and forth between different, yet, interdependent steps. Ideally, data analysis started during transcription of the interviews when I started seeing codes emerging across the participants' descriptions and began to take note of them. Even though a data analysis plan was not practically in place at this juncture, I kept noting what I was observing in the data and these notes became part and parcel of the overall analysis process. Data analysis and interpretation went on all the way to report writing. Figure 3.2 depicts data analysis and interpretation in this study.

Figure 3.2

Conceptual Framework of Data Analysis and Interpretation in this Study



Data Management

Transcription and Translation of Interview Transcripts

All the interviews were audio-recorded and transcribed verbatim in the local language, *Chichewa* by me. After transcribing, an independent person translated the transcripts into English. Then I proofread all the transcriptions against the audios and audited them for accuracy. Specifically, I took the English translation and went through the interviews one by one, listened to the audio files and verified their accuracy. Minor differences were observed. For instance, there were some participants' thoughts that the translator translated literally and were not capturing the broader meaning. I discussed this with the translator and after reaching consensus, corrections were made accordingly.

Coding, Categorization, and Generation of Themes

After transcription and translation I cleaned all data. I removed all identifying information from the interview transcripts and developed code numbers and later pseudonyms to be used in data analysis and reporting.

Essentially, data analysis and interpretation followed the four key steps discussed by Green and colleagues (2007), namely: immersion in the data; coding; creating categories; and the generation of themes and also as discussed by other researchers (Elo & Kyngas, 2008; Hsieh & Shannon, 2005). Specifically, I used content analysis approach (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005; Kondracki, Wellman & Amundson, 2002) to analyze the data. I used memoing and the general inductive coding approach (i.e., developing codes after directly examining the data) (Elo & Kyngas, 2008; Graneheim & Lundman, 2004; Johnson & Christensen, 2012; Kondracki et al., 2002; Mayring, 2000) to come up with a coding framework, code the raw data into meaningful segments, and derive themes. This involved the following two important processes: 1) major coding; and 2) subcoding.

Major coding: Using the interview guide, I thoughtfully examined the guiding questions and reviewed participants' responses across all interview transcripts to gain an insight of the emerging themes across all study participants. While reviewing the interview transcripts, I reflected on what the participants said, and jotted down important observations and broader emerging themes. During this process I identified a number of common themes. Then I used segmentation to group these thoughts into major themes that formed the major

parts of the tree diagram as reported in the next chapter. In essence, this stage produced the four major dimensions of what a healthy family meant to the participants.

Subcoding: After the first phase, which essentially focused on overarching themes, I went back to the interview transcripts and field notes and rigorously reviewed them repeatedly, this time by reading between the lines, and by listening to the audios whenever there was need to crosscheck the conversation. I attentively read paragraph by paragraph, line by line, and word by word, going across all participants on that specific question/topic, categorizing and assigning what the participants talked about to the most appropriate codes. Based on thematic content, these codes were categorized and assigned to the most appropriate subthemes, and then to major themes developed in the initial stage.

Finally, based on the major coding and the subcoding, a preliminary coding framework was developed that encompassed hierarchical category systems and that established clear links between the research questions and the study findings. The preliminary coding was discussed with my supervisor and modifications were made accordingly. Such modifications included rephrasing and regrouping of the major themes and subthemes. During this stage, subthemes were identified under each of the four dimensions of the descriptions of a healthy family that were identified during major coding phase. After the modifications, I continued coding until all interview transcripts were coded. When I encountered new codes and themes, or wanted to reassign a particular code to a more suitable

theme, I coded them accordingly. Data analysis and interpretation continued throughout the writing and reporting process (Richardson, 2000).

Rigor or Trustworthiness

Rigor or trustworthiness refers to actively engaging in strategies that establish the authenticity of the research process, truthfully represent the meanings of the participants, and enrich the credibility of the findings (Cohen & Crabtree, 2008; Johnson & Christensen, 2012; Shenton, 2004). There is overwhelming evidence showing that just like validity (i.e., correctness or truthfulness of the inferences made from the study results) and reliability (i.e., consistency or replicability or repeatability of the study results) are clearly two cornerstones to establish the credibility of study results in quantitative research (Golafshani, 2003; Graneheim & Lundman, 2004; Johnson & Christensen, 2012; O'Leary, 2010; Tobin & Begley, 2004), rigor or trustworthiness is the fundamental principle researchers use to guard against bias and to demonstrate competence, robustness, integrity, and believability of the research process in qualitative studies as well as enrich the authenticity of the findings (Johnson & Christensen, 2012; Lietz, Langer, & Furman, 2006; Lincoln, 1995; O'Leary, 2010; Tobin & Begley, 2004; Morse, Barrett, Mayan, et al., 2002; Rolfe, 2006b; Shenton, 2004). Morse and colleagues (2002) argue that "without rigor, research is worthless, becomes fiction, and loses its utility" (p. 14).

Guided by previous literature on the topic of rigor or trustworthiness in qualitative research (e.g., Lietz et al., 2006; Mauthner & Doucet, 2003; Morrow, 2005; Morse, 1995; Morse et al., 2002; Ochieng, 2010; Poland, 1995), I used

specific strategies to establish and maintain rigor or trustworthiness of the research process and study findings. Firstly, I used purposive sampling to ensure that the participants met the criteria for inclusion (i.e., both mother and fathers were targeted because it was envisioned that they had excellent knowledge of issues about their family's health). Secondly, I used the same interview guide across all participants to make sure that interview questions were capturing similar areas of study interest. Thirdly, I wrote field notes (both descriptive and reflective). Further, I exercised reflexivity throughout the entire study. For instance, during the interviews I actively listened, prompted, probed, and encouraged participants to express their views. Again, based on the first few interviews with the participants I made necessary adjustments to how I would approach the remaining interviews so as to maximize generation of rich data. In addition, I employed the principle of data saturation. Specifically, I reflected on the interviews and reviewed the interview transcripts and before the end of data generation I made sure that no new information was forthcoming. Lastly, I applied the principle of data triangulation (explained later in this report). Because of their centrality to rigor or trustworthiness in qualitative research, the last three strategies (i.e., reflexivity, data triangulation, and data saturation) are discussed subsequently.

Reflexivity. The concept of reflexivity (also called self-analysis) is popular in qualitative research and has been widely discussed in literature (Charmaz, 2006; Cohen & Crabtree, 2008; Finlay, 2002a; Finlay, 2002b; Gilgun, 2006b; Gilgun, 2008; Gilgun, 2010; Johnson & Christensen, 2012; Macbeth, 2001;

Mauthner & Doucet, 2003; Morrow, 2005; Ochieng, 2010; Pillow, 2003; Sandelowski & Barroso, 2002; Smith, 2006. Gilgun (2010) explains that "researchers are reflexive when they are aware of the multiple influences they have on research processes and on how research processes affect them" (p. 1). Johnson and Christensen (2012) explain that reflexivity "involves self-awareness and critical self-reflection by the researcher on his or her potential biases and predispositions as these may affect the research process and conclusions" (p. 266). Rolfe (2006a) refers to reflexivity as "turning thought back on itself" and "turning action back on itself" (p. 215). Reflexivity is exercised throughout the whole research process (Guillemin & Gillam, 2004).

Literature supporting the importance of reflexivity in qualitative research is overwhelming (Charmaz, 2006; Davies & Dodd, 2010; Finlay, 2002a; Finlay, 2002b; Gilgun, 2006b; Gilgun, 2010; Horsburgh, 2003; Johnson & Christensen, 2012; Lietz et al., 2006; Mauthner & Doucet, 2003; Ochieng, 2010; Pillow, 2003; Smith, 2006; Watt, 2007). Gilgun (2010) believes that "all researchers, no matter which methods and perspectives they use, must be reflexive if their research is to be useful" (p. 1). Emphasizing the importance of reflexivity in qualitative research, Sandelowski & Barroso (2002) explain that:

> Reflexivity is a hallmark of excellent qualitative research and it entails the ability and willingness of researchers to acknowledge and take account of the many ways they themselves influence research findings and thus what comes to be accepted as knowledge. Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share (p. 216).

Researchers contend that exercising reflexivity in qualitative research adds integrity, and authenticity of the data and trustworthiness of the study findings (Abdoli, Ashktorab, Ahmadi et al., 2011; Dowling; 2006; Finlay, 2002a; Finlay, 2002b; Fontana 2004; Jootun & McGhee, 2006; Jootun, McGhee, & M arland2009; Primeau, 2003; Smith; 2006; Watt, 2007). Gilgun (2010) stressed that reflexivity "increases researcher accountability, not only to the intellectual communities who are part of our audiences but to other audiences as well, such as practitioners who may apply findings to the lives of living, breathing human beings… and it is an open and honest approach to doing and reporting research" (p. 1–2). Jootun et al., (2009) conclude by emphasizing that "the research process is influenced by values, beliefs, experience, and researcher's interest; as such, reflexivity helps to make the process open and transparent, helps the researcher to be aware of the his/her influence as well as that of the participants on the research process and outcome, hence, ensures rigour in qualitative research" (p. 45).

Reflecting on these important principles in ensuring rigor or trustworthiness in qualitative research studies, I exercised reflexivity throughout the whole study. Firstly, I spent time reflecting on how ethical to the Malawian culture was the research topic, specific research questions, data collection tools, study procedures, and how best to approach the research process. Secondly, I thought about the plausibility of conducting the study within the timeframe of the study program. Thirdly, I explored the best method possible to meet the demands of the study while keeping in mind the most effective and efficient ways of interacting with the participants (e.g., by thinking about the socioeconomic

environment in which the data were collected, by being sensitive not to use words that were not culturally appropriate to the Malawians, such as those that show disrespect, and by being calm, maintaining unwavering attention, and politely bringing back the participants into the topic of interest each time they diverted the conversation). Further, I wrote reflective notes throughout the study (some of which were raised and discussed with my supervisor during formal meetings) and kept going back and forth between the interview transcripts and audio files every time something important came to my mind. Furthermore, I used what is called "reflection-in-action" (Rolfe, 2006b) by modifying the interview approach to meet the demands of specific participants or context and ultimately facilitate them to give thick descriptions of their perspectives. For instance, after the first few interviews it was clear that to some participants the question on *factors within the family that affect family's health* needed more introduction and a few examples to help them understand what was exactly being asked, and ultimately provide rich data. Lastly, I was conscious about my identity (both my sociocultural and socioeconomic location) in the whole research process, especially during data generation.

It is important to underscore the point that while I took all these measures to enhance rigor or trustworthiness and enrich credibility of the findings, I make no claims to indicate that I was absolutely detached from the research process, that I did not influence the research process, or that there were no unintentional influences on the research process, as such claims may simply not be practical (Jootun et al., 2009; Rolfe, 2006a). Because of the crucial importance the

researcher's relationship with the participants has, the subsequent paragraphs provide details on how I, as a researcher navigated through my identity as an insider/outsider.

Researcher's identity in the study (insider/outsider relationship). There is a plethora of recent literature on how the identity of the researcher may influence the research study, and more especially data generation, and how being conscious about one's identity in the research process contributes to quality research (Allen 2004; Al-Makhamreh & Lewando-Hundt, 2008; Broadsky & Faryal, 2006; Ergun & Erdemir, 2010; Gregory & Ruby, 2011; Guevarra, 2006; Kusow, 2003; Mahoney, 2007; Ochieng, 2010; Paerregaard, 2002; Shahbazi 2004; Sherif, 2001; Watts, 2006). Gair (2012) defines the insider/outsider status as "the degree to which a researcher is located either within or outside a group being researched, because of his or her common lived experience or status as a member of that group" (p. 137).

Notably, the identity of insider/outsider is dependent on various factors (i.e., socioeconomic, sociocultural, and sociodemographic) at play during fieldwork. It is not always obvious or automatic, it is not rigidly dichotomous, and one may find himself or herself in the middle or shifting between being an insider and an outsider or even being partially an insider or partially an outsider (Breen, 2007; Ergun & Erdemir; 2010; Gair, 2012; Jootun & McGhee, 2006; Jootun et al., 2009; Ochieng, 2010; Sherif, 2001; Watts, 2008; Watts, 2006). Ergun & Erdemir (2010) concluded that "one can, therefore, find himself or herself in the position of an insider in a foreign land or an outsider in his or her own land" (p. 34).

In this study, I recognized the fluidity of my identity as I interacted with the participants and approached the research process with this caution in mind. On the whole, it was clear that I had two identities and these identities played a significant role in shaping the research process and adding credibility of the findings. The two identities are explained subsequently.

The researcher as an insider. On one hand, by virtue of birth (nationality) and upbringing, I was an insider in this study because ethnically I am a Malawian. I grew up and did all my education up to and including my undergraduate degree in Malawi. Thus, I am very familiar with the Malawian culture. Ergun and Erdemir (2010) summarize the advantages of being an insider to the researcher as follows:

> For the insider, shared citizenship, ethnic, linguistic, religious, gender, and cultural identities or simply affinities facilitate the researcher's access to the field. Such common ground has the potential to increase the perceived trustworthiness of the researcher while also ensuring openness on the part of the respondents, thereby facilitating rapport. Informants tend to benefit from cultural proximity and so are willing to share information more easily (p. 18).

In this study, being an insider (e.g. sharing the same religion, language, culture, and ethnicity with the participants) had several advantages. Being an insider helped me to conduct the interviews in the participants' mother language (*Chichewa*). This allowed easy communication with the participants and facilitated deeper understanding and interpretation of their thoughts.

Secondly, it helped me to smoothly navigate through the ethical requirements from the Research Ethics Boards both in Canada and in Malawi, and obtain permission from the local authorities (i.e., from the Chief Executive

Officer of Blantyre City Assembly, who emphasized the cultural adherence in the conduct of the study, and from the Commissioner of Police, Southern Region Police Headquarters Assembly).

Thirdly, being an insider to the participants facilitated development of culturally appropriate data generation approaches which not only were sensitive to the needs of the participants (a thing that facilitated generation of rich data from the participants) but also suitable for meeting the research objectives. For instance, I deliberately designed individual interviews (as opposed to joint interviews) to help participants, especially mothers to be free to express what they could not culturally express in the presence of other family members, especially their husbands.

Being an insider also helped me to develop rapport with the participants, hence enhance the richness of data. Ochieng (2010) emphasizes that "field relationships are central to any ethnographic study, and the quality of the rapport between the researcher and researched is crucial to the quality of the relationship established to meet the research objectives" (p. 1729). In this study, even though I spent a relatively short time in the field, I took every effort to develop and sustain rapport with the participants. For instance, in between the recruitment and interviews date, I called the participants asking about their life (to be culturally appropriate), reminding them of the scheduled interviews, and answering their questions and concerns. Because of this, the participants were very open to express their views during the interviews because they had developed trust with me and considered me as one of them. It was interesting to note that the

participants even looked at me as a source of knowledge and advice on their healthy family functioning in everyday life. For instance, after the interview, one father explicitly asked me to give him any advice regarding his family's health.

Further, being an insider helped me to interact with the participants in ways that were culturally respectful, a thing that was a very important ingredient in enhancing rapport with the participants. For instance, taking off the hat when arriving at the participant's home and putting it on after leaving their home, starting the meeting with general talk about their life then working this into the day's interview, holding hands together to show respect and appreciation when arriving at the participant's home, showing gratitude by not rushing through goodbyes, and expressing non-verbal cues that were culturally appropriate, like constantly nodding the head to show attentiveness, and holding study material with both hands when giving them to the participants and getting them back.

Finally, being an insider played a very significant role in the analysis of data, interpretation, and reporting of findings because I was very conversant with both verbal and non-verbal culturally situated cues the participants used during the interviews. Some participants used culturally-oriented metaphors which could only be deciphered by someone who understands the Malawian culture. For instance, the participants used metaphors like "eating vegetables" when talking about a situation where the family is going through financial problems. From the discussion I had with my supervisor in one of our regular meetings on data analysis, "eating vegetables" would mean a good thing in North America, something that would be interpreted as healthy eating. The limitation about my

position as an insider to the Malawian culture and family life could be that I may have overlooked certain responses or observations which an outsider may have found important or interesting. For instance, I may not have probed further when exploring things that seemed obvious to me such as eating together, church attendance, and division of household chores.

The researcher as a semi-insider. Even though I assumed an insider identity in several ways and occasions, it was clear that I sometimes found myself in a position where I was a semi-insider, especially with regards to how I was perceived by the participants during data collection. Even though I was born and grew up in Malawi and shared the same ethnicity with all the participants in this study, being someone who had been abroad (in Canada) somehow made the participants view me as partly Malawian and partly foreigner. This was in spite of the fact that I had spent less than two years in North America. Sometimes they viewed me as an outsider– as someone who was Westernized and not truly Malawian. In one interview the participant referred to me with a phrase "as someone who was born here in Malawi" meaning that he [the participant] felt that I was not fully an insider, hence was partly an outsider.

However, my educational credentials and profession as an academic played an important role in developing a strong rapport with the participants. I graduated from the best college in the country and I lecture there. This college is very popular, practically admired by most Malawians, and is a household name when parents are encouraging their children to work hard at school and go to college. Hence, being a lecturer at this college led the participants to treat me with

respect and to view my research as something that could directly inform policy and ultimately impact their lives. For instance, some of the participants explicitly expressed that they believed the research would benefit them and other families in the country.

My education credentials also helped to develop trust with the participants. One of the mothers explained how she had initially intended to turn down the study invitation because of misconceptions. However, when I revealed my identity and explained the study to her, and when she read the Information Sheet and accompanied forms she changed her mind and was very willing to be in the study. Importantly, to minimize limitations arising from my positions as a researcher and as an academic at the University of Malawi, I reduced myself to the status of my participants. For instance, starting the interview by talking about their everyday life, a thing that portrayed to them that I was no different from them, and also listening to them without objecting their views even in circumstances where they expressed something contrary to my views. This helped to reduce the power gap between me as a researcher and the participants.

Overall, there were no significant challenges that arose out of this semi-insider relationship. One advantage of this semi-outsider perception among the participants was that they did not take for granted that I knew everything about the Malawian culture or other issues related to family functioning in everyday life. Hence, they went considerably beyond what they otherwise could have explained.

Debrief meetings. Apart from being conscious about my identity in the research process, I also had regular debriefs with my supervisor during the whole

research process. This helped to enhance reflexivity and enrich the trustworthiness of the research and its findings. For instance, I had thorough discussion with my supervisor on the data analysis plan, and also compared notes on preliminary coding on major themes where I was an insider and my supervisor was an outsider to the Malawian culture.

Corroboration of evidence. Last but not least, during writing up of the findings I ensured that the interpretations I made and reported were corroborated with the participants' own words. As such, the words that I used in the report were supported by direct quotations from what the participants actually said during the conversations with me.

Data triangulation. In qualitative research, triangulation refers to the technique of using different data sources and/or data collection methods to provide "a more inclusive view of the participants' world" (Tobin & Begley, 2002, p. 7). Thus, triangulation not only enriches the quality but also adds credibility or authenticity, and completeness of the data (Astedt-Knrki, 1994; Golafshani, 2003; Johnson & Christensen, 2012; Krefting, 1991; Lietz et al., 2006; O'Leary, 2010; Nuran, 2008; Reimer, 2008; Tobin & Begley, 2004; Whitehead, 2005).

In this study, I used three data collection approaches to generate data. Firstly, I used in-person (face-to-face) semi-structured interviews with the participants which centred on the objectives of the study and the research questions (see Appendix D on pages 18–19). These face-to-face interviews were complimented by field notes. The field notes comprised descriptive notes (i.e.,

based on my thoughts about the participant's demeanor or nonverbal expressions or cues jotted down during the interviews), and reflective notes (i.e., written after the interviews and based on my review of and reflections on the interviews). In addition, I also used field observations which I documented in my field notes and were part of data analysis. This was possible because all but two interviews were conducted in the home of the participants. Hence, during recruitment and interviews I paid attention to other important things (e.g., how members divided and performed tasks, how they interacted, especially interactions between parents and children and the roles of children within the family, and what assets the family had), some of which was not provided by the participants during the interviews. Thus, field observations were another important source of data that I used in this study.

Apart from using three data generation approaches, I personally conducted all the interviews, and also did a verbatim transcription of the interviews to make sure that the participants' expressions were captured exactly as they were spoken. Such expressions as involuntary vocalizations (e.g., coughing, laughing), response tokens or filler words (e.g., uum, yeah, umhu), and word or phrase repetitions (McClellan, MacQueen, Neidig, 2003; Oliver, Serovich, & Mason, 2005) were transcribed.

The importance of verbatim transcription of interviews is widely acknowledged in literature (Bailey, 2008; Easton, McComish, & Greenberg, 2000; Halcomb & Davidson, 2006; MacLean, Meyer, & Estable, 2004; Oliver, Serovich, & Mason, 2005). In the words of Halcomb & Davidson (2006), "a

verbatim record of the interview is clearly beneficial in facilitating data analysis by bringing researchers closer to their data" (p. 40), hence, deepens the credibility of the findings. Verbatim transcription is also considered as one of several ways through which triangulation is exercised in qualitative research (Poland, 1995).

Thus, by using verbatim transcription of the audio-recorded interviews, the study rigor was enhanced because participants' views were captured and presented as accurately as possible. Conducting the interviews personally and using verbatim transcription was also beneficial in terms of boosting rigor of the study because I had first-hand knowledge of the participants and the interviews and had participated in both verbal and nonverbal exchanges with the participants during the conversations (Halcomb & Davidson, 2006).

In addition to using two data generation approaches and verbatim transcription of the interviews, I generated data from multiple perspectives of family members (i.e., from both the fathers and the mothers). Generating data from more than one member of the family provides a better understanding of family functioning processes and dynamics and family point of view on the issue (Beitin, 2008; Kushner, 2007). Therefore, both mothers and fathers were selected for the study and it turned out that including both of them added significant information in some interviews and added to the quality of data that was generated.

Data saturation. There are no standard guidelines prescribing the number of participants selected or number (or rounds or length) of interviews conducted in a qualitative research study to validate its findings (Coyne, 1997; Guest, Bunce,

& Johnson, 2006; Mason, 2010; Morse, 1995; Tuckett, 2004). Still, the concept of *saturation* is widely used, frequently cited, and strongly recommended when justifying the number of participants selected or interviews conducted in qualitative research (Johnson & Christensen, 2012; O'Leary, 2010; Morse, 1995). Saturation has become the "gold standard by which purposive sample sizes are determined in health science research" (Guest et al., 2006, p. 40).

Saturation is defined as the point during data generation at which additional conversation with the participants no longer adds new or relevant information or richness to the understanding of the issue being researched; in other words, when the researcher is no longer hearing or seeing new information (Johnson & Christensen, 2012; Gibbs, Kealy, Willis, Green, Welch, & Daly, 2007; O'Leary, 2010; Morse, 1995). Morse (1995) refers to saturation as "data adequacy" and asserts that saturation is the "key to excellent qualitative work" (p. 147). The goal of saturation is not on the frequency of data; rather, it is on the richness/thickness of the participant's descriptions or explanations (Carey, 1995; Morse, 1995; Polkinghorne, 2005; Tuckett, 2004).

In this study, in order to obtain rich data and achieve saturation, I was generally guided by a number of factors as discussed by qualitative researchers (e.g., Charmaz, 2006; Morse, 1995; Morse, 2000; Ritchie, Lewis, & Elam, 2003). Ten couples participated in this study. This translated to 19 participants and 19 interviews. The decision to select ten couples (i.e., 19 participants) was reached after considering the following factors (some of these factors are discussed in detail by Charmaz, 2006, Morse, 1995, and Morse, 2000): the research used a

purposive sampling so that participants satisfied all the conditions for inclusion in the study (details of recruitment and eligibility criteria are provided in the "Data Generation" section); the scope of the study was not broad as it focused on the participants' everyday life processes and activities; the study was small and had modest claims; the topic was clear; the quality of data were rich (i.e., where the participant was not forthcoming with information, the researcher used probes to get down to the depth of the topic); the group of the study participants was homogeneous (i.e., there were no significant variations in terms of characteristics of the participants); there was time limitation in terms of working within the time framework of Master's degree program; and financial resources for the study were limited.

Data saturation was reached within the 19 interviews such that the data became repetitive and returned no additional codes (i.e., no more new codes or information appeared to emerge from the data). This was not surprising as previous studies using homogeneous samples also claimed to have reached data saturation within a few interviews (see Guest et al., 2006).

Ethical Issues

Ethical approval to conduct this study was sought from and granted by the University of Alberta Research Ethics Board (REB 1) in Canada and also from Chancellor College Ethical Review Committee at the University of Malawi in Malawi. The former reviewed the proposal for this study and made sure it adhered to ethical guidelines and the latter was instrumental in making sure that it conformed to all ethical requirements for what was culturally appropriate in

conducting this study in Malawi. Permission to recruit the participant families for the study was sought from and granted by the Chief Executive Officer of Blantyre City Assembly and also from the Commissioner of Police, Southern Region Police Headquarters.

All ethical issues concerning the study were thoroughly discussed with the participant families before asking them to participate in the study. Details of this process have already been discussed above (see the section on "Recruitment Strategy" on page 62).

On the day of the interview, before the start of the interview, I reminded the participants of their freedom to withdraw from the study at any point of time up until one week after the interview. I assured the participants of the confidentiality of their information and anonymity of their identities. I also told them that all interview transcripts will not have their names and that code numbers marked on the front of the interview transcripts would be used to identify cases during data collection, management, and analysis. In this report I have used pseudonyms to conceal the identities of my study participants. Since the results of this study will be shared with government departments and non-governmental organizations in Malawi, I have also omitted more detailed demographic information on each individual to protect their identities.

To conform to the Malawian culture, a gratuity of $15 Canadian was given to each participant as an expression of gratitude for being in the study. To make sure that those who participated did so out of their willingness and that they were not persuaded by monetary gains, I did not tell the participants that they would be

given a gratuity. I gave them the gratuity after completing interviews with both the mother and the father of that particular family. As per Malawian culture, the gratuity for both the mother and the father (i.e., $30 Canadian) was given to the mothers and it was put in a "Thank You" card enclosed in an envelope.

This study was a partial replication of a study called Family Functioning in Everyday Life (FFEL) which is ongoing in Edmonton, Canada. The original study is looking at processes engaged in by families as they function in their everyday lives, and is focusing on social, economic, and political influences on family functioning.

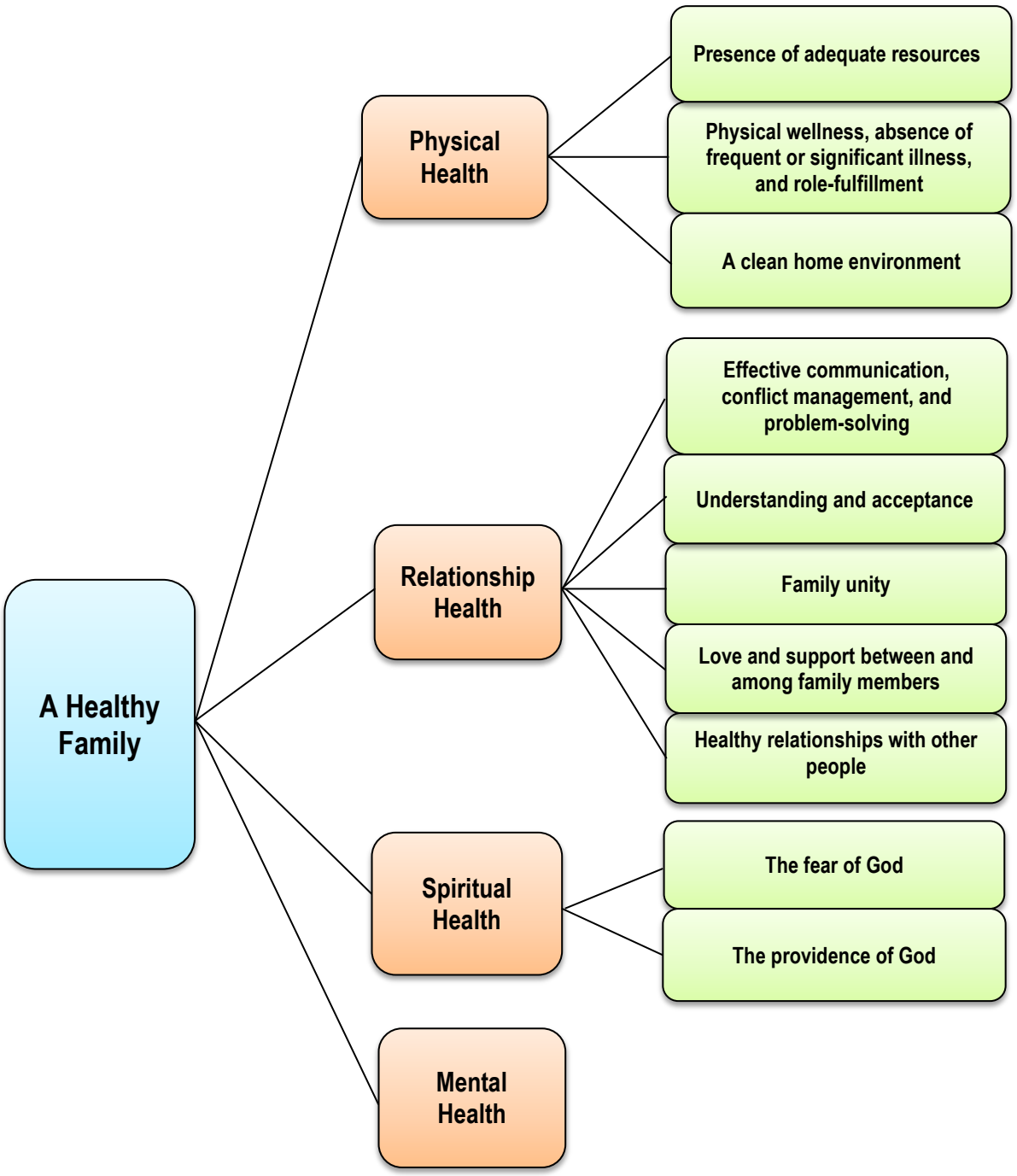
CHAPTER 4: FINDINGS

To encourage participants from urban Malawi to reflect on and describe healthy family functioning, they were asked what a healthy family meant to them, what one would observe if they walked into a healthy family home, what it means to them to say a family is not healthy, and what practices they engaged in to maintain a healthy family. Specifically, they were asked about the practices they engaged in individually and as a family unit to support having a healthy family. Four major themes and several sub-themes emerged from analysis of the participants' descriptions. The major themes were reflective of four dimensions of health: physical health; relationship health; spiritual health; and mental and emotional health (see figure 4.1 below).

Throughout the findings chapter, some individuals were quoted more frequently than others because they expressed their views more eloquently or more concisely. However, it is important to note that the perspectives reflected in the quotes from the views of these individuals were shared more broadly by most participants.

Figure 4.1

Themes and Sub-themes Describing a Healthy Family in Urban Malawi



Theme 1: Physical Health

The first major theme that emerged during analysis was a focus on the physical health of the family members and the family as a whole. Participants described three aspects of physical health that contributed to a healthy family: presence of adequate resources to meet the family's basic needs, such as food, shelter, and clothing; family members' physical wellness and absence of frequent or significant illness, especially for the parents to enable them to fulfill important roles in the family to ensure that the family's everyday needs were met; and, finally, a clean home environment.

Presence of adequate resources in everyday life. The findings of the study revealed that adequate availability of resources for growth and development of members of the family was central to participants' understanding of family health in everyday life. Similar to Maslow's hierarchy of needs, participants described a healthy family as one that had an adequate income and was able to adequately provide for family members' everyday needs, including food, shelter, and clothing. For example, participants described a healthy family as follows:

> …if we say the family is healthy that means that… food should be available, whether it's clothes they should be available, but also income should be there so that the family should go well, meaning that all the necessary things should be available, everything that could be needed in the family, whether it's for the children for their school, whether it's for YOU the parents, food for the whole family. If all the needs are found adequately we can say that… in that context we can say that the family is is healthy. **(Love, father)**

> … "health family" is to say that they are people who in their everyday life they are able to find food, clothes, right? A good home to stay… to sleep… that good place which is well cleaned... **(Mercy, mother)**

> I think such things like basic needs, I'm able to clothe myself, I'm able to have food, Okay? Such things, children are able to go to

> school, when they sleep they're sleeping on a good place without any problem, they cover themselves, when sleeping they don't feel cold till morning, that is a "healthy family"! Yes, to me that is it. (**Odell, father)**

When asked what one would see or observe in a family that is healthy, participants mentioned availability of basic necessities in everyday life as a sure sign that the family is healthy. Odell explained that some of the major things you would observe in a healthy family are the adequate availability of food for the family members as well as their visitors and also a good place to sleep:

> **Researcher:** What would one see/observe in a family that is healthy?
>
> **Participant:** It means you'll see all that we have talked about. When you come, as you have done this time around, I'll tell them to prepare tea[1] for you, if you'll still be around at noon you'll have lunch, same thing with supper in the evening. If you'll sleep here we'll provide you a comfortable place to sleep, will give you good bed sheets, whether it's a blanket from Jon[2] you'll have it, you should feel like "oh yes, I think I'm really covered up". **(Odell, father)**

Clearly, having provisions that support everyday living was a fundamental part of the participants' life and survival and a key aspect of how they perceived their family's health. To them, failure or struggling to meet their everyday needs, especially food, shelter, and clothing, simply meant that their family was not healthy. When asked to describe a family that is not healthy, participants described it in the following way:

[1] In Malawi, tea is sometimes synonymous with breakfast. Tea may also mean any beverage (e.g., people may say they have tea when in actual sense they had coffee or cocoa or other beverages)
[2] "Jon" is a short term for Johannesburg, a large and popular city in South Africa. Malawians usually say "Jon" when they are referring to South Africa as a country in general. Blankets from "Jon" (South Africa) are very popular in Malawi because of their warmth. At the same time, they are expensive. Thus, only those who have adequate income afford to buy blankets from Jon.

> When we say that this family is not healthy it means a lot of things. You find that maybe in the family you are even sleeping without eating[3]. At the same time we have to think that when it reaches a point of sleeping without eating it is mostly a sign that things in that family are not going well. Sometimes it's not that it's deliberately happening. It's because something is happening or is lacking in that family. Yeah, there is a lot that happens in a family that is not healthy. You find that say children their sleeping place is rather in a very bad condition, they don't have bed covers, they don't have even clothes. **(Grace, mother)**

> … if we say that a family is not healthy most people look at say maybe how they find their everyday needs, it's through a lot of struggle, maybe for them to find… to even eat meat to eat beef it means they have to struggle a lot. So people say "but this family there's a lot suffering, it's not healthy". **(Trust, father)**

In describing a healthy family, participants went beyond describing the adequate availability of food (and other family resources such as shelter and clothing) to the quality of food that members of the family eat. The participants talked about eating balanced meals that included three basic food groups, namely: energy yielding foods (carbohydrates, fats/lipids); body building foods (proteins); and protective foods (vitamins and minerals). For example, participants described a healthy family as follows:

> It means that the family is eating food which is balanced, food which is needed in our bodies to be well… (**Hope, father)**

> … a healthy family we are talking about the kind of food that is available and that the family is eating, really it should be that kind of food that is good food maybe as nutritionists tell us that it should be balanced and what what, a variety of foods should be really available… **(Love, father)**

> … a family that is healthy it means they live a good life… they are able to have proper food for their bodies… **(Patience, mother)**

[3] Interestingly, in Malawian households, supper is valued more than breakfast or lunch. People can afford to go without breakfast and lunch but they try their best to have supper. So when you reach a point where you're missing supper it means that the economic situation in your family is very poor. That's the point Grace is trying to convey here.

It was clear during the conversations with the participants that meeting everyday family needs was a central issue to having a healthy family. As such, they reported that they took an active role in ensuring that they have resources in the family to support their everyday life so that they have a healthy family. Participants felt that it was their responsibility as individuals and as a family unit to make sure that they had provisions and were able to take care of their children. Hope explained what he did as a father to see to it that his family stayed healthy:

> What I do is that I try my level best that if something is not available in the family I try to look for money to buy that need. Like on the part of food I try to buy enough food for the family, really, so that my family lives well. If there is no soap I buy soap so that my family should be looking clean. **(Hope, father)**

Odell echoed this point:

> I make sure that there's always food in the home. There should be… the kids should not suffer from hunger. May be you've seen yourself an example just happened here: "I want something"[4]. Yes, so it's already there. "Go and get it from such such a place". That is one way to make sure that the kids are not staying hungry. So I make sure that always there's food in our family. Yes. I also make sure that in our family there are basic necessities like soap, and so forth, such things should not be a hurdle. If something is used up I make sure that I replace. Therefore in so doing, we stay happily in our family. (**Odell, father)**

In Malawi, there are culturally defined roles for men and for women (i.e., men's responsibility is to provide for the family while women responsibility is to look after the home, including doing all household chores) and this was evident in

[4] Odell was referring to his youngest daughter. She came asking for food while I was interviewing him outside his home and he told her to go and get it somewhere inside the house.

this study. For instance, here is how a participant described his wife's responsibility in making sure that their family stayed healthy:

> Aaa, for her, her responsibility… what she does so that we're living happily and that our family is healthy, she really ensures that our clothes are washed well, the kids have bathed, she also make sure that if there is no food at home she tells me soon enough so that I should also have time to find food, enough food in good time, really, not waiting until all the food is finished. **(Hope, father)**

Even though culture influences how Malawian families live their everyday life, it seemed that it did not have much impact on the issue of providing for the family. It appeared that when it came to making sure that the family had adequate resources to support their health, participants, particularly women, went beyond cultural norms and did what they had to do to make sure their family stayed healthy. Mothers in this study did not feel that it was the sole responsibility of the father to provide for the family. They felt that they had to actively contribute to the income of their family so as to be able to meet their family's everyday needs and have a healthy family. As such, most of these mothers were engaged in income generating activities and used the money to buy family needs like food, clothes, soap, and other necessities. When asked what she did individually to support her family to be healthy, Patience, a stay at home mother, explained how she was actively engaged in income generating activities and how she provided for the family's needs to make sure they stayed healthy:

> Then the other thing I do is what I said earlier that I do business. I bought a knitting machine and I design sweaters. I try that if we need vegetables, tomatoes I buy so that I should not ask my husband for things like these. Yes. So that's why I decided to… of course, for me to manage to buy the machine this business started way back. So apart from doing household chores one thing which I think I do to help the

> family is doing this business because it helps to generate some money for the family which really helps us to meet our needs in our family [Researcher: Okay, alright, so how does that affect your family's health]. It's like… you know when you have… having income helps us to meet our needs as a family. I think without money a lot of things would not be purchased like food, soap, clothes and so forth. So having money helps us to have no headaches of how we are going to take care of the kids. **(Patience, mother)**

It was also interesting to observe that even mothers who were employed full time still felt the need to engage in additional income generating activities to supplement their own and their husband's monthly salaries so as to have enough income to support their family. Lindiwe, an employed mother, explained how the extra she made, in additional to her regular salary, was used to buy goods to meet the basic needs for her family (e.g., food and clothing) and ultimately helped her family to stay healthy. She explained:

> I try to do a business apart from working. I open second-hand bales of clothes. This normally depends on season. Like right now I have opened tops for kids and I am expecting to open a bale for duvets. This business helps me a lot in that when sometimes maybe my husband… you know nowadays how difficult it is to have income. So if I see that there's need to buy something but the money is not enough… that money is my income, but if there is a shortage somewhere I take the money from my business and help, yeah, really, so that helps us to have the things we need in our family like food and clothing and stay healthy. **(Lindiwe, mother)**

Notably, children's engagements in income generating activities were very subtle in the participants' descriptions of the activities they engage in individually to support having a healthy family. However, I observed that, even though children were hardly mentioned by the parents during the interviews and the parents appeared to be the only ones involved in the day-to-day running of their income generating activities, children also were active participants in these

income generating activities. For instance, in Orlando's family, the income generating activities was headed by the mother, supported by the father, and the children were actively involved in running errands to buy supplies (e.g., crates of soft drinks, salt, and gallons of cooking oil), bringing water for washing potatoes, cleaning the business premise, and relieving the parents by doing household chores so that parents could concentrate on serving the customers. It was surprising to me that the parents did not talk about their children's contributions. During my brief involvement with the families, it was obvious that children played an important role in contributing to family income generating activities.

Physical wellness, absence of frequent or significant illness, and role-fulfillment. In addition to the presence of adequate resources to support everyday family life, a second sub-theme related to physical health was family members' physical wellness, absence of frequent or significant illness, and their ability to fulfill roles. For instance, some participants spoke directly about how physical wellness was important to family health:

> If we say this family is healthy, to me, how I understand it, it means a family that is physically well, really. **(Hope, father)**
>
> It [a healthy family] means that it is a family in which the family members are well physically, they are strong... **(Thando, mother)**

Participants also recognized the link between eating nutritious food and prevention of illnesses or diseases. Praise explained how failure to eat balanced meals could lead to malnutrition:

> …if we say "healthy family", as I see it, it means that… food that makes up a balanced diet it means it's found in that family because if

> there's no balanced food in the family, you hear that they have marasmus[5], kwashiorkor[6] whatsoever. **(Praise, father)**

Others described that a healthy family to them meant a family whose members do not fall sick frequently. Using her family as an example, Faith expressed this view of health as follows:

> I can give an example of my family because I think that now my family is healthy. Because aaa in the past my family was not healthy due to frequent sicknesses, right? The children could fall sick, they could fall sick for a long time. But now I can see that my family is healthy because there's no frequent illnesses. We are living a good life and we are also happy. **(Faith, mother)**

Other participants echoed this kind of description of what a healthy family meant to them:

> … a family that is healthy it means they live a good life, a life without frequent sickness. **(Patience, mother)**

> … [even] the ordinary person in the village when they say healthy it means that this family aaa frequent illnesses are not there... **(Praise, father)**

When asked why they said frequent sicknesses render the family to be unhealthy, participants expressed a direct link between frequent sicknesses in their family and how it affected their income as well as how they functioned in their everyday life, which ultimately affected their health. Clearly, their views on this issue went beyond the physical discomforts that sickness brings in the person's body. Their description was linked to the previous subtheme of having adequate

[5] Marasmus (also called wasting) is a form of malnutrition caused by prolonged dietary deficiency of protein and calories (http://medical-dictionary.thefreedictionary.com/marasmus).
[6] Kwashiorkor is a form of malnutrition most often found in children and is caused by not eating enough proteins (http://www.nhs.uk/conditions/kwashiorkor/Pages/Introduction.aspx)

availability of provisions/resources. For instance, Patience explained that the frequent sicknesses have a direct effect on their family income because they have to shoulder transportation bills incurred when taking the family member to the hospital as well as paying for medical bills. Hence, by affecting their income, sicknesses also negatively affect their access to everyday needs like food.

Patience also talked about how frequent sicknesses negatively affected the ability to perform and fulfill everyday family tasks. During her explanation it was clear that the greatest concern was over the ability to perform everyday tasks, raise income, and provide for the family. Patience also stressed that when there was sickness in the family it affected not only the person who was sick but also the whole family as a system. Thus, frequent sicknesses contributed to lack of family health. Patience explained:

> I think… [Pause]. I think for a family to function well there is also need to be no frequent sicknesses. By that I mean that when your family is well… you don't… your efforts are not directed to a family member who is not feeling well. So you put your effort… or I should say your energy is committed to doing your chores such that your family functions well, you generate income and your family life is well. While if your bodies are sick often times you'll waste money going to the hospital, two you'll not be able to do any work, such kind of things. Yes. So for me, a healthy family is also one characterized by absence of frequent sicknesses. **(Patience, mother)**

Participants' descriptions focused on the *frequency*, *significance*, and *length* of the illnesses. According to them, the presence of illness in the family did not necessarily mean that the family was not healthy; rather, what made a family unhealthy is how *frequently* members fell sick, how *significant* or *serious* the

sickness was, and how *long* had the sickness lasted in their family. Ollatile captured this perspective in this way:

> A family that is healthy… for me, right? Healthy family… to my understanding, it's not necessarily that people in that family do not fall sick, no, they do fall sick but their sickness is like these minor ones, say common cold or flu or what... , that's how I think… healthy family I think that it's that you are living without falling sick frequently, right? Yeah, but not necessarily living without falling sick at all such that sicknesses… that even colds are not experienced, no, minor sicknesses will be there but the kind of sickness is that of… not major sicknesses, really. **(Ollatile, father)**

This perspective of describing a healthy family by focusing on *significance*, *frequency*, and *length* of illness clearly illustrates their focus (as illustrated above) on being physically healthy and being able to perform their everyday tasks and provide for their family. So it appeared that even when participants experienced minor sicknesses but were able to go about their day and perform their tasks, they considered their family to be healthy.

A clean home environment. The third sub-theme that emerged as part of the major theme of physical healthy was the need for a clean home environment. Participants explained that a healthy family is one whose members always observed good hygienic practices, and who kept their home and surroundings clean. According to them, living in a family environment where members of the family did not observe hygienic practices and did not live in an environment that was clean was characteristic of a family that is not healthy. Love explained:

> Aaa some of the things are the ones I have already said but adding to that aaa another thing that you could see in a family that is not healthy is… just by looking at the home you can see, say, how clean the home is. If the family is not healthy you will see that the home is not clean, things are… just left haphazardly, you will also have a picture of how

> things are left or placed in the home, say where there is supposed to be maybe maize flour maybe that maize flour has been left… has been left maybe in the bathroom, or soap is just left anywhere, you can… actually tell that aaa I think something is… is amiss, eheee that somewhere somehow things are… not going well in this family, yeah. **(Love, father)**

Victor echoed this perspective of a healthy family and provided a detailed example of how his family worked systematically to make sure that they lived in a clean home and avoided illnesses or diseases. When asked what one would observe in a family that is not healthy, he stressed the point that there is no cleanliness in the home. Victor provided an elaborate example of how maintaining cleanliness was handled in his family to make sure that they stayed healthy. He expressed that without observing such hygienic practices a family could not be healthy. Victor explained:

> Yeah, it means aaa most of the times I can… aaa I can just say that it's the opposite of what I've said about [a healthy family]. So it means that upon arriving at this family that is not healthy you'll see lack of hygiene, say the dogs messed up the surrounding you'll find it there… "I've delayed the guys to do abcd because the dogs were playing around the home during the night so they were taking used diapers somewhere else and scatter them all over our place". So she said I've delayed the guys so that they clean those things and throw them in the right place. That is to say that if ours was not a healthy family… to me I look at my family as a healthy family… you could have found that trash still around when you came here because it was all over the place. That could have been the first sign to see that would have made you say that "I think there's something wrong in this home. So you could have found that trash. Such kind of things. **(Victor, father)**

Because of the importance participants attached to personal hygiene and cleanliness of the home environment, participants reported several practices they engaged in to support having a healthy family in their everyday life. Participants

explained that everyone in the family made sure that he/she took an active role in maintaining cleanliness of the home environment. In most cases, such responsibilities included cleaning inside of the house (e.g., sweeping and mopping inside the house), cleaning outside of the house and surrounding areas (e.g., cutting grass, sweeping), cleaning dishes, putting garbage in the right place, and washing clothes. Importantly, it was observed that all members of the family took an active role in ensuring that their family stayed clean. Participants explained:

> sometimes what he [husband] does… let's say if he is at home he likes talking to the boy that they should keep the home and the surrounding clean… So he oversees the cleanliness of the home and the surrounding. **(Grace, mother)**

> They [the children] have duty roster which they follow, say someone will clean the house, right, someone will clean the toilet, the other one is cleaning dishes **(Praise, father)**

> Uum, there are two boys and a girl, so they agreed that boys, one boy aaa one sweeps outside, one boy cleans inside the house, their room and the sitting room, the girl also cleans her bedroom and they share the corridor, and my wife cleans our bedroom. **(Darryl, father)**

It was interesting to observe that children took a very active role in ensuring that the family was staying in a clean environment which ultimately made them to be healthy. Victor, a father of three school-age children highlighted what his children did to support a healthy family in their everyday life:

> Say the kids, individually when they wake up in the morning they see that they should clean up the home, when they clean up the home everybody sees that it's clean, when we have visitors they see that the home is clean. When they clean the dishes there won't be bad smell. So individually when the family member is doing something it's like… but aaa by the end of the day it's the whole family that lives well and stays healthy and shows that at least these people know what they are supposed to do. **(Victor, father)**

Memory reiterated this point and illustrated a well-established trend of how members of her family individually engaged in hygiene promoting activities with the purpose of making sure that they stayed healthy. She described:

> Aaam [Pause], what we do maybe everyone individually? There is… say if we want to wash clothes, it means that each child will wash their own clothes, it's me who I can say that I wash for both my clothes and my husband's. Apart from sharing work but those are other things we do individually. Maybe sometimes when the boys see that here the grass has grown, that is the work of boys, so they take a slash and cut the grass. **(Memory, mother)**

Memory went on to provide specifics of what they did in her family to maintain hygiene in their home so as to make sure that they did not catch diseases:

> Aaa, what we do are things like say individuals ensuring that at home there are no unhygienic practices, say someone after eating banana he/she should not just throw the peels anyhow, because that will attract flies, so it's everyone's responsibility to ensure that they should throw their litter in a bin, right? So it's a responsibility for everyone in the family who sees that it benefits us in making us to be free from diseases. **(Memory, mother)**

Clearly, physical health was an important aspect of a healthy family among the participants, especially because of its importance to their capacity to perform and fulfill family roles and be able to meet their needs in everyday life.

Theme 2: Relationship Health

The second major theme that emerged from the analysis was relationship health. During the discussions with parents it was clear that maintaining healthy relationships between and among members of the family was a theme central to their perspective on what constitutes a healthy family. Even though they occasionally spoke about their extended families, friends, and neighbors, it was

observed that participants mostly talked about healthy relationships within their immediate family.

Participants' everyday life was shaped by their commitment towards developing and maintaining healthy relationships between and among family members. They identified several aspects of a healthy family related to engaging in and maintaining healthy family relationships. Analyses yielded five subthemes of relationship health, namely: effective communication, conflict management, and problem solving; understanding and acceptance; family unity; love between and among family members; and healthy relationships with other people (e.g., their neighbors).

Effective communication, conflict management, and problem solving. Participants expressed that effective communication between and among family members was one of the fundamental pillars of a healthy family. Participants talked about effective communication in a family in three ways: type of communication (e.g., open, easy, and free-flowing communication); how communication takes place (e.g., with love and affection, without harshness, and respectfully– without anger or yelling at each other); and why communication is important (e.g., to solve problems or conflicts, to prevent problems arising from a lack of understanding, and to create a sense of cohesion and unity in the family). Thus, communication was a key feature to having healthy relationships and a healthy family.

Participants described a healthy family as a family in which members *are able* to talk to one another freely and openly, air their views and concerns without

fear or resentment, and do so regardless of age or gender. Participants explained that such a free and open environment helps members of the family to not conceal their feelings. Patience explained:

> I think "a healthy family" is one where family members are free and open to each other without a problem, if somebody has something in his/her heart he/she should be able to say it "I have this or that problem, what should I do?" **(Patience, mother)**

These fathers and mothers said that, in a healthy family, freeness and openness was also evident when members of the family were able to engage in family discussions about their goals and other issues that affected their welfare. Participants also stressed that free and open communication enhanced interaction between and among family members and supported them to spend time together. Ultimately, this kind of communication enriched healthy relationship between and among them. A participant explained:

> [what makes a family to be healthy?] I don't know, for me I think that… if in that family… you are able to communicate, it doesn't matter there is money or there isn't money but if you are able to communicate "aaa brother what what…, aaa brother what what", it happens that… because you are able to communicate you will find that in many things you're together, you're doing things together. That's how I understand it, to say that if a family is healthy then it means that the people are able to communicate, yeah. Because you are able to communicate then you are able to stay together well, chatting what what, because of you… ahaaa if there is no talking to each other I don't think you can stay together and spend time together chatting, it means one will be doing his/her own things, one will go this way the other that way. **(Ollatile, father)**

Further, participants also said that a healthy family was also one where there was transparency between and among members. In such a family, issues concerning the welfare of the family and its members are not hidden; rather, they

are freely and openly communicated, discussed, and decided. For instance, members discuss how to help extended families while making sure that the immediate family is well looked after and stays healthy. Participants explained:

> I think that for a family to be healthy, when everything is happening or when you want to do something you should discuss first or if you find money and you want to buy something, you should discuss first to find out what is needed in the family. When you want to help relatives [you sit down and discuss], yeah, what is it that we should help them and what's gonna left for us here in the family. **(Faith, mother)**

> …if you understand each other, you are united, you discuss your issues and concerns freely, that's what can make your family healthy. **(Hope, father)**

Faith's point about being open when assisting extended families is critical to understanding why transparency was raised as an important aspect of a healthy family. In Malawi some men and women have the tendency to assist their relatives financially without the knowledge of their spouse and children. Such behaviors may bring tensions in the family when discovered and may worsen relationships between and among family members.

Participants also described a healthy family as one where there is adequate flow of information in the family. They pointed out that adequate flow of information between and among members of the family (i.e., between the parents, between and among the parents and the children, and between and among siblings) on a day-to-day basis and on all important issues that affect their everyday welfare contributes to having healthy relationships between and among family members and ultimately a healthy family. Praise elaborated this point by providing a well-articulated example illustrating how adequate flow of

information (which he referred as "proper communication") is important to the health of the family. He expressed:

> Okay, aaa behavior. When I say behavior there should be good and bad behavior. Now good behavior… where there is good behavior in that family, it means you are doing things together, everything. You tell each other what what then that takes us to communication "aaa, mum, today we will stay without eating, I don't have any money", then everybody will be aware that today we are not eating because there is no money. You have communicated. That is proper communication, but if you just leave the family without telling them that aaa today there is no money… "mum that money I gave you, is it still available?" "No, it's finished", "Okay." Then you just go out when you know there is no money. Here in town everything needs money, right? So maybe even in the fridge there is no relish[7] then you…as you go out you know that people will stay without eating, yet you are just going out coming here at work. That is bad behavior, right? Automatically, you haven't communicated to your wife. But if you aaa "me too I don't have money but I am going to look for some money and I will give you a call". Then if you do that it means you have communicated, right? But if you have not done that and you just left the home and come here at work while people at home have no food and then in the evening you go home and ask for food aaa "where is the food", yet you know that there is nothing and when you come from work you have not even brought anything, yet you are asking for food and shouting, right? You are shouting, that is very bad behavior. Yeah, but for people where everything in the family is okay they… they tell each other like "me too mum I don't have money, I'll see what I can do, I'll communicate back to you". You come here at work maybe you… you borrow some money from your friends aaa "can you lend me some money", then you call you wife or you drive home aaa "mum here is the money", "here is the food", then it means that you people are able to communicate well... you are linking together. If something goes wrong, that's it, everyone knows. When it's found you also communicate aaa "tomorrow we will find such such, today let's hold on", that means everyone knows what is happening. That's how things should be. So communication is VERY VERY important because at least the other one knows what will happen or what is happening at that time. **(Praise, father)**

[7] Relish in Malawi does not mean a condiment; it refers to the protein and vegetable dishes that are key parts of the main meal/course. The main meal is comprised of a carbohydrate (locally called *nsima* or can be rice), a protein source (e.g., meat, fish, or dry beans) and a vegetable (e.g., cabbage, pumpkin leaves, or lettuce). For more information about "relish" and the Malawian meal visit http://en.wikipedia.org/wiki/Nshima.

Victor echoed this point and went further to say that a family cannot be healthy if there is lack of adequate flow of information between and among members of the family. What was interesting in his explanation was the view that good physical health (e.g., having enough food and living in a clean home environment) is not enough to say that a family is healthy. He explained that for a family to be healthy, good physical health had to be accompanied by good relationship health. Victor expressed:

> So for me, one weapon to make the family to be strong is the flow of communication between amongst that people… amongst the people of that family. Because even if you're wealthy, or there's food available in your family, or the home is very clean, but if that flow of communication is lacking it means this person will not know what this one is thinking and this one will not know what the other person is thinking and in the end there's nothing good coming out. **(Victor, father)**

Participants highlighted that adequate flow of information between and among members of the family not only helps to have healthy relationships in the family but also helps the parents or guardians to identify problems which dependents are facing in their everyday life. Ultimately, this helps the parents or guardians to assist their dependents optimally. Asante explained:

> For a family to be healthy there is also need to be good communication between the husband and the wife and also with children. Really, there should be good communication between parents and children, there should be good communication between the mother and the child, understanding one another in conclusion. Then that means the family is healthy. Everyone should be free to talk "I don't have such such a thing, I have such a problem… this that… Because of that freeness it helps that you as the one who's helping him/her you should see that "how do I help, where exactly does this person need help"? (**Asante, mother)**

When asked about what one would observe happening in a family that was not healthy, participants talked about absence of effective communication as one of the things one would observe. They stressed that when a family was not healthy there was lack of communication between and among members of the family. They went on to say that if there was communication then it was poor communication. The participants explained that in a family that was not healthy members did not speak to one another adequately (e.g., they did not greet each other), they were not free and open to talk to one another, and when they spoke to one another they did so mostly without love, without respect, and also with words that were harsh and hurtful to each other. Participants described a family that is not healthy as follows:

> You will also be able to see how aaa the family members chat or how they communicate to each other, are they communicating with love? Or they are communicating disrespectfully by calling each other names "you what, you what" while standing there[8], contrary to… you know, our way of showing respect as we do it here in Africa. **(Love, father)**

> For a family that is not healthy it's easy to identify, it doesn't really require you to stay for a day to know that this family is not healthy. Just by staying maybe 5 to 10 minutes you can actually see that in this family there are problems, right? Just by looking at how people are doing their things, maybe they are not communicating well, they are talking to each other with words that are harsh. **(Mercy, mother)**

Another important perspective that the participants offered in describing what a healthy family meant to them was their emphasis on *how* families talk to

[8] Culturally, it is a taboo for a child or a younger person to talk to or address adults by their first name or to talk to them while standing unless the context or circumstance does not allow one to sit down or kneel. The same also applies to men and women when they are addressing their spouses in the presence of other people. A child never addresses his/her parents, aunts, uncles, or grandparents by their first name.

each other. The participants explained that beyond *being able to* talk to one another freely and openly, and solving problems effectively, there was also need to think about *how* the family members speak or talk to one another. They emphasized that a healthy family was a family where members talked to one another with affection, respect, and love, in ways that did not hurt each other emotionally or psychologically, and also in ways that united or built the family other than dividing or breaking it. Victor explained that:

> There's supposed to be good communication in the family because even when there's food or you have time to exercise but if you're not speaking well it means you're not in good terms and that as a person you'll be filled with worries and that means your health will not be good. So I make sure that there's openness in our family. As a parent I should not talk to the kids in a way that they shouldn't enjoy their food even if it's there. **(Victor, father)**

Participants expressed that effective communication was important because it created a sense of cohesion and unity in the family, and also contributed to positive mental or psychological health of the members of the family. For instance, Mercy said:

> The way we communicate as members of the family can hurt and divide you or can unite you. If you communicate well you will also understand each other and there will be no problems in the family. So good communication is very important because it helps the family to be united and also live peacefully, without worries about how you talk to one another. **(Mercy, mother)**

Participants also said that effective communication prevented problems arising from a lack of understanding and played a crucial role in managing conflicts in the family. They explained that through effective communication family members were able to identify and iron out their

differences in a positive way, hence living harmoniously. For example, when asked what makes a family healthy, Darryl said:

> I think it's the relationship. Yes, the main thing is the relationship… on relationship I mean communication, aaa people are free to communicate, people are free to express say aaa to one another about things that seem not okay or… what is supp… what is… not… those that… good things. The goal is to that… say if there is someone who is upset or wounded, she or he can see that aaa maybe we can iron this problem in this way, coming together maybe to… discuss what looks bad or what looks good, or the way forward of the family maybe it's when… if you notice such things and see that it's possible for these people to deal with their differences, it's when you can say that at least people are living a healthy life. Sure. **(Darryl, father)**

Darryl went further to stress the point that failure to talk to one another and not being able to air out problems or grievances in the family simply meant that the family was not healthy. When asked what one would observe in a family that is not healthy, Darryl said:

> If they're not [able to communicate], it means that there is something wrong in the family. So that is where you can say aaa "so if there are these wrong things but these people they're not able to interact to each other, or they're not able to express themselves saying that "such such a thing is not okay, we were supposed to do abcd", then that family is not healthy. **(Darryl, father)**

Understanding and acceptance. Understanding each other in the family was another important aspect of relationship health which participants pointed out as a key feature in their description of what a healthy family meant *to them*. They explained that a healthy family was a family where members of the family, especially the parents, understood and showed acceptance of each other as they interacted, related to each other, carried out everyday tasks, and fulfilled family goals.

These mothers and fathers highlighted a number of positive outcomes that were realized if members of the family understood and accepted one another. They said that understanding and acceptance positively contributed to freeness and openness in the family, created a favorable environment that fosters forgiveness between and among the members of the family when they wrong each other, brought peace in the family, promoted healthy relationships between and among family members, lessened conflicts between and among family members, and enhanced family unity– all of which ultimately contributed to a healthy family. Hope emphasized this point as follows:

> What makes a family to be healthy, the most important thing is understanding each other and accepting each other, really. Yes, that's what makes a family to live well, because if you do not understand each other in the family even if you have everything but if you do not understand each other on what you should be doing, the family cannot live well, but if you understand each other, you are united, you discuss your issues and concerns freely, that's what can make your family [to be] healthy. **(Hope, father)**

Victor's view on this issue reflects what Hope and the other participants expressed. Victor went further to explain that understanding each other was also a very important aspect in having peace of mind in the family because there it contributed to less conflict. He described a healthy family in this way:

> … and understanding each other because when there's understanding in the family and there's peace it makes it to be healthy as opposed to a family where you just disagree and you wrong each other... **(Victor, father)**

Participants explained that lack of understanding especially between the parents affected the whole family and this may have a strong long lasting negative impact on the life of the children. They pointed out that if there was lack of understanding in the family, it became harder for family members to work towards a common goal. Patience vividly recalled her own childhood and gave a striking testimony of how lack of understanding between her parents brought frequent disruptions in the family and how that was ultimately affecting the children:

> You know the thing which I think stands out is… the things which makes the family not to be healthy are… if you're staying with people and you really don't know each other or you don't understand each other, say someone always shouts or gets angry quickly, so it requires the other person to be patient, to be humble, he/she should understand that this person is losing control maybe I should just be quiet, maybe if there's need to discuss the issue it should be another time, not now. Yes such things that another person is short-tempered and neither of you wants to give in then things will go bad and your family will be affected, you'll just be shouting at each other. Since you said I can give an example, my father and my mother, the way they were living it was clear that they did not understand each other. So every time they were fighting, as a result it was affecting us the children. Sometimes they could separate; one goes to his way another to her way and us the children were the ones suffering. So such kind of things, there's need to understand each than both of you having that spirit of not giving in, the family cannot live well and be healthy. **(Patience, mother)**

Therefore, the participants felt that understanding was one of the cornerstones for having a healthy family. They said that lack of understanding between and among members of the family created disunity in the family, hence affecting the family's health negatively. Thus, in the absence of understanding you could hardly have a family that was united and that was healthy. Participants explained:

> According to what I know if we say "this family is not healthy" it means that there is lack of understanding between and among one another and on anything, children are doing their own things, the father and the mother are also doing their own things, it means that family is not healthy. **(Asante, mother)**

> What makes a family not to be healthy, as I said in the beginning, you should be able to understand each other. If you do not understand each other a family cannot be healthy. **(Hope, father)**

Hope went further to stress that the availability of resources (e.g., food) to support the family in everyday life can be meaningful only when you understood each other as members of the same family. He implied that lack of understanding created a tension in the family that negatively affected functioning of the family and that made it difficult for the family to work as a system. He explained:

> If we say the family is not healthy for me it means that in that family they can have everything, food, having enough money, really, but if they do not understand each other the family cannot be healthy, really. **(Hope, father)**

Family unity. Another important issue related to understanding that came out when participants were describing what a healthy family meant *to them* was family unity. Having strong family bonds and doing things as one clearly shaped the participants' everyday lives. The participants explained that to have a healthy family required that there were no divisions or different camps in the family and that as a family you did things with oneness. They said a healthy family was one where members, especially the parents, were united. Participants said:

> If we say this family is healthy it also means that you and your husband and your family are united, you are cooperating. **(Faith, mother)**

> Aaa, I can say that that for a family to be healthy it's all about unity. Yes. [**Researcher:** Unity, aaa between whom and whom?]. Between the father and the mother because children are just followers they just do according to what you tell them. But if you, the father and mother are united then the rest of the family goes on well because children… because even children listen to you without a problem. Because if in the family the father and the mother are divided or don't get along well, they're fighting or doing all sorts of things, then even the children will be divided, one will be for the father the other one will be for mother then the family cannot be healthy. **(Memory, mother)**

Participants' emphasis on family unity especially between the parents came out strongly during the conversations. When asked how they could describe a family that is not healthy, participants explained that it is a family where there is lack of unity among members of the family. They said that in a family that was not healthy members did not do things as a system; rather everyone did his or her own things and there was lack of concern for each other. They stressed that when the spirit of oneness was lacking in a family it was a clear indication that the family was not healthy. Participants explained:

> A family that is not healthy is not difficult to identify because… one, among the family members there is no unity. **(Love, father)**

> According to what I know if we say "this family is not healthy" it means… children are doing their own things, the father and the mother are also doing their own things, it means that family is not healthy. **(Asante, mother)**

> The other thing that can make the family not to be healthy is when there's no unity in the family, because if I am doing my things and my husband is also doing his things, nothing is going to work. Then we will have two camps here in our family and that creates chaos in the family. **(Grace, mother)**

Participants also explained that if there was no unity, especially between the parents, it negatively affected members of the family especially children and other dependents in the family. Similar to what she talked about on lack of

understanding, Patience pointed out that lack of unity made it harder for family members to work towards a common goal. Patience recalled how lack of unity between her parents constantly affected the children. Her parents were not united and each was doing his/her own things. As a result, the family was lacking basic needs (e.g., food), and she thought her family was not healthy. Patience recalled:

> Another thing which I have just remembered is about being one as a family [Researcher: Okay, what do you mean by being one?]. I mean that a family should be united especially on the part of parents. If the parents are not doing things as one it also affects the kids negatively. I can give you an example from my parents' home [R: Go ahead]. Yes, aaa it was clear that my parents were not getting along, there was no unity between them. Between my mother and my father there was no unity, everyone was doing his/her own things. Both were working but between them no one could touch the other one's money, they did not even know how much the other person was getting at work. Each of them was doing his/her own things, it seemed that each of them was living his/her own life. As a result, they could annoy each other, disagree and one could go his/her way and stay somewhere and the children were the ones who were suffering. So sometimes my father could go to a beer hall, drink and sleep there while there was no food at home. So it's such kind of things, in the end the children are the ones who suffer most and also the other people you're staying with in your family. That's what happens when there's no unity. So there's need for people especially parents to do things with oneness so that things go well in the family. **(Patience, mother)**

Clearly, the participants felt that family unity was important to having a healthy family. In Malawian culture, family unity is considered one of the important pillars that holds the family together and supports whatever is happening in the family. For instance, without unity roles may not be fulfilled, resources may not be used properly, there may be more conflicts in the family, and ultimately the family may not work and live well. Because of the important place family unity has in Malawian families, participants in this study talked about what they did to promote unity in their family and support their health.

Subsequent paragraphs provide details of two major practices participants did to promote family unity, and ultimately have a healthy family.

The first practice participants talked about was eating together (family mealtimes). Eating together as a family is a practice that is strongly entrenched in the cultural value system of Malawian families (both in rural and urban areas) and it is passed on from generation to generation. The findings of this study revealed that this practice was frequently reported by the participants. Importantly, it was observed that family mealtimes were not just practicing it for the sake of conforming to cultural norms, but it was also one of the many activities participants reported they did to support having a healthy family in their everyday life. Participants explained that eating together brought a spirit of togetherness and promoted unity in the family. Ultimately, this nurtured healthy relationships between and among family members because it also created an environment where family members interacted while eating. In Orlando's words, mealtimes helped them to "live as a family" because it brought them together to chat. Orlando explained:

> Another thing is that eating together helps us to live as a family [**Researcher:** What do you mean?]. During mealtimes it's not like just eating but we also tell each other stories and all sorts of things, which really create a good environment to interact with the kids since during the day everyone is doing his/her own things and we don't really have time together as a family. Sure. **(Orlando, mother)**

During the conversations with the participants it was interesting to observe that families were making every effort to ensure that they were eating together.

Hope explained how his family always waited for him to come back from work so that they had supper together:

> We usually eat together. Let's say I'm still at work and they have prepared food earlier or maybe I come back home a little late say around 7pm, they do not eat, they always wait for me so that we should eat together as a family. Sure. Like during the weekend we eat together, we wait for each other and eat together as a family. Actually we use one plate for children and us parents. Yes, we sit down all of us and eat together in one plate, really. **(Hope, father)**

Praise talked about his family norm of making sure that every time they eat it is together as a family. He also emphasized the point that it did not matter whether the family had enough food or not but they made it a point to eat together. He narrated:

> For us like at home one thing we do together is that we eat together. If you come today in our home you will find us eating together. Every time… and what they do is that they cook the food and put it in a big container, all of us… everyone comes and takes his/her share from there, everyone taking one's share, everyone taking one's share. So all of us we eat together, whether it's not enough we eat together, whether we have plenty we eat together and when we are satisfied we leave it there. So all the time we do eat together. **(Praise, father)**

Even though these two-parent families in urban Malawi reported that they ate together as a way of supporting their health in everyday life, it was observed that during the weekdays they did not eat together in all the three meal times of the day. It was evident that they rarely ate lunch together during weekdays because of different schedules that family members had. It was equally clear that they ate breakfast, lunch, and supper together during the weekends and also breakfast and supper almost weekday. Participants explained:

> …we eat together [Researcher: How often do you eat together as a family]. Aaa, most of the times I can say in a day it's mostly once [Researcher: When would that be?]. I should not say twice or three times no, but once and it is usually in the evening [Researcher: Okay, why?], aaa because in the morning, we have different timetables, different times for waking up and also different times for me to go to work and for my wife to go to the business place, and at lunch one is somewhere and the other is somewhere too. So usually it's supper that we eat together as a family, but if it's on weekend when we are together then it's breakfast, lunch, and supper, because we are together you find that we are eating together but usually aaa I can say that aaa we eat together usually in the evening, that's when I see that we sit together often… **(Upendo, father)**
>
> Mostly, we eat together supper, but for breakfast most of the time my husband eats alone because he has breakfast very early, sometimes even before the kids are awake, or sometimes he eats while the kids are taking their baths to get ready for school. So because they have different schedules, most of the times my husband eats breakfast alone, the kids eat alone, and I eat usually after I have completed morning chores. During lunch usually I am all alone, so I eat alone. Supper is the one we eat together. **(Patience, mother)**
>
> Yes, there are a number of things which we do together as a family like eating together especially in the evening [Researcher: Especially in the evening?]. Yes, because one of the children knocks off from school at 5 o'clock, our son is in Form 4[9] so sometimes he knocks off from school after 5 o'clock or closer to 6 o'clock, so it's not possible to have lunch together because he comes home late. And the kids it's like… like my 6 years old daughter comes back home after 3 o'clock so she packs her lunch as she goes to school. (**Orlando, mother)**
>
> [Researcher: what do you do together to support having a healthy family]. We eat together [Researcher: You eat together, like how many times in a day?]. Breakfast, breakfast because all of us are here at home, during lunch it's me and my baby who are here, then we eat together as family in the evening. **(Thando, mother)**

The second practice participants reported they did to promote family unity and support having a healthy family was spending quality time together. The findings revealed that the participants spent quality time together in a number of ways both in the home and out of the home. Spending quality time together at

[9] Form 4 is last grade of secondary school in Malawi. Graduates of Form 4 qualify for post-secondary education and if they have excellent grades they sit for university entrance examinations (UEE). Those who pass UEE are selected into the University of Malawi.

home usually took place indoors and mostly happened in the evening because it was almost impossible to do that during the day due to differences in individual schedules (i.e., work, school, and family business). Participants reported that they spent quality time together through: watching live television (e.g., soccer matches on local and international channels); watching films (e.g., Nigerian cinema); chatting (telling each other stories); and listening to radio programs. For example, participants described their indoor activities as follows:

> … we also spend time together especially in the evening. We chat a lot while eating but also after eating we spend sometimes 2, 3 hours just chatting, before we go to sleep we spend time telling each other stories and all sorts of things. Stories just come automatically. If you could come and say you are outside the house you would think that there are visitors here with us, but no, it's just us chatting. There is nothing like just coming back home and… of course as a human you can't be 100% fine, everyone has one's own faults, right? Say maybe that day you wake up with a bad mood others know that this person things are not okay today so they just leave it there but for us normally we like chatting, SO MUCH. **(Mercy, mother)**

> Sometimes we have… say in the evening like after we finish eating supper we have some time together and watch films like Nigerian films. **(Hope, father)**

Spending quality time together outside the home (outdoors) was a practice which typically happened during the day, on the weekends, and when the family had enough funds to support outdoor activities. The participants reported several outdoor family times like visiting friends and relatives (especially during the weekend), attending weddings of friends and relatives (usually during the weekend), going out for family trips for vacation, and going out for lunch or supper as a family. They explained:

> Sometimes we go for family trips, when we have money we travel to distant places whether in Mulanje mountain, whether in [district "C"], maybe going to eat out as a family in the evening when we have money. **(Lindiwe, mother)**
>
> … we have time together, as I have said, we visit relatives or just having a time and say "let's go out to such such a place". Yeah. **(Hope, father)**

Recognizing how important spending quality time together had on their family's health, participants felt that a healthy family could hardly be realized if members were not spending quality time together. When asked what they do together to support having a healthy family, Patience reflected on her upbringing and said this:

> The other thing is spending time together [R: Say more about that]. As a family you should find time to be together, not like one is somewhere another one is somewhere else, no. There's need that you should have time to be together as a family, as I said that you sit down with the kids and chat and play, it helps to know the kids, how their life is going, and also at the same time the kids become free and are open to their parents about their problems. So I think that's how "a healthy family" is supposed to live. As for me, where I grew up in my parents' home we did not have a chance of sitting down and spending time with my parents. Sometimes we could meet problems but we could not tell them because we did not have time for each other as a family. One parent could leave in the morning and come back late evening, the other one the same thing, so there was no time for us to spend with the parents. So "a healthy family" to me is the one where…also you sit down together and spend time with the kids, chatting with them. **(Patience, mother)**

It was observed that there was special effort and commitment on the part of family members, especially the parents, and mostly the fathers, to provide and/or facilitate opportunities for the family to have quality time together, whether indoors or outdoors. Upendo explained how his busy schedule made it difficult for him to spend time with his family and how he pursued every possible

opportunity he saw and thought would made it possible for his family to spend time together, and kind of making up for the time his family did not spend together. He explained:

> Aaa, the second thing, aaa as I have said that the trips I travel are long ones and usually I… I take… I take my family along with me, so that I go with them, that is because I travel a lot such that often times I am missed at home. So on Sunday for instance, we are together, we travel together… sometimes you find that your journey is afar like this one of coming here in [city "Z"], if it were a Saturday, we could have said that "okay, because it is Sunday that I am doing my work, what if we go on Saturday afternoon or evening, if we spend a night there then, Sunday afternoon we will be coming back together", so that there should company, aaa so that the few days I had been away should be kind of replaced to some extent. Aaa sometimes just the whole family going to some place to eat like aaa "let's go and eat together". **(Upendo, father)**

Love and support between and among family members. In addition to effective communication, understanding and acceptance, and family unity, participants also described a healthy family in terms of love. They described a healthy family as one where there was love and support between the parents, the parents and their children, and the people who were staying with the family (e.g., extended family, maids, servants, adopted children), and between and among the siblings. For example, participants described a healthy family as follows:

> …if we say the family is healthy that means that the main thing… basically is that there must be… you should love each other regardless of your respective backgrounds. **(Love, father)**

> [what makes a family to be healthy?]. If you love each other it also helps the family to be healthy [Researcher: Do you have any specific example on that?]. When you love each other, when you show each other love it helps your family to be healthy… **(Faith, mother)**

These mothers and fathers underlined the point that it is through love that healthy relationships are developed and maintained and that ultimately helps the members of the family to live peacefully. What participants meant by living peacefully and having peace in the family was that there were no unnecessary arguments in the family, when members wronged each other they forgave each other and did not keep record of wrong doing, there was less conflict in the family, and there were no tensions (whether emotional or psychological) between and among family members. Lerato described a healthy family as follows:

> … a family that is healthy to me I... I see it like one where they love one another in that home. If they love one another then there will be peace in that family… that's when I say that this family is healthy. **(Lerato, mother)**

Upendo echoed Lerato's perspective and went further to explain about the need for love between and among members of the family, and put much emphasis on the parents:

> Every aspect of life that helps a person to live a free life, peacefully but also a progressive life, should be happening EVERY DAY. So to me I see that if we say that "this is a healthy family", then those things are met. Aaa, I can't forget that issue of relationships, between a man and his wife and also the people he is staying with, they should be living well, and and may be when we say relationship between… aaa between a man and his wife, we are not just looking at the relationship that you are staying in the same house but we are also looking at the kind of relationship between the two you, am also talking about the issue of love, the way you are living. Aaa, how you are living say in your bedroom, or how you live when you go out of the home. All those make… I think constitute "a health family". **(Upendo, father)**

Although participants did not talk much about love directly when they were describing what a healthy family meant to them, their comments about the

practices they engaged in to support having a healthy family revealed that developing and maintaining loving relationships between and among family members was central to their everyday lives. For instance, the participants reported several things they did to nurture love between and among family members. The subsequent paragraphs provide details for the specific practices family members engaged in to support having a healthy family.

Participants reported three ways in which they expressed love to one another to support a healthy family in everyday life. Firstly, participants explained that they made sure that they were always there for each other, supporting each other through difficult times. For instance, participants said that they were there for each other during times of sickness. It was clear that being cared for during sickness strengthened a sense of belonging and also helped to build healthy relationships between and among family members, especially spouses. As such, the participants cherished sharing such moments. Praise recounted how his wife offered him unconditional support and care throughout his illness. He explained:

> I have an example, aaa I think it was in [year] I was VERY SICK and was on the brink of DEATH, you get me? Aaa my mother… my father live in the village, of course there were my father's relatives. It came to a point where all this part was paralyzed, right? and my wife… I have a child… there is [son "J"] there in my home, so he had just been born. I was sick to the extent that I could even pass out bad things right where I was, but my wife could remove all that, take it to the right place, then she could take me to the bathroom and bathe me. So, during that sickness she helped me a lot, right? Had it been that I was alone then the house could have been filled with bad smell, really. These are things that as a person one way or the other you are supposed to appreciate. **(Praise, father)**

It was also interesting to learn that in some cases spouses took days off from their usual salaried employment to make sure that they were at home to care

for their sick family member (e.g., his/her partner) until he/she got well. Such acts showed unwavering love for each other, cemented healthy relationships between members of the family, helped the family to keep moving in spite of the adversity, and helped them to be able to meet their needs in everyday life. Orlando explained how her husband had always been a pillar of support and care whenever she fell sick:

> On the part of my husband he really helps me a lot. Say I am sick, usually when I fall sick my husband does not go to work. He stays at home, so he makes it a point whether it's a day he's supposed to go to work he asks his colleague like "can you please do abcd for me", so he is here at home making sure that I get well but also looking after the business because when I am sick it means the business will come to a stop but at the same time we depend so much on this business. (**Orlando, mother)**

Secondly, participants said that they made sure that they were there for each other by giving each other a hand in doing household chores so that one person was not overworking and exhausted. As explained, in Malawian culture men's responsibility is to provide for the family, and women's responsibility is to take care of the home, including doing all household chores. Thus, men are not expected to do household chores like cooking, cleaning dishes, sweeping and mopping inside the house, bathing the kids, and washing clothes. If husbands do these chores, it is usually out of love for their family, specifically their wife. As such, in this study, the one "helping" the other with doing household chores was the man and the one "being helped" was the woman. Thus, women viewed their husband's involvement in doing household chores as an expression of strong love for the family, and specifically for them because it went beyond the confines of

tradition and the prescriptions of culture. Importantly, participants explained that helping each other with household chores kept their family flowing. Odell explained:

> [**Researcher:** What things do you do which you think help your family to be healthy?]. Helping each other. [**Researcher:** What do you mean by "helping each other"? Is there any specific example you can give to help me understand what you mean by that?]. Yes, an example is that… a very clear example as I said my wife is always preoccupied with business which is just in front of our house, maybe you've seen it as you were coming here. So sometimes it happens that there are lots of customers to take care of while at the same it's lunch time and there's need for us to prepare lunch. I take the responsibility of preparing the food. Yes really. Actually, I don't even complain[10] like "why is she not coming to prepare food"? No, I don't do that. I prepare the food, give the kids their share, and when some customers have left she knows that food is ready, she comes to eat, and while she's eating I go and take care of the business. Yes, we do that. (**Odell, father)**

Orlando corroborated as follows:

> The other thing is that I am busy with customers most of the times. When it's not a weekend, when it's a weekday usually I have lots of customers to the extent that I even don't find time to eat. But when my husband is around, he does everything possible to make sure that things are moving. He cooks relish, goes to buy relish and cook lunch for the children. When he finishes preparing for lunch he comes and says "since now the number of customers is not overwhelming, go and have your food and I'll look after things here". (**Orlando, mother)**

Mercy explained that her maid commuted and that her busy work schedule was putting so much pressure on her ability to fulfill family

[10] In Malawian, culturally, women (wives) are responsible for doing household chores (even if they are employed outside the home or are busy running family business) and men (husbands) are responsible for providing for the family. Hence, it is culturally understandable if a husband complains to his wife or their *ankhoswe* (tradition marriage counselors) that she's not fulfilling her roles. Failure to address such issues may ruin the marriage to the point of divorce. So Odell is trying to make a point that he rises above the boundaries of culture to see to it that they have a healthy family. In spite of clear traditional roles for men and women in Malawi, there is much flexibility in fulfilling roles among some families in urban areas.

responsibilities as a Malawian woman. Thus, her husband's involvement in household chores was vital for smooth running of the family and better health. She explained:

> Say there is some work to do in the family you help each other because like in our case the maid we have commutes from her home so she knocks off here at 5 o'clock. When she goes it means everything happening in the evening depends on us, right? Yeah, so as the mother and the father of the family we are supposed to give each other a hand to say that maybe while one is preparing supper the other one is bathing the child. So we do such things together and at the end of the day we eat on time, the child is clean, for me I am not so tired so is the father because we helped each other, and we go to sleep with bodies that are not so exhausted. **(Mercy, mother)**

Apart from taking care of each other during sickness and helping each other doing household chores, the participants also said that they were there for each other during difficult times (e.g., when one of them was upset or feeling low because of work-related problems) to support each other emotionally and/or spiritually. They said they offered each other words of encouragement and also the Word of God to help one another deal with emotional pains. Ollatile recounted how his wife was passing through a problem and how he was there for her and encouraging her emotionally and spiritually. He explained:

> Uum it's true problems do come. For example, like two days ago her things were stolen, right? So she comes home… complaining what what, you know it's my duty that I should… to comfort her, right? Telling her that this and that that aaa and tell her that having your things stolen it's not that you are the first person, people have their things stolen and they have their stolen, more valuable things than what… more than these, what has been stole from you are just small things, Uum you know… perhaps aaa if you could remember some verses you also tell her that… aaa so and so or people like Job went through big problems not these problems, yeah really they went through real problems not these ones. So… in so doing you find that… you find that she has recovered a little bit that you are able to chat well, even eating she is able to eat because sometimes it happens

> that her things got stolen and the person is not eating. **(Ollatile, father)**
>
> So when I come home I explain the problem and she encourages me that aaa "don't worry that's how things sometimes go, that's how life is, not all days are good". **(Hope, father)**

Other participants also expressed the same point that they supported each other spiritually and emotionally when one was passing through trying times. They added that such support played an important role in restoring one's peace of mind. Participants explained:

> Issues like those say maybe there is a certain problem whether at our business or at work that… as you have said that maybe being disappointed, if say it's my husband, when he comes what I do I just encourage him that the most important thing as a person who was created by God, the same God who allowed that you should come in this world, He has the ability to do anything that you need because God says in the Book of Psalms that "He is a good shepherd" and He says that "those who trust in Him will never be put to shame", so I just encourage him that you... what we are supposed to do is to have faith in God because He is the One who takes care of all our needs and our problems. If there is any problem that seems that maybe which… it happens that sometimes you face situations that… that are really hard, and in such situations we just commit everything into prayer and in supplications as I have already said that God tells us that all our requests should be known to Him. **(Asante, mother)**
>
> Another thing that we do individually, I guess is to make sure that we are there for each other [Researcher: Say more about that]. I will give an example of… say something has disappointed me at work and I am upset. I have arrived here, right? Normally, we greet each other, we ask each other how your day had been whether at the office or as you were travelling back home, whether the child at school, or the maid while she was here and we were away. Everyone here is free, okay? We are free people, we chat a lot. So we greet each other and everyone say his/her worries he/she met in that day. We sit down and talk about it and we see that the person is helped and has peace of mind. **(Mercy, mother)**

The last thing participants mentioned they did to express love to one another and support having a healthy family was buying gifts or presents for each

other. Notably, fathers were the ones who bought gifts for their wives and/or children. Participants reported that they bought each other gifts (both as a regular thing and during special events) as an expression of love and also to maintain healthy relationships between and among members of the family. They explained:

> Aaa sometimes I really make it a point say maybe I've seen something and I feel like "why can't I buy this for my wife"? And also everywhere I go I make sure that I buy something for the children too, aaa because most of the time if you were out and you come back home with empty hands you will appear to the kids as if you do not think or care about them, you know? So apart from that aaa maybe when coming back home I buy even other things whether it's relish whatever which you think you can buy for the family, you know, buying those things you think could make your wife happy, you know your wife likes this, my kids like this, so I try to buy things like these. **(Upendo, father)**

> When it's a birthday for one of us he buys us a cake or something special. **(Thando, mother)**

Healthy relationships with people. Clearly, most of the things participants talked about as aspects of relationship health focused on their immediate family. Nevertheless, they also talked about a healthy family by referring to people outside of their immediate family. In describing what a healthy family meant *to them*, participants talked about being in a good relationship and developing and maintaining peace with their relatives, friends and neighbors. Upendo described a healthy family as follows:

> I believe that a family that is is is "healthy" needs also to be in good terms with people who surround them, the neighbors. **(Upendo, father)**

Although participants only infrequently talked about healthy relationships with relatives and friends (e.g., neighbors) when they were asked to describe a

healthy family, this subtheme was common when participants were asked about the practices they engaged in to support having a healthy family. Spending time with, and maintaining healthy relationships with their relatives and friends was one of the things participants did to have a healthy family. The participants reported that they regularly visited their relatives and friends, especially on the weekends:

> So on the weekend it's when we find a chance to go and visit our relatives and have some time with them. **(Hope, father)**
>
> … sometimes if there are events like weddings of relatives we may go as a family…You also know, as a Malawian, if there are such events/activities we go as a family, "let's go and help them", we do that. **(Odell, father)**
>
> … just being with relatives or friends somewhere and spend time with them telling some stories, maybe some weekend going somewhere with friends just staying at some places, yeah that's it and life goes on. **(Upendo, father)**

In Malawian culture, making sure that extended families from both the father's and mother's sides are supported without bias is critical to having a healthy family because it lessens conflict in the family. It was not surprising that the participants in this study talked about maintaining good relationships with extended family as one of the things they did for each other to have a healthy family. Praise expressed:

> And also even the relatives… for us aaa we have extended family, we Africans, so there is also need to balance how you help them, whether it's relatives from the husband's side or relatives from the wife's side… I'm still talking about the same issue of doing things for each other, right? If my wife's relatives come in our home and I welcome them nicely, happily, whatsoever, I don't think my wife will be angry when my relatives visit us. She too will also be happy at them. Likewise, all these are the things we do for each other. Therefore that

> good story is spread across "I visited them and I was welcomed, they received me so well" but if you look carefully you will discover that it's the wife who did that and you were even not around, you see? Maybe you just come from work and maybe your wife is not there, you welcome her relatives nicely. Aaa all that is what you are doing for each other so that you're treating both sides well. **(Praise, father)**

Overall, the findings show that relationship health was a central aspect of participants' everyday life. Hence, they made an effort to ensure that they developed and maintained healthy relationship between and among family members as well as with people outside their family.

Theme 3: Spiritual Health

Maintaining spiritual health was the third major theme that emerged from the participants' descriptions of a healthy family. When describing what a healthy family means to them, participants mostly talked about spiritual health in two ways: fearing God; and depending on God's providence for their family's needs in everyday life.

The worship (fear) of God. When asked what a healthy family meant to them, some participants explained that it meant a family that feared God and had a good relationship with Him in their everyday life. The participants went on to say that such a right relationship went further to also include their relationship with the Church. During the conversations, they referred to the Bible in their explanation of a healthy family and said that a healthy family could be created and maintained if family members conducted themselves in ways that were in line with what the Word of God teaches. Asante stressed this point:

> For me, because I still believe that the beginning of a family is… it's God who began it in the garden of Eden, so if we say "health family"

> then it's a family that fears God and it's usually in close fellowship with God… **(Asante, mother)**
>
> Okay, the most import… let me say one point on that, everything begins with God, so I believe that each one of us… let's say in our country Malawi if we put God first in everything, there is nothing that can be a problem to us and we can have healthy families. **(Asante, mother)**

When asked what makes a family to be healthy or to live a healthy life, the participants explained that fearing God and doing His will was the utmost thing to do. Because of the importance these families placed on their spiritual health, mothers and fathers took a leading role in making sure that their family was spiritually healthy. For instance, Darryl explained that as a father he oversaw the spiritual welfare of his family and encouraged his family to be in the right stand with God both as a family unit and also as individuals. He emphasized his belief that being in good relationship with God is the genesis of a healthy family. Darryl explained:

> Aaa for me I could refer to the Bible, saying that if we can be God fearing our family can also live healthy. **(Darryl, father)**

The providence of God. Apart from fearing God and having a good relationship with Him, the participants also expressed that trusting and depending on God and His power or intervention in their everyday life was important to having a healthy family. It was interesting to learn that the participants directly linked their spiritual health and their physical health, specifically, the availability of resources in the family. The participants expressed that being able to find resources in their life rested in their strong belief in God's power and ability to provide for their family needs. Thus, a healthy family was a family that not only

lived in the right stand with God but was also one that depended/relied on God as their Provider in their everyday life. The participants talked about this dependence/reliance in two major areas of their life: depending on God's providence for their everyday needs in life; and depending on God's power and intervention in times of adverse circumstances such as sickness/illness of family members or economic hardships. Darryl explained his strong belief in the providence of God as follows:

> God is the One who gives everything that is needed for a person's life. So what I emphasize most is that everyone should at least dedicate himself/herself to God. That means God's will… or I should say the needs of a person or the needs of the family they are provided by God. **(Darryl, father)**

What was interesting to observe when some of the participants described their perspective of a healthy family within the theme of spiritual health was how they stood firm in their faith in God and strongly conveyed their belief in healing within the fabrics of both medical and spiritual realms. To them, healing of their diseases was something that not only came from medical treatment but more importantly from God through medical treatment. For instance, when one of the participants was asked how they dealt with illness or disease in their family, it was clear from her narration that depending and relying on God's power and intervention was the basis on which they stood in responding to adversities like sicknesses. While acknowledging the importance of medical treatment when a family member got sick, Asante expressed that prayer in God was something that should always be put first in such circumstances because, in her own words, "God is the One who heals". She narrated:

> If someone has fallen sick in this family we… aaa the hospital personnel say that… they encourage that we should be people who keep medicine like Panado, Aspirin in our homes. So if someone has fever we take… first before we give him/her medicine we pray with him/her first, after praying then we take the medicine and give him/her. If we see that… let's say that we gave him/her medicine in the evening, then in the morning what we do is to check how he/she is feeling. If he/she is not feeling okay, we get ready and go to the hospital so that at the hospital they should examine him/her thoroughly and see what the problem is and also they should give him/her suitable medication. Apart from that, we also keep praying for him/her because we believe that God is the One who heals. **(Asante, mother)**

Evidently, spiritual health was fundamental to the everyday life of these two-parent urban Malawian families and this was reflected in their lifestyles and everyday living. Most of the participants explained that they began their day by praying and dedicating their day unto the hands of God so that they had "a fruitful day" (Asante, mother). At the end of the day they also gathered together as a family and prayed before they went to sleep.

During the conversations with these mothers and fathers it was clear that praying in the morning (usually individually just after waking up) and in the evening (usually as a family just after supper), and also going to places of worship (i.e., going to Church on Sundays and Saturdays) were common practices among these two-parent urban Malawian families. It was how they met their spiritual needs. Participants expressed that a family could be sick, not only physically, but also spiritually and that having a good spiritual life was key to having a healthy life. For example, Mercy said:

> I can say that if we say a healthy family to me it really means a lot because a healthy family… by just looking at person, maybe how

> he/she looks maybe he/she is fat[11] and you may think that this person is healthy, right? Say the way the husband is looking you would think that aaa he is healthy or this child is healthy but internally these people are not healthy. Maybe they are sick spiritually… I cannot tell. **(Mercy, mother)**
>
> … a family that is healthy to me I... I see it like one where… their spiritual life is good, that's when I say that this family is healthy. Sure. **(Lerato, mother)**

It was observed that participants were engaged in specific practices whose goal was to promote their spiritual health. One of these practices was praying together. Participants explained that they prayed together in the home and also went together to worship at Church. Participants mentioned that they had regular times set aside for the family to meet together and pray. For example, Memory explained how her family made every effort to see to it that they gathered and prayed as a family before they went to sleep. She pointed out that sometimes they could miss having meals together but they made it a point that they met at an established time to pray together. She explained:

> Aaa, usually what we do together… because sometimes the boys go out in the morning but in the evening we try to come together, aaa like food we put there at the table, if all of us are around we eat together, but if some are not around we don't wait for them, the one who is hungry goes and takes their share and sits down to eat. But we try that at the time of going to bed everyone knows that by 8:45pm we are supposed to be together to share the Word of God briefly, we should pray and go to bed (R: Uum). Yes, those are the things we do together. **(Memory, mother)**

It was observed that the participants usually prayed together every evening, just after supper before family members went to bed. When asked what

[11] For many Malawians, there is a belief that being overweight means healthy.

they did together as a group to support having a healthy family in their everyday life, Darryl explained:

> I think its praying. Like when we finish everything we do in the evening before we go to bed we gather together and pray. So we pray together. **(Darryl, father)**

Apart from having evening family prayers, another practice the participants said they did together to support having a healthy family was going to worship places (i.e., attending Church services and other programs). Odell explained:

> That [what they did together to make sure their family stay healthy] should be praying. Especially on Sunday, like tomorrow is Sunday right? We go to church together as a family, pray and come back. Yeah. **(Odell, father)**

Besides praying together, participants also reported that they individually prayed for the family. For example, when asked what she did individually to support her family's health, Lerato said that she prayed for the family and she went further to explain how strongly she felt that involving God in the affairs of the family was key to having a healthy family. She explained:

> Apart from these things, the others that I do so that the family should be healthy then it's… then it's praying for the family, yes praying because in all God… for everything to go well in the family God must be involved. Yeah. **(Lerato, mother)**

Similar to physical health and relationship health, spiritual health was an important issue when participants described what healthy family meant to them. Evidently, they engaged in various practices to ensure that they maintain a spiritually healthy family.

Theme 4: Mental and Emotional Health

The last major theme which emerged during analyses was mental and emotional health. The participants described a healthy family as one whose members were mentally and/or emotionally and/or psychological well. In most cases the participants' descriptions of mental health was focused on issues of stress, worry, and depression. The most prevalent phrases these mothers and fathers used when talking about mental and emotional health were: "having a peace of mind" or "not having a peace of mind" and "worrying" or "not worrying" or "not having major worries".

Participants emphasized the point that the absence of major worries and the presence of peace of mind among family members were important facets of a healthy family. They explained that major worries and lack of peace of mind had a direct negative effect on the person's life and affected other facets of his/her health and could have a spill-over effect onto the health of the family. For example, they described a healthy family under this major theme as follows:

> Healthy family blends a…. number of things because if we say "healthy"… say someone is being tortured/abused indirectly, right? That torture/abuse will make that person not to have peace of mind. So how can that person be healthy when somewhere somehow something is lacking? **(Mercy, mother)**

> … if we say healthy family… in…i…i…in… in our culture here in Malawi it's to say that… it's to say that the family members stay in peace… they live in peace, okay? In peace, meaning that… we can say that… I don't know but I should say in brief that they live in peace there is nothing that's like… shaking them or troubling them but they live in peace, I think that is a healthy fa… a health family. I don't know how you can say it but that's how I am seeing it. (**Trust, father)**

> … the moment I get sick it means my wife as well will get sick because just by the fact that she is thinking that my husband is sick, it means she too is psychologically affected, she's sick as well. If she is

> sick, me too, as I have come here aaa "how is my friend feeling now" I should go and check her, I should take her to the hospital", automatically I am also SICK, so that is not a healthy family. But if I come here [at work] and I am not feeling anything bad and I have left them well then I knock off and go back home and all is well there aaa the… children too are well, then that is a health family. **(Praise, father)**

For participants, common sources of worry, stress, or depression were everyday family challenges such as employment related issues (e.g., late and/or insufficient pay), failing or struggling to find basic needs in their everyday life (e.g., food), poor communication in the family, lack of emotional support from other family members, lack of unity in the family, not sharing one's problems with other members of the family, and failing to manage conflicts and solve problems. The participants explained that these stressors affected one's mental and emotional health. One participant reported that if not positively managed, stress, worry, and depression could lead to heart related diseases and affect physical health:

> I think to me it [a healthy family] means that there's peace of mind. That is to me. Because when I go about my day without any worry about my family, automatically I have peace of mind. We hear other people say "his/her BP has shot or has what…?" Such things happen sometimes because there are some family problems which they are not able to solve. **(Odell, father)**

Odell went further to explain that a family where family members are lacking peace of mind (for instance, because of lack of or poor communication) it means that they are not healthy because their mental and emotional health are negatively affected. Odell explained:

> …I mentioned about having peace of mind, right? If you as a family you have poor communication, a child for example has a problem but is not able to share it with his/her brothers and sisters or the parents, it means that problem will affect his/her peace of mind negatively and it means he/she will not be happy, or even mentally he will not be healthy, right? That's how I can put it. **(Odell, father)**

Other Interesting Observations

Apart from the findings provided above, there were two other interesting observations that came out of this study. Firstly, I looked to see whether there were differences in participants' responses across sociodemographic characteristics (e.g., family income, gender, and education level) and did not find any differences. Secondly, I also observed that mothers and fathers did not talk much about their children. For instance, despite the fact that children were very much engaged in everyday family tasks and activities (e.g., buying supplies for the business, cleaning the business place, cleaning the home, doing laundry, and cooking), mothers and fathers hardly mentioned them. Lastly, I also observed that there was consistency in the descriptions of things by mothers and fathers from the same family were very similar. For instance, when asked to describe what a healthy family meant to them, the mother described it as follows:

> … "health family" is to say that they are people who in their everyday life they are able to find food, clothes, right? A good home to stay… to sleep… that good place which is well cleaned...

The father from the same family described a healthy family in this way:

> …if we say the family is healthy that means that… food should be available, whether it's clothes they should be available, but also income should be there so that the family should go well, meaning that all the necessary things should be available, everything that could be needed in the family, whether it's for the children for their school, whether it's for YOU the parents, food for the whole family. If all the

> needs are found adequately we can say that… in that context we can say that the family is is healthy.

Consistency in how mother's and father's (from the same family) descriptions of things was also observed when participants were asked about the practices they engage in to support having a healthy family in their everyday life. A father explained that they shared workload and helped each other with doing household chores. He explained:

> [**Researcher:** What things do you do which you think help your family to be healthy?]. Helping each other. [**Researcher:** What do you mean by "helping each other"? Is there any specific example you can give to help me understand what you mean by that?]. Yes, an example is that… a very clear example as I said my wife is always preoccupied with business which is just in front of our house, maybe you've seen it as you were coming here. So sometimes it happens that there are lots of customers to take care of while at the same it's lunch time and there's need for us to prepare lunch. I take the responsibility of preparing the food. Yes really. Actually, I don't even complain[12] like "why is she not coming to prepare food"? No, I don't do that. I prepare the food, give the kids their share, and when some customers have left she knows that food is ready, she comes to eat, and while she's eating I go and take care of the business. Yes, we do that.

The mother from the same family corroborated as follows:

> The other thing is that I am busy with customers most of the times. When it's not a weekend, when it's a weekday usually I have lots of customers to the extent that I even don't find time to eat. But when my husband is around, he does everything possible to make sure that things are moving. He cooks relish, goes to buy relish and cook lunch for the children. When he finishes preparing for lunch he comes and says "since now the number of customers is not overwhelming, go and have your food and I'll look after things here".

[12] In Malawian, culturally, women (wives) are responsible for doing household chores (even if they are employed outside the home or are busy running family business) and men (husbands) are responsible for providing for the family. Hence, it is culturally understandable if a husband complains to his wife or their *ankhoswe* (tradition marriage counselors) that she's not fulfilling her roles. Failure to address such issues may ruin the marriage to the point of divorce. So Odell is trying to make a point that he rises above the boundaries of culture to see to it that they have a healthy family. In spite of clear traditional roles for men and women in Malawi, there is much flexibility in fulfilling roles among some families in urban areas.

This consistency in the mother's and father's (of the same family) constructions and description of things were observed across most couples in the study.

Summary of the Findings

Participants were asked to describe in their own words what "a healthy family" meant to them, and what it means to them to say a family is not healthy. Generally, participants responded by describing "a healthy family" holistically by focusing on the physical health, relationship health, spiritual health, and mental and emotional health of the family and its members. For example, Mercy captured most of this holistic view of a healthy family as follows:

> I can say that if we say a healthy family to me it really means a lot because a healthy family… by just looking at person, maybe how he/she looks maybe he/she is fat and you may think that this person is healthy, right? Say the way the husband is looking you would think that aaa he is healthy or this child is healthy, but internally these people are not healthy. Maybe they are sick spiritually or physically, I cannot tell, but when we say a healthy family you actually see how the people live their life, right? They are people who do things together. Healthy family blends a…. number of things because if we say "healthy"… say someone is being tortured indirectly, right? That torture will make that person not to have peace of mind. So how can that person be healthy when somewhere somehow something is lacking. Because when we say "healthy family" it means everything in that family… everything is fine, there is no one who is sick frequently, whether funeral… of course death it's there but "health family" is to say that they are people who in their everyday life they are able to find food, clothes, right? a good home to stay… to sleep… that good place which is well cleaned, there are no mosquitoes troubling them. **(Mercy, mother)**

From the participants' description of a healthy family, it emerged that their conceptions of a healthy family integrated aspects of physical health, relationship health, spiritual health, and mental health, and they engaged in various practices to maintain a healthy family in their everyday life. Participants described a

healthy family as characterized by the following: firstly, physical wellbeing of family members so that they could engage in family and work roles that would allow them to adequately provide for the basic needs of the family, especially food, shelter, and clothing; secondly, "oneness" or family unity, where there is lack of conflict and family members are in agreement and work cooperatively together towards family goals, where family members express and receive love, support, understanding and acceptance from one another, where family members communicate effectively in an open, easy and respectful way that facilitates effective family problem-solving and conflict management, where family members spend quality time together (e.g., eating, talking, story-telling, and praying together as a family), and where families spend time socializing with extended family and friends; thirdly, the spiritual wellbeing of family members fostered by praying, church attendance, and remaining true to the beliefs in fearing God and God's providence; and lastly, a sense of peace within the family as a whole and a peace of mind for individual members.

Interestingly, this study also showed how important the wording of questions is in procuring desired information. When participants were asked to describe what a healthy family meant to them, their responses mostly focused on outcomes of a healthy family and less on the processes. For instance, participants talked about a healthy family by focusing on meeting needs such as food, shelter, and clothing. Similarly, when they were asked to describe an unhealthy family, participants talked mostly about the outcomes. For instance, their description centred on absence of essential needs of the family, especially material need (e.g.,

lack of food, and clothes), and emotional needs (e.g., lack of emotional support and love from other members of the family). By contrast, when participants were asked about the practices they engaged in to support a healthy family, they mostly talked about processes that facilitate meeting family's needs in everyday life. For instance, they talked about allocation of tasks, fulfillment of roles, good communication, and quality family times. It was observed that asking them specific questions about practices yielded rich data about family processes.

In summary, when responding to the questions about the meaning of a healthy family and the practices they engaged in to maintain a healthy family, participants provided complementary information about the overall view of a healthy family in urban Malawian families. They talked about processes that families in urban Malawi engaged in to maintain a healthy family and also the outcomes of these processes. Thus, a healthy family among these participants was a family that engaged in specific and intentional practices essential for enabling the family to meet members' needs in their everyday life, such as material, emotional, and spiritual needs.

CHAPTER 5: DISCUSSION

The findings of the study show that two-parent families in urban Malawi describe a healthy family holistically. Broadly, their view of a healthy family is similar to the views of North American family members and to many aspects or dimensions of North American models of family functioning. Importantly, however, there are notable differences between North American view of a healthy family and that of Malawian families. These differences reflect social-cultural and socioeconomic differences between the two contexts.

Similar to North American families' views of a healthy functioning family (e.g., Denham, 1999b; McCreary and Dancy, 2004; Niska et al., 1999), two-parent families in urban Malawi described a healthy family holistically. First, participants described a healthy family by focusing on physical health and specifically: presence of adequate resources to meet the family's needs in everyday life; the physical wellness and absence of frequent or significant illness of family members to enable them fulfill family roles; and a clean home environment because it supported the family's physical health and also a reflection that family members were able to fulfill roles.

In describing the importance of physical health, mothers and fathers emphasized their capacity to perform and fulfill roles and tasks in the family and having adequate resources to meet family needs (e.g., food, shelter and clothing) in everyday life. Even though this may not be a new finding, it was observed that in Malawian families it appeared that physical health was critically important in ensuring that family members could fulfill family roles and ultimately be able to

meet the family's everyday basic needs. Malawi is one of the poorest countries in the world, and much of Malawians' time is devoted to meeting basic needs. Thus, it is not surprising that being able to adequately provide for the family's needs such as food, shelter, and clothing was paramount in discussions of what it means to have a healthy family in Malawi. Meeting these basic needs would be taken for granted in most North American families, especially the middle-class families on which most of the research in support of the development of the North American models of family functioning were developed (Fine, 2001).

Similar to the McMaster Model of Family Functioning conceptualization of a healthy functioning family in the dimension of role fulfillment (Epstein et al., 2003), it was observed that in Malawian families, family members had clear roles and functions that they performed to meet their needs in everyday life. For instance, it was observed that members of the family actively performed certain economic roles and tasks to make sure that they had resources in the family such as food, shelter, and clothing. These roles and tasks were culturally oriented such that there were clearly defined roles for men and for women.

An interesting observation in the present study was that even though the participants talked about eating balanced meals as one way of achieving good physical health, they did not talk about health practices (e.g., doing physical exercises, having enough sleep) or other health risk behaviors (e.g, alcohol and substance abuse, cigarette smoking, lack of sleep, and physical inactivity) as it would be expected in Western cultures. During the conversations with the participants, only two of them talked about being engaged in physical exercises

such as jogging and walking as one of the things they do to maintain a healthy family. Given my insider knowledge that most Malawians do not engage in physical exercises other than the manual work they do in their everyday tasks, it was not surprising that most of the participants did not talk about it as it at all. Further, it may be understood that in Malawi issues of cigarette smoking, alcohol abuse, and substance abuse are more to do with spiritual life than physical health because Malawi is predominantly a religious nation. For example, if you asked someone why he or she does not smoke, the likely answer would be that it is against his or her religious values, and rarely would you hear that it is for health reasons or concerns.

Participants in the present study also described a healthy family by focusing on relationship health. A healthy family was described as a family where members communicate effectively, manage conflict positively, and solve problem successfully, understand and accept each other, are united as a family, love each other, and develop and maintain healthy relationships with people outside their immediate family. Generally, these descriptions of healthy family relationships captured some aspects or dimensions of healthy family functioning in North American models (Beavers & Hampton, 2000; Beavers & Hampton, 2003; Epstein et al., 2003; Olson & Gorall, 2003; Olson, 2011). Similar to Western conceptualizations of a healthy functioning family in these models, two-parent Malawian families stressed that communicating effectively, managing conflict in a positive way, and solving problems positively were important aspects of a

healthy family. For instance, they explained that free and open communication is critical to addressing differences between and among family members.

Further, the participants in the present study reported that they expressed love to each other and offered each other support in a number of ways such as being there for each other during sickness, offering each other spiritual and emotional support when one is going through difficult times, buying each other gifts to show affection for each other, and helping each other do household chores. This is not different from the dimensions of affective responsiveness and affective involvement in the McMaster Model of Family Functioning. What was interesting in the present study was that some of the things participants said they did for each other went beyond the prescriptions of culture. For instance, the participants reported that men helped women do household chores and women were actively involved in providing financially for the family. This was a reversal of cultural expectations of a traditional Malawian family where a man's responsibility is to provide for the family and a woman's responsibility is to take care of the home, specifically doing household chores such as cleaning, cooking, bathing the younger children, and doing laundry.

Furthermore, similar to the McMaster Model of Family Functioning's concept of maintenance and management of family system in relation to extended family members, friends, and neighbors (Epstein et al., 2003), participants in the present study reported that they made sure that their relationships with their extended families, friends, and neighbors were healthy. Most of the participants reported that they visited and spent time with their extended families and friends,

especially during the weekends. This was an investment they made both in terms of time and money.

What was notable in the present study was the participants' strong focus on understanding and family unity. The participants emphasized that you could not have a healthy family if there was a lack of understanding between and among family members, especially the parents. The meaning of the concept of understanding in the Western societies may not be similar to that in Malawi. In Malawian culture, understanding is a basis of the important fabrics of family life. Understanding between and among members of the family is a fundamental pillar that holds the family together and that shapes the way of life of that family. For instance, a family whose members understand each other discuss issues about the welfare of the family, solve conflicts amicably, accept each other, give each other both family and individual time, cooperate in their undertakings of roles and responsibilities in the home and are united, listen to each other without passing judgment, show affection and compassion for each other, and put the family's interests above individual interests. Importantly, the emphasis on family unity came out strong in this study when compared with the North American models. Participants talked about "being one" and "doing things as one" as an important aspect that facilitates healthy family functioning. The strong focus on family unity reflects both the collective culture embedded in Malawian families and also the need for the family to work as a system to ensure that they meet their everyday basic needs.

Two-parent families in urban Malawi also described a healthy family by focusing on their spiritual life. Within this theme, the participants talked about two important areas of spiritual health. They explained that a healthy family is a family that fears God, and depends on God's provision for their family's needs in everyday life. Even though Western scholarly models of family functioning do not specifically focus on spiritual health, studies in North America have reported spiritual health as one of the dimensions that families themselves discuss as important for a healthy family (e.g., Denham; 1999b; Niska et al., 1999).

What was interesting in the present study was the issue of healing of disease. One of the participants explained that she believed that when one of the members in her family fell sick, their faith in God's healing was as important as medical treatment. According to her, healing comes from God through medical treatment. Believing that God's power to heal diseases is as important as medical treatment and that "God is the One who heals" (Asante, mother) is a unique finding and has not been widely reported in previous studies. While this view is common among Malawians, it may not be the case in other areas of the world where spirituality or religion is not at the centre of the people's everyday life like it is among Malawians.

Another interesting finding within the major theme of spiritual health was that these participants' everyday life was very much in line with their belief in God. Their day started with a prayer time either individually or as a family unit, and it also usually ended with a family prayer time. Participants explained how

they made it a point that the spiritual life of the family was strong at both the individual and family levels.

Lastly, two-parent families in urban Malawi also described a healthy family by focusing on mental and emotional health. A healthy family to these fathers and mothers meant a family whose members were free from major worries and stresses of life, family members supported each other emotionally in times of need, and family members avoided behaviors that would mentally and/or emotionally hurt one another. Although Malawian culture is different from North American culture, there was no unique finding under this theme which was quite different from North American perspectives. In the present study, participants' descriptions of a healthy family under mental and emotional health mostly focused on issues of worry, stress, and depression. Participants reported that common sources included the following: employment related issues such as delayed salary pay or lesser pay; failing or struggling to find basic needs in their everyday life; poor communication in the family; lack of emotional support from other members of the family; emotional and psychological abuse or torture; lack of unity in the family, and negative influences from people outside of their immediate family.

In addition to describing a healthy family, participants also provided rich descriptions of the practices they engage in individually and as a family unit to maintain a healthy family in all the four dimensions: physical health, relationship health, spiritual health, and mental and emotional. Many of the practices participants in the present study identified were directed towards developing and

maintaining healthy relationships between and among family members. While some of these practices may reflect what happens in other Western and non-Western families, there were also notable differences. An example could be eating together. Although mealtimes are critical for maintaining a healthy family (Hamilton & Wilson, 2009), they are not frequently practiced in other parts of the world as was the case with families in this study. For example, researchers have observed that the busy schedules in the modern world have made it difficult for North American family members to eat together as was the case a century ago (Hamilton & Wilson, 2009; Ochs & Shohet, 2006). In the present study, members of the family made every effort to ensure that they had meals together as a family, for instance, waiting for the father and/or mother to come from work so that they eat together.

The fact that most of these practices were directed towards developing and sustaining healthy relationships between and among members of the family suggests that in Malawian culture family is more important than the individual. Clearly, family members took great effort and commitment to support their relationship health and they followed various avenues to accomplish this. Thus, for these two-parent families in urban Malawi, relationship health was central to healthy family functioning in their everyday.

It was also observed that most of the time these practices served multiple purposes which ultimately contributed to maintaining a healthy family in everyday life. For instance, going to Church together as a family not only helped them nurture their spiritual health but also promoted the spirit of togetherness and

strengthened family unity, which ultimately contributed to good relationship health. Another example is the importance placed on family roles and responsibilities. Malawian culture has clearly defined roles for men and women. In this study, participants reported husbands helping wives doing household chores and wives being actively involved in providing for the family through salaried employment and/or business. These overlapping roles and responsibilities were instrumental in building healthy relationships and were also critical in achieving good physical health. For instance, when a husband helped his wife with doing household chores, it was a strong sign of love because it was an act that went beyond the prescriptions of culture. At the same time, it also relieved the wife and gave her time to rest and physically refresh.

Overall, the study shows that there are some similarities between the descriptions of a healthy family functioning by Malawian families and that of North American families and scholars (e.g., issues of communication, stress and depression, and physical wellness). However, these similarities should be interpreted with caution because I did not employ the models to ascertain whether there are similarities and difference. I simply asked participants what a healthy family meant to them. I did not seek to establish the validity of specific North American developed measures. As such, the validity of these Western measures in the Malawian context is still not established.

Notably, the study reveals important differences. While North American models focus on family processes (e.g., communication, behavior control, and problem solving and conflict management), families in Malawi greatly focused on

outcomes (i.e., on physical, relationship, spiritual, and mental and emotional wellbeing of family members). The challenge that Malawian families face to meet everyday needs may explain why participants in this study strongly focused on outcomes. The findings show that better outcomes in the thematic areas of a healthy family mean good overall wellbeing of family members and the ability to work and meet their basic needs.

Furthermore, the focus on outcomes also explains why family unity is important in Malawian families. Unity helps family members to work as a system, fulfill roles, and be able to meet the family's needs. Through unity, family members divide tasks to achieve common family goals, for instance, engaging in economic activities that support their family's welfare. For instance, in one of the families I observed that the father was preparing lunch for the family, the mother was serving customers at their business place while I was interviewing, and the children had gone to buy supplies for the business. The mother of this family explained that all this was possible because their family was united.

Again, in this study, there was a strong focus on spirituality. Most Malawians are active in their religion and worshipping God is an important part of their everyday life. The country's poor economy poses tremendous challenges to most families in Malawi in meeting basic needs, such as food, clothes, and shelter— needs that are taken for granted in North American families. Malawians believe that their needs can be met by divine intervention from God. Hence, they find hope and solace in their faith. It was not surprising that their descriptions of a

healthy family and the practices they engaged to maintain a healthy family included spirituality.

Implications of the Study

Evidence from this study clearly shows that families in Malawi define a healthy family holistically and that they engage in specific practices to maintain a healthy family in everyday life. Thus, their meaning of a healthy family and the practices they engage in to maintain a healthy family could be used as a starting point for developing programs and services that are tailored towards meeting everyday needs of the family. The study reveals that everyday life of Malawians is characterized by the struggle to meet family's basic needs such as food, shelter, and clothing. Such circumstances may create stress and interfere with other aspects of family functioning. Thus, using local resources such as community clubs, women's groups, men's groups, youth clubs, and community leaders, government and non-government organizations (NGOs) or agencies in Malawi could focus on policies and programs that are aimed at economic empowerment of families. Such programs could be streamlined with projects that focus on other aspects a healthy family as identified in this study such as the importance of healthy communication, reducing family violence, promoting healthy communication between and among family members, and strengthening family unity.

The present study also reveals some similarities in how scholars and families in North America and families in Malawi conceptualize a healthy functioning family. Some aspects of family functioning appear similar across

different cultures. However, it is important to note that North American models have not yet been tested in Malawi and, therefore, it cannot be concluded with certainty that they are appropriate and applicable to the Malawian and other African contexts. Thus, there is need to operationalize constructs to reflect the meaning of healthy family functioning embedded in the African culture. This could also be taken further by developing models that are true to healthy family functioning in African culture.

Limitations of the Study

Firstly, the study is limited in that most of the data were self-report from mothers and fathers. Data from children and adolescents, or maids, or teachers, or others who may be able to provide insight into family functioning was not generated. For instance, while mothers and fathers did not talk much about their children when talking about income generating activities, I observed that children, too, were actively involved. This may suggest that interviewing children may have revealed other things which the parents did not talk about. Further, because the study mostly relied on interviews with the participants, I did not generate more objective observational data except for what I observed during the course of the interviews.

The study involved two-parent urban Malawian families with children living in the home. Based on Malawian context, most of these participants were middle-aged and came from two-parent families, most of which were nuclear. Most of them had a minimum of Malawi School Certificate of Education (equivalent of O'Level Certificate in the United Kingdom) and college diploma.

The family incomes of these families were not very different from each other and could be considered as fairly poor. Thus, this sample could be regarded as homogeneous. It would be important to extend this study to other socio-demographic groups in the country and ascertain if these findings cut across different socio-demographic groups. For instance, it would be important to involve participants from rural families, families with high income, and families with different composition (e.g., those who live with extended families, couples without children, etc.). Such studies may shed more light on the topic, especially on the practices they engage in to support having a healthy family in everyday life.

Lastly, I did not seek views of local scholars or professionals on how they define a healthy family. It would be important to ask this group about what they think is a healthy family and ascertain whether their meaning is similar to that of lay people and families.

Future Research

There is dearth of research in the area of family health, specifically on the meaning of a healthy family, in most sub-Saharan Africa countries, including Malawi. This warrants further research on the topic. A number of areas could be explored to further knowledge and understanding of the meaning(s) families have for a healthy family. Firstly, future research could focus on including self-reports from family members other than mothers and fathers and to include use of observational methods. Even though participants in the present study talked about family roles, tasks and routines, it would be important to actually observe them as

they go through their typical day. This is where observational methods would be useful because "actions can make implicit meanings visible" (Charmaz, 2004, p. 981).

It is still not clear whether the meaning of a healthy family is similar or different across different sociodemographic groups in Malawi. Therefore, future research could also focus on investigating the meaning of a healthy family across a spectrum of diverse sociodemographic characteristics such as age-groups or generational cohorts, different family structures (e.g., single-parent families, child-headed families, and HIV/AIDS affected families), and place of residence (rural and urban).

Future research could also focus on investigating whether the problem with using North American models and measures lies in the conceptualization of the dimensions of these models or in the operationalization of the terms and concepts. Such investigations would shed light on this issue and ascertain whether Western-developed measures are appropriate and applicable to other cultures.

Lastly, future research on the meaning of a healthy family could focus on the comparisons of the perspectives of lay people and those of scholars. Such comparisons could establish whether there are differences between their meaning and those of lay people and families. Such information is important in developing programs and services that are in line with the needs of the families.

Attending to the issues highlighted above holds the potential for furthering knowledge and understanding about how families in Malawi, the sub-Saharan Africa, and other countries in the world view their health in everyday life

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APPENDICES

Appendix A: Information Sheet

Study Title: The Meaning of a Healthy Family in Sub-Saharan Africa: Perspectives of Two-Parent Families in Urban Malawi

Research Investigator:

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Background

You are being invited to participate in this study because you meet the eligibility criteria of this study and because I believe that you can provide important information about family health in the country. I am recruiting two-parent families with pre-school and school-age children. Your name was provided to me by the local community development leaders upon my request to help me identify participants for this study. I am conducting this study to understand how families in the country define "a healthy family", what they do individually and as a family unit to take care of your family's health, and factors within and outside their family that affect their health in everyday life. The results of this study will be used in support of my thesis. The findings may also be used by other scholars and

researchers in future studies. Again, they may also be used by policymakers in planning and delivering programs and services for families in the country. Therefore, your participation in this study is very important and is greatly appreciated.

Approval by Authorities

The University of Alberta Research Ethics Board in Canada and the Chancellor College Ethical Review Committee at the University of Malawi here in Malawi reviewed and approved my proposal to conduct this study here in Blantyre. I have also sought permission from the Chief Executive Officer (CEO) of Blantyre City Assembly, and the Commissioner of Police, Southern Region Headquarters at Blantyre Police Station to allow me to contact you and ask if you could participate in this study.

Who is doing this study?

This study is being conducted by me, Mayeso Chinseu Lazaro. I am a graduate student in the Department of Human Ecology at the University of Alberta in Canada. I am carrying out this study as part of the Master of Science in Family Ecology and Practice program in the Department of Human Ecology at the University of Alberta.

Purpose of this Study

Healthy families create healthy communities which in turn create a healthy nation. Importantly, the way families define their family's health affects their behaviors, and ultimately influences how programs and services are designed and delivered by the government and non-governmental organizations (NGOs) to help

them live better lives. Therefore, in this study I want to understand from your point of view how you describe "a healthy family", what you do individually and as a family unit to take care of your family's health, and the factors or conditions within and outside your family that affect your family's health.

Findings from this study are important in that they will contribute to knowledge in family health in the country. Such knowledge plays a significant role in informing policy on programs and services that can help address the challenges that families are facing in everyday life thereby helping them meeting their health needs.

Study Procedures

This study involves a face-to-face interview in which I will engage in conversation with you. The interview will be individual and I will talk with both the father and the mother of the household separately and also in the absence of any other family members. I will not discuss with any member of the family what either of you tells me. The interview will be conducted in *Chichewa* in your place of convenience and at the time we will mutually agree. I will record each interview and I may also take notes during the interviews. The interview is expected to last between 60 and 80 minutes.

The Interview: As said above, the interview will involve individual members of the family and will be conducted in the absence of the other members of the family. I will first ask you to complete the demographic form on which you will record, among other things, your age, education level, religion, and individual/family income.

After completing the demographic form I will talk with you about your family's health. The main focus of our conversation/discussion will be to help me understand what "a healthy family" means to you. I will ask you questions from the following topics:

- Your family life.
- What you do individually to take care of your family's health.
- What you do as a family unit to take care of your family's health.
- Factors or conditions within your family which affect your family's health.
- What the meaning of "a healthy family" is to you.

Benefits of Taking Part in this Study

The information you tell me will help me (and other researchers) understand what "a healthy family" means to you and other families in the country, what you do individually and as a family unit to take care of your family's health, and factors or conditions which affect your family's health. Therefore, it is expected that findings from this study may be important in informing people who plan public health and social programs and services for families to align them according to the needs of families. Ultimately, these programs and services may benefit families like yours.

Risks of Taking Part in this Study

I do not think that there is any risk for you for participating in this study. However, in the event that some of the things you tell me or some of the questions I ask upset you and/or provoked feelings of discomfort in you, I will talk with you and help you decide how to deal with your feelings. I will also suggest

professionals and places near your home where you could go and be helped at your cost. Also note that you are free not to answer any question that you feel uncomfortable answering or you may choose to ask me to turn off the tape recorder.

Voluntary Participation and Freedom to Withdraw from the Study

Participating in this study is absolutely voluntary and I will include only people who choose to take part. Please take your time to make your decision. I want you to also understand that even though you agree to participate in this study, you are not bound to continue to be in the study against your will. If you change your mind and would like to stop taking part, feel free to tell me and I will respect your decision. In such event, please note that you do not have to give reasons for stopping and there is no penalty for withdrawing from the study. If you decide after the interviews that you do not want me to use your information, you can call and tell me this – up to one week after the last interview with your family. When you tell me this, I will not use your information.

I want you to also understand that before you agree to be in this study it is very important for you to understand all of the information related to this research study. Please ask me to explain any words or terms or anything in this document you don't understand, and make sure that all the questions or concerns you have are addressed to your satisfaction before signing the consent form. Feel free to consult your friends and family or anyone and discuss the information in this document with them.

Confidentiality

All the information you provide in this study will be kept private and confidential. It will be used by me in support of my thesis. The Supervisory Committee of my thesis research (i.e.,, my Supervisor and Co-Supervisors at the University of Alberta in Canada) may have access to it for the purposes of supersizing my thesis. Please also note that the University of Alberta Research Ethics Committee and Chancellor College Research Ethics Committee may have access to the information you provide. Importantly, I would like to assure you that I will not use your name in my report or any publication(s) or presentation(s) resulting from this study. I will always adhere to your anonymity. All the information you give me will be kept in a locked cabinets and on a secure computer networks at the University of Alberta in Canada and at Chancellor College here in Malawi.

The Interview. The interview will be conducted, tape-recorded, and transcribed (i.e., typed out) by me, the researcher. To protect your identity and privacy, I will not use your name in any of the interview transcripts. Instead, I will use a unique code that will be used for data management and analysis. The information that you give in the individual interviews will not be shared with other members of your family. In reports or talks about the study, I may use your actual words, but I will not use your name or the names of your family members. Instead, I will use pseudonyms (i.e., fictitious names) to conceal your identify.

Some of the transcribed interviews may be translated from Chichewa into English and back into Chichewa by two other persons. However, since the

transcripts will not have your name or any identifying features when these people access them, it will not be possible for them to identify you from these transcripts. These people will not have access to the original transcripts. In addition, these two people will each sign an oath to keep private and confidential any information they will access when translating the transcribed interviews.

All information will be kept private except when professional codes of ethics or the law requires reporting. For example, suspected child abuse or neglect must be reported. This is the only information that cannot be kept private. If this situation occurs, I will talk to you about it.

Use of Information from this Study

The information from the study will primarily be used in support for my thesis to fulfill the requirements of being granted a Master's degree in Human Ecology (Family Ecology and Practice) at the University of Alberta in Canada. Therefore, I will use the information to produce a report for my study. I may also use the information to write article(s) to publish in journals or to make presentation(s) at local or international conferences. In addition, I may also disseminate the findings of this study to government ministries and departments, non-governmental organizations (NGOs), donors, and international agencies to reach out to them on how families in Malawi perceive their family's health. In all this, all identifying information will be removed. The information from this study may also be used again in the future by other scholars and researchers to answer other research questions in Malawi, sub-Saharan Africa, or other parts of the world.

As a participant you are privileged to know the findings of this study. Therefore, in the consent form I will ask you to indicate whether you would like to have the findings sent to you. And if you indicate "Yes", I will ask you to provide accurate details of your surface mailing address or electronic mail (email) address.

Informed Consent

After reading and understanding this information sheet you can now tell me whether you agree to take part in this study. If you agree, I will ask you to read and sign the "Consent Form" before beginning our first interview. Once again, signing a consent form does not mean that you cannot stop participating in the study. You have the right and freedom to stop participating if you decide to do so and there will be no penalty for that.

Questions or Concerns about this Study

Research ethics boards at the University of Alberta (Canada) and at Chancellor College (University of Malawi, Malawi) have approved the plan for this study. If you have any questions, please contact any of the following:

Mayeso Chinseu Lazaro (The Researcher)
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If you have concerns about the study or your rights as a study participant, you may contact the University of Alberta Research Ethics Office at (**+1)780–492–2615** or Chancellor College Research Ethics Committee at (**+256)1–524–222**.

Appendix B: Consent Form

Study Title:

The Meaning of a Healthy Family in Sub-Saharan Africa: Perspectives of Two-Parent Families in Urban Malawi

Researcher and His Contact Details:

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Mobile Phone: (+265)99–223–1536 (Malawi) or (+1)780–710–5797 (Canada)
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Supervisor:

Dr. Berna Skrypnek, Human Ecology Department, University of Alberta

Co-Supervisors:

Dr. Deanna Williamson, Human Ecology Department, University of Alberta

Dr. Kaysi Eastlick Kushner, Faculty of Nursing, University of Alberta

Dr. Pushpanjali Dashora, Human Ecology Department, University of Alberta

Consent:

*Please answer the following questions by checking **"Yes"** or **"No"***

Do you understand that you have been asked to be in a research study?

Yes ☐ **No ☐**

Do you agree to take part in all the two interviews in this research study?

Yes ☐ **No ☐**

Have you read and received a copy of the Information Sheet describing the study?

Yes ☐ **No ☐**

Do you understand the benefits and risks of taking part in this research study?

Yes ☐ **No ☐**

Have you had a chance to ask questions and discuss this study with the researcher?

Yes ☐ **No ☐**

Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without any penalty?

Yes ☐ **No ☐**

Do you understand who will have access to the information you give?

Yes ☐ **No ☐**

Do you understand what the researcher will do to ensure privacy of the information you give?

Yes ☐ **No ☐**

Do you give the researcher permission to use photos that you produce as part of the study – including photos of your children? (Specific permission will be sought if the researchers wish to use a photo for a report or talk).

Yes ☐ **No ☐**

Do you give the researchers permission to use drawings and notes developed by the members of your family as a result of participating in this study?

Yes ☐ **No ☐**

Do you give the researcher the permission to tape-record interviews?

Yes ☐ **No ☐**

Do you understand how information collected in this study will be used?

Yes ☐ **No ☐**

Do you give the research permission to use the information you give in this study for future related studies, reports, presentations, and publications?

Yes ☐ **No ☐**

Do you give the researcher the permission to contact you in future about this or related studies?

Yes ☐ **No ☐**

This study was explained to me by the researcher.

Yes ☐ **No ☐**

I agree to take part in this study.

Yes ☐ **No ☐**

Participant's Name (Printed in Full):_____

Participant's Signature:_____Date:_____

Name of Witness (Printed in Full): _____

Signature of Witness_____ Date:_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Researcher's Name (Printed in Full):_____

Researcher's Signature:_____ Date_____

THE INFORMATION WAS ATTACHED TO THIS CONSENT FORM AND A COPY BE GIVEN TO THE RESEARCH PARTICIPANT.

Report of the Study Findings:

Would you like to receive a report of the study findings?

Yes ☐ **No ☐**

If yes, would you like a paper or an electronic copy? Please, check one.

A paper copy of the report ☐

An electronic copy of the report ☐

If you choose a paper copy of the report, please provide your mailing address below:

_____

_____

_____

_____

_____

_____

If you choose an electronic copy of the report, please provide your e-mail address(s) here:

_____

_____

_____

Appendix C: Demographic Profile for Participants

The Meaning of a Healthy Family in Sub-Saharan Africa: Perspectives of Two-Parent Families in Urban Malawi

Participant Code Number:_____ Date:_____

Introduction

Thank you for your time to participate in this study. In this form I would like you to write your demographic information or I will ask you and write it by myself, whichever way you prefer. I want to assure you that what will be filled in this form will be kept confidential and will not be shared in any way with other family members I will interview as part of the study or anyone who is not directly involved in this study. Your feedback is very important and it will be used for academic purposes. Results of this study will be made public but I would like to assure you that I will not use your name or anything that would identify you or other members of the family. I may use textual content in the report, publications, and presentations but be assured that I will use pseudonyms to conceal your identity.

If you have any questions about this demographic form or anything about this study please feel free to ask me in person any time. You can also call me at **(+265)99–223–1536** or email me your question(s) at lazaro@ualberta.ca or mlazaro@cc.ac.mw.

Demographic Information

Please write your answer in the spaces provided or check the appropriate box for you answer:

Mother:_____ Father:_____ Age:_____

Number of children in the family: _____

Child Number 1: Age_____ Gender_____
Child Number 2: Age_____ Gender_____
Child Number 3: Age_____ Gender_____
Child Number 4: Age_____ Gender_____
Child Number 5: Age_____ Gender_____
Child Number 6: Age_____ Gender_____

If more than 6 children, please write their age and gender below:

_____
_____
_____
_____

Household members and their relationship to you

	Household Member	Relationship to Participant
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

If there are more than 8 members in your household, please write their ages and gender here:

_____
_____
_____
_____
_____

Highest level of education

☐ No Education

☐ Primary School Education ☐ Secondary School Education

☐ Technical or Trade Certificate ☐ Technical or Trade Diploma

☐ College diploma ☐ Bachelor's degree

☐ Master's degree ☐ Doctoral

☐ Other. Specify_____

Current employment status

☐ Full-time. _____days per week ☐Part-time_____days per/week

☐ Self-employed ☐ Student

☐ Homemaker ☐ Retired

☐ Irregular, casual, seasonal, contract ☐ Unemployed & seeking work

☐ Other. Specify:_____

Individual or family income (approximate monthly income)

☐ Less than MWK20, 000

☐ MWK20, 001 – MWK50, 000 ☐ MWK50, 001 – MWK100, 000

☐ MWK100, 001 – MWK150, 000 ☐ MWK150, 001 – MWK200, 000

☐ MWK200, 001 – MWK250, 000 ☐ MWK250, 001 – MWK300, 000

☐ MWK300, 001 – MWK350, 000 ☐ MWK350, 001 – MWK400, 000

☐ Above MWK400, 000

Source(s) of this income (check all that apply)

☐ Employment-related ☐ Family business

☐ Pension ☐ Other. Specify:_____

Religion

☐ No religion ☐ Christian

☐ Islam ☐ Other. Specify:_____

Appendix D: Interview Guide

The Meaning of a Healthy Family in Sub-Saharan Africa: Perspectives of Two-Parent Families in Urban Malawi

Participant Code Number:_____ Date:_____

Interviewer:_____

Time Interview Started:_____ Time Interview Ended:_____

Preamble

Once again, thanks a lot for your time today. Before we begin the interview today, I would like to assure you that whatever you tell me in this interview will be kept confidential and will be used for academic purposes. I will not share with your spouse what I discuss with you today. Similarly, I will not talk with you about anything your spouse tells me. So feel free to express your views.

In this interview, we will start by talking about your family life. After that, we will talk about what you do individually to take care of your family's health. Then, we will talk about what you do as a family unit to take care of your family's health. Throughout our conversations, I would like you to respond to the questions by reflecting on your family and/or other families in general.

A. Introduction

1. To begin with, please tell me about you family life.

   Probes:

   a. If I were watching your family life, for example throughout the day, what would I see? How would your day be like? What would be the family roles and processes like? Who would do what?

B. Practices Family Members do Individually to Promote Family Health

2. What do you do individually to take care of your family's health?

   Probes:

   a. In your own view, how do these behaviors and/or practices affect your family's health? Tell me more.

C. Practices Family Members Do as a Family Unit to Promote Family Health

Now, let's move our focus from you as an individual to your family as a unit.

3. What do you do as a family unit to take care of your family's health?

   Probes:

   a. From your perspective, how do these behaviors and/or practices affect your family's health? Tell me more.

D. Factors or Conditions that Affect the Family's Health in Everyday Life

We have talked about the things/practices/behaviors that you do individually and as family unit to take care of your family's health. Now I would like us to talk about factors ***within your family*** that affect your family's health.

4. From you point of view, are there any ***factors within*** the family which you think have a significant impact on the health of you, your family members, and your family as a unit?

   Probes:

   a. What are these factors?
   b. How do they impact your family's health?

E. Meaning of a Healthy Family

You have told me about your family life, what you do individually and/or as a family unit to promote your family's health in everyday life, and also factors within your family that affect your family's health.

5. What does it mean to you to say that a family is healthy? In other words, what is a healthy family to you?

   Probes:

   a. From your point of view, what is it that makes a family "healthy"?
   b. Please describe to me things/attributes I would see if I were observing/watching "a healthy family" (e.g. in the morning, during the day, in the evening)?

6. In your own words, how would you define a family that is "not healthy (unhealthy)"?

   Probes:

   a. What is it that makes a family "not healthy (unhealthy)?
   b. From your point of view, describe to me things/attributes/behaviors I would see if I were observing/watching a family that is "not healthy family?

7. Different terms are used by researchers, the media, and the general public to refer to families that work and live well. For example, “strong families”, “good families”, and “happy families”. Reflecting on the meaning of “a healthy family” you have told me:

    a. Is the meaning of “a healthy family” similar or different to “a strong family”?
    Probe: How similar or different are these families?

    b. What about the meaning of “a healthy family” and “a good family”, are they similar or different?
    Probe: How similar or different are these families?

    c. What about the meaning of “a healthy family” and “a happy family”, are they similar or different?
    Probe: How similar or different are these families?

F. <u>Advice to Policymakers, Program Planners, and Service Providers</u>

8. What advice would you give to program planners and/or policymakers about family health?

G. <u>Closing the Interview</u>

This is all I wanted to talk with you today. Before we finish the interview:

9. Is there anything about your family’s health or family health in general we have not touched in our discussion which you would want to tell me?

H. <u>Affirming Consent</u>

10. Now that you know what you told me about family health, are you willing to have the interview used for the study?

I. <u>Final Remarks</u>

Thank you very much for your time today and I look forward to talking to you again in the next interview.