
Mother, Child and Community in Rural Malawi: Security-Seeking Behaviour and the Role of Under-Five Clinics

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Abstract: Health care delivery has emerged as a major challenge in global health. Despite unprecedented advances in medicine, as well as significant financial investments, innovations in health have yet to reach most of the world's population. Under-Five Clinics in rural Malawi offer a window onto how rural African communities are responding to new initiatives in health care. This article claims that participation in Under-Five Clinics is part of a broader social process of security-seeking behaviour in which individuals work to improve their sense of human security in an environment of extreme poverty, lack of adequate employment and limited access to health care services.

Keywords: HIV/AIDS, Malawi, global health, access to health care, social capital, vulnerability

Résumé : La prestation de soins de santé constitue de nos jours un défi majeur pour la santé mondiale. En dépit de progrès sans précédents dans le domaine de la médecine et d'investissements financiers importants, une partie considérable de la population mondiale n'a toujours pas accès aux innovations en matière de soins de santé. Les cliniques *Under-Five* au Malawi rural ouvrent une fenêtre sur la façon dont les communautés rurales africaines répondent à ces nouvelles initiatives. Cet article soutient que le fait d'avoir recours aux cliniques *Under-Five* s'inscrit dans un processus social plus large par lequel les individus cherchent à accroître leur sentiment de sécurité humaine dans un environnement marqué par l'extrême pauvreté, le sous-emploi, et l'accès limité aux soins de santé.

Mots-clés : VIH/Sida, Malawi, santé mondiale, accès aux soins de santé, capital social, vulnérabilité

Introduction

It was not yet noon, but the sun was already heavy in the sky as David, a community health worker, stood in front of the women who were sitting under the big tree outside the village headman's house. Many of the women were holding their young children, while younger babies were secured safely on their mother's back. After a short pause David looked at the women in front of him with a big smile and said, "If you women continue to be pregnant all the time, we men will leave you and look for younger women because you will not be pretty anymore." The women and the health workers burst into laughter. Later, David would say to me, "It is important to joke when you are talking about family planning, though some women will tell you it is not really a joke."

The past few decades have seen a significant increase in the number of interventions and outreach programs targeted at rural communities in the developing world. Both governments and NGOs have introduced a range of new health care services and programs to rural communities in the hope of improving access to health care. Among these services are Under-Five Clinics in rural Malawi, which provide vaccinations, weight monitoring and health education to women and children. Under-Five Clinics offer an important window through which to examine how communities in rural Africa are responding to the influx of health services. Prevailing theory suggests that health-seeking behaviour in vulnerable populations is characterized by passivity. However, tremendous efforts on the part of women and community members to facilitate and participate in government-sponsored services such as Under-Five Clinics suggest the need for a broader view of health-seeking behaviour that attends much more carefully to local perspectives and the contexts in which individuals and communities operate.

The social capital perspective dominates current understandings of health-related behaviours. Social capital, however, provides a limited perspective on people's

lived experiences. The need to go beyond the models of health-seeking behaviours, and the dominant perspective of social capital, stands at the heart of this article. Based on insights from this study, I suggest a new framework through which to examine health-seeking behaviour in the developing world, one that situates health-seeking activities within their broader social contexts and thus fills a gap in the current analysis, which tends to focus exclusively on health-related behaviours. I analyze participation in Under-Five Clinics in rural Malawi in the context of a range of other community enterprises, such as women's self-help groups, home-based care networks and orphan-care initiatives. All of these activities represent strategies of what I call *security-seeking behaviour*. Elaborating on Ann Swidler and Susan C. Watkins' (2009) work on the consequences of the sustainability doctrine, I argue that security-seeking behaviours are shaped by the need to navigate the unstable and ever-changing terrain of material and social resources stemming from care and development programs. Security-seeking behaviours are strategies to explore and take advantage of new opportunities to improve one's sense of human security in an environment characterized by instability, extreme poverty, limited access to resources and constant threats to human security.

To that end, I wish to elucidate the ways in which women, rural activists and health workers regard Under-Five Clinics as an opportunity to improve their social statuses. Taking into account such improvements, as well as the social context in which these activities take place, this article redefines common notions of health-seeking behaviour, especially among women and poor rural communities in resource-limited settings and revisits current theoretical approaches to health-seeking behaviour.

The article opens with a brief theoretical overview of health-seeking behaviour in vulnerable populations. I address the role of social capital in access to health services and discuss the concept of human security and its promise as an analytical tool. This is followed by a description of the Under-Five Clinics in the villages of the southern district of Malawi and the social context in which they operate. To conclude, I return to the theoretical discussion to readdress the issue of health-seeking behaviour in vulnerable populations and the way in which these behaviours are best understood in the overall context of care and welfare activities in rural communities, all of which constitute security-seeking behaviours.

Accessing Care: The Theoretical Perspective

Under-Five Clinics in rural Malawi operate in an environment of extremely limited resources and infrastructures. Though clinics are equipped with little in the way of equipment or personnel, they are nonetheless an important resource to the rural communities they serve. The extent of the uptake of these services is not solely attributable to the extreme poverty faced by their clientele or to their lack of social power. Rather, we must understand the success of Under-Five clinics as being driven by security-seeking behaviour, which is grounded in three important concepts: health-seeking behaviour, social capital and human security. The first two have a strong foothold in medical anthropology and public health but, I argue, limit our appreciation of the complexities of health-seeking behaviour. I argue that the concept of human security, borrowed from the fields of international relations and political science, offers critical insights into the realities of people's daily lives.

Health-Seeking Behaviour, Social Capital and Human Security in Vulnerable Populations

The relationship between health status and social power has a strong grip in anthropology. Studies have shown that members of disadvantaged social groups are exposed to greater health risks over their lifetimes. The social and cultural dimensions of the relationship between inequality and health are at the heart of many anthropological research projects (Nguyen and Peschard 2003). Social power is not only possessed by individuals but is also connected to different levels of power that various groups hold during social, political, historical and economic processes. These power differentials influence people's ability to confront health risks and are expressions of structural violence (Farmer 1997). With social power as part of the equation, health-seeking behaviour among vulnerable persons has been defined as "the steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem" (Chrisman 1977:353).

Two axes of inequality discussed extensively in the anthropological literature are those of gender and socio-economic status. Women and the poor are often afflicted with many of the hardships that define vulnerability. Social groups deemed as vulnerable are "the poor, persons subjected to discrimination, intolerance, subordination and stigma; and those who are politically marginalized, disenfranchised and denied human rights" (Flaskerud and Winslow 1998:69). Studies have attributed

uneven health-seeking behaviour among women and the poor to their lack of access to resources, their lack of knowledge regarding health risks, and structural violence, social powerlessness and stigma (see Ahmed et al. 2000; Currie and Wiesenbergh 2003; Guralnik and Leveille 1997; Link and Phelan 1996; Okojie 1994; Vlassoff 1994).

Health behaviours among populations with low socio-economic status have often been explained with reference to vulnerabilities. In the context of health care provision models, the vulnerable population model (Aday 1994; Bragg-Leight 2003; Flaskerud and Winslow 1998) suggests that the relationship between resource availability, relative risk and health status is a vicious cycle in which the lack of resources increases relative risk, relative risk damages health status, and health status, in turn, further depletes resource availability. According to this model, communities are responsible for providing individuals with the socio-economic and environmental resources needed to maintain good health (Flaskerud and Winslow 1998). Nevertheless, the relationship between resource availability, relative risk and health is affected by multiple intervening variables. As a result, they cannot be understood as independent factors. This complex social reality is further complicated by the fact that the resources in question are not just material but also social and cultural. Thus, this cycle of vulnerability is influenced by the ability to access and use social as well as other forms of capital.

The role of social capital in access to health care is of crucial importance. Grounded in social relationships, *social capital* was originally defined as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (Bourdieu 1985:248). This instrumental concept encapsulates the benefits of belonging to a social network and being able to access its resources, both material and non-material (Portes 1998). The concept of social capital, originally used to explain social inequalities (Bourdieu 1973), has since been used to analyze different forms of public action (Coleman 1988; Putnam 1995). Ware et al. have defined social capital in the context of health as “resources accruing from a network of relationships that helps individuals to solve problems and get things done” (2009:0045).

The social capital perspective has been applied to the analysis of a wide variety of health-related behaviours, ranging from the health of older women in disadvantaged communities in Britain (Boneham and Sixsmith 2006) to high adherence rates to antiretroviral therapy in

sub-Saharan Africa (Ware et al. 2009). While social capital is generally believed to be beneficial (Putnam 1995), some research has shown that social capital can actually hinder individuals from seeking needed health care services (Carpiano 2006; Portes 1998; Sixsmith and Boneham 2003).

The complex nature of social capital testifies to the intricacy not only of the term itself but also of the ways in which it is manifested and used in social life and as part of a larger context of health-seeking activities. Furthermore, the tendency among researchers to use social capital as a silver bullet in explaining health-related behaviours bears the risk of oversimplifying a broad and complex range of social and individual activities that do not necessarily relate directly to health improvement. Nevertheless, social capital is a useful concept for understanding health-related behaviours, as individuals often learn about, and are able to access health care services through, their social networks.

A person’s ability to cultivate and benefit from social capital is highly contingent on the stability of their environment. Human security should therefore also be considered when exploring patterns of access to health care services and health-seeking behaviours. The concept of human security as it is used here was first articulated in the 1994 United Nations *Human Development Report*, which focused exclusively on the issue of personal security. The authors noted that “the concept of security has for too long been interpreted narrowly: as security of territory from external aggression or as protection of national interests in foreign policy or as global security from the threat of a nuclear holocaust” (United Nations Development Programme 1994:22). They called for a definition of human security that extended beyond threats at the national level to include threats to an individual’s security, which arise “more from worries about daily life than from the dread of a cataclysmic world event” (22).

Human security as a person-centred perspective acknowledges both violent and non-violent threats to one’s rights, health and life (Beebe and Kaldor 2010; McRae and Hubert 2001; Onuoha 2009). Although contested and criticized at times (MacFarlane and Khong 2006), the term *human security* expands the notion of security to include “the security of individuals and communities, expressed as both ‘freedom from fear’ and ‘freedom from want’” (Kaldor et al. 2007:273). Understanding the individual aspects of security, the multidimensionality of the source of harm (Dunne and Wheeler 2004) and the relationship between the threats of daily insecurity and the need to protect oneself from their

results provides a valuable perspective for the analysis of daily practices directed at reducing risk and increasing a sense of security, especially under conditions of extreme poverty and instability.

Based on available theory regarding health-seeking behaviour among vulnerable populations, one would expect to find members of rural communities—especially women—in a poor developing country like Malawi struggling to access the limited health care services available to them. Yet, in many areas, this is not necessarily the case. On the contrary, rural women and other individuals in Malawi have been known to actively seek health care for themselves and their families. To better understand this phenomenon, I posit that one must look beyond social capital to understand patterns of access to health care as part of a broader spectrum of security-seeking behaviours. Such activities are aimed at exploring and taking advantage of new opportunities to expand an individual's sense of personal security in an unstable environment characterized by extreme poverty, limited access to resources and constant threats to human security.

Methods

This article is drawn from 12 non-consecutive months of ethnographic fieldwork conducted between 2004 and 2007 in rural Malawi. The study of Under-Five Clinics was part of a larger research project examining how communities in Malawi are coping with the growing numbers of orphans and vulnerable children resulting from the HIV/AIDS epidemic. The project involved a combination of participant observation in both village communities and institutional settings, as well as 45 open-ended, in-depth interviews in both settings. Although Under-Five Clinics are routinely held in health centres and hospitals across the county, the focus of this article is the outreach clinics that travel to remote rural communities to provide services to people who are either too remotely situated or too poor to travel to the health centres. Since it is estimated that only 54 per cent of the population in Malawi is within a five-kilometre radius of a health centre (Ministry of Health 2004), understanding the work of outreach services in remote communities, especially when pediatric health is concerned, is of the utmost importance. Observations and interviews in Under-Five Clinic settings were conducted during clinic days, and with clinic staff and women in various locations. Additional interviews included members of the communities where the clinics operated, community leaders, workers in Malawian and international NGOs, and government officials. Informal interviews and obser-

vations were conducted daily during fieldwork, with the consent of participants in all settings and with clearances from all institutions involved. Mothers, community members and health workers were invited to share their views, although it was made clear that they were under no obligation to participate. I transcribed all interviews and changed all names to protect the privacy of interviewees.

Background: The Malawian Health Care System

The importance of Under-Five health services in Malawi cannot be understood without addressing the colonial and post-colonial social and economic history of the country. Decades of colonial and post-colonial policies and years of international economic pressures in the form of structural adjustment programs resulted in increased poverty and the weakening of the small-scale farmers' rural households. In the colonial period, the British Protectorate of Nyasaland was a commercial agricultural outpost, with a marginal role in the colonial mining economy of southern Africa. After independence in 1964, most Malawians remained small-scale farmers or migrant labourers (Englund 2006).

The neglect of small-scale farmers continued in the years after independence. Although the shift to democracy in 1994 resulted in new civil and political freedoms, these achievements were often used to divert attention from the failure to achieve significant poverty reduction (Englund 2006). Loans received from international donors in the 1980s were conditioned by structural adjustment programs that pushed for market liberalization and the minimization of public spending on services. These programs, which resulted in the privatization of services, not only negatively affected the economic status of the country but resulted in what Dalitso K. Kubalasa (2003) has described as "continuing economic retrogression and social depravation with declining per capita income."

Based on the colonial and missionary health systems, health services in the country are provided by three separate entities: the government through the Ministry of Health, the Christian Health Association of Malawi, and various private health providers, which include several NGO-run clinics (Nyirenda and Flikke 2012; Turshen 1999). Within this three-provider system, services provided by the Ministry of Health are free of charge; however, years of reduced public spending have created a weak, understaffed and poorly resourced government health system (Turshen 1999; Wendland 2010).

Within this depleted health system and based on the rising attention to pediatric health in the developing

world, Under-Five Clinics in Malawi were established in the early 1970s on the basis of the concepts outlined by David Morley (1973). They are dedicated to developing comprehensive services to reduce malnutrition and improve nutrition-related knowledge, prevent infectious diseases and raise the quality and quantity of health services in the country (Cole-King 1975). While pre-dating the current age of global health interventions, the Under-Five Clinics were quickly adopted into the new structures of health, both in the service of pediatric health and as a strategy to disseminate other health messages and opportunities that did not reach remote communities via other services. In the environment of limited health services in Malawi, and considering the limitations in access to services by remote populations (Ministry of Health 2004), Under-Five Clinics have historically reached out to remote populations and provided services both within and outside health centres.

Under-Five Clinics: History, Theory and Practice

The health of under-five children in Malawi and their parents' health-seeking behaviours were studied from medical and cultural perspectives, examining both the structural barriers to accessing health services and the cultural context in which these services are used or underutilized. From a public health perspective, under-five health in Malawi was analyzed in the context of malaria treatment and prevention (Mathanga and Bowie 2007), diarrheal diseases (Munthali 2005a) and vaccinations (Munthali 2007). In addition, studies have explored the cultural context in which parents understand under-five health and pursue biomedical treatment options. Ethnographic studies have highlighted the importance of common perceptions of the etiology of disease, trust in traditional medicine, distance from health centres and the limited availability of drugs as factors shaping treatment-seeking behaviours among parents of under-five children (Chibwana et al. 2009; Munthali 2004, 2005a, 2005b, 2006).

While this body of work does account for both the epidemiological evidence and the cultural context in which health-seeking behaviours are shaped and duly discusses both the structural barriers to care and the cultural ones, it often analyzes parents' health-seeking behaviour for under-five children as a unique health-related activity. Exploring Under-Five Clinics as part of a broader network of activities may bring into question their exceptionality and allow for a more complex view of health-seeking behaviour for children.

Under-Five Clinics are gatherings held by health providers for children under the age of five years and their mothers. The clinics are run by health surveillance assistants (HSAs), who are high school graduates trained by the district health authorities in nutrition, vaccine handling and basic public health education in the areas of sexually transmitted diseases, family planning, malaria prevention, clean water maintenance and children's health. HSAs' role within the Malawian health care system has undergone changes in recent years (Nyirenda and Flikke 2012). As a rule, they usually represent the lowest rank of government-paid health care providers. Vaccinations and nutrition surveillance conducted in these clinics are recorded as part of district and national surveillance systems, with data submitted monthly to health authorities (Pelletier and Johnson 1994). Trained nurses who work in clinics or health centres do not, in most cases, take part in the outreach Under-Five Clinics.

HSAs collaborate with "village coordinators" who are male community elders appointed by village headmen or the elders' council to assist in managing and coordinating the clinic's activities. Village coordinators are charged with informing all village households about the clinics and ensuring the participation of all mothers of young children. In most cases, male HSAs and village coordinators are the only men present in the clinics. On clinic days, the coordinators do not cultivate their fields but remain in the village to oversee clinic procedures.

While routine health centre-based Under-Five Clinics are held weekly for women arriving from the villages surrounding the health centres, outreach clinics, which target the more remote communities and are the focus of this article, are held approximately once a month in every village or cluster of villages. Village clinics are held at the same location every month, usually a central area in the village close to the headman's house, the school or other known meeting point. The clinic's schedule is routine: women and their children gather at a designated hour, generally in the morning, as publicized in advance by the village coordinators. Many women bring more than one child to the clinic, often assisted by older daughters, who help carry their siblings. Women frequently arrive long before the HSAs do and form a line by placing their belongings at the area where weighing will take place. When the HSAs arrive, on foot, bicycle or motorbike, the women and children gather facing the HSA who is leading the meeting, while other HSAs and the village coordinators arrange the vaccination area. The meeting starts with a

prayer led by one of the women with the HSAs' encouragement. After the prayer, the women sing a few songs with messages involving children's health, nutrition and family planning.

After singing, a senior HSA leads a class which usually involves messages about nutrition and children's health, with special attention to malaria prevention and family planning. The class is run as a series of questions and answers ends with a summary of the main messages for the day. In one family planning class, the repeated message was that animals keep having babies while people should remember "child spacing" for the benefit of their family and to keep women looking good and healthy.

When the class is over, the women, carrying their children, form a line in front of the mobile scales hung up by the HSAs. Each mother holds a notebook, the child's "health passport," in which the HSA records the child's weight. When the weighing is finished, the women turn to another HSA, who copies the results into a clinic follow-up book for surveillance purposes. The tallies from the clinic's follow-up book are reported to the district and national health authorities. The HSA in charge of surveillance refers women with children in need of vaccinations to the HSA responsible for vaccinations. Children found to be suffering from malnutrition are identified at this stage of the clinic. If mild malnutrition is diagnosed, the mother is advised what foods to provide, and if donations are available, she may receive some food items from the clinic's staff. In severe cases of malnutrition, the mother is advised to go to the district hospital, but as one of the HSAs remarked in an interview, "many of these people are so poor that they can't afford the fares to the hospital and they would probably just take the child home and we don't have a car to take him there."

Women start to disperse as the lines get shorter. After all the children have been weighed and vaccinated, the HSAs gather their equipment with the village coordinators and head back to the clinic, where they will update their surveillance books, store the vaccination materials and, on occasion, hold a meeting to discuss any problems encountered during the clinic, such as supply shortages or a lack of cooperation from the village coordinators.

Clinics may last the whole morning depending on the number of women and children and the duration of the vaccination process. Since clinics are held at the centre of the village or in a central village in a cluster of villages, women's attendance involves, in many cases,

very long walks, up to 10 or 15 kilometres, with one or more babies and toddlers. In addition, a morning spent in the clinic is a morning in which no work is done in the household and other children are entrusted to the care of neighbours and relatives. Thus, attending the Under-Five Clinic is anything but passive. On the contrary, it demands that women take an active role and place it at the top of a never-ending list of chores and obligations.

Beyond Under-Five Health: The Broader Context of Health and Welfare Activism

At this point I wish to broaden the scope and look at women's and other community members' participation in Under-Five Clinics in a broader context of health and welfare activities taking place in rural communities. The first question one might ask is, why do Under-Five Clinics seem to work? Before we try to answer this, it should be made clear that the present situation is far from satisfactory. Poor rural communities in Malawi, and elsewhere in the developing world, continue to suffer from poor health and limited access to health care services and in no way is this situation improving. Furthermore, the realities described and analyzed in this article are not without tensions and power struggles, which will be addressed in the following sections. Nonetheless, understanding the context of health-related activities might be helpful in highlighting ingredients of success for future programs targeting poor and vulnerable populations. That said, we also need to better understand the case of the Under-Five Clinics presented in this article?

One explanation is that Under-Five Clinics make resources available to women and to the community. As explained in the vulnerable population model (Aday 1994; Bragg-Leight 2003; Flaskerud and Winslow 1998), resource availability has a critical influence on health-seeking behaviour. Thus, making resources such as food supplies, vaccinations and basic pediatric care available is an obvious draw. Beyond this, health and family planning education services can be empowering not just for women but also for the community as a whole. A very different resource accessed through the clinic is the support and companionship of the other women, as these clinics offer women an opportunity to meet other women from neighbouring villages and to broaden their social network.

It is difficult to directly link improvements in resource availability with improvements in health outcomes. Available data from rural Malawi do not necessarily point

to an improvement in women's and children's health status (National Statistical Office and ORC Macro 2005). Nevertheless, immunization rates in Malawi are on the rise (Chee et al. 2008; National Statistical Office and ICF Macro 2011; Nyirenda and Flikke 2012), and although immunization coverage is not enough to improve health status (Bowie et al. 2006), outreach clinics provide parents with more information regarding nutrition and health, even if in many cases they lack the financial resources to implement what they know. Accordingly, access to resources may explain some of the effects that participation in Under-Five Clinics has on the lives of rural populations in Malawi. Nonetheless, I contend that access to resources, both material and social, should be viewed in a broader context, not only accounting for the resources made available by Under-Five Clinics but examining other health- and care-related activities as well.

However unique, the extent of community participation in Under-Five Clinics should not be viewed in isolation but as one component in a larger network of activities. Much of the literature on health and power underscores the role of agency as a motivating force influencing vulnerable populations' health outcomes. The extent to which agency can be viewed as a force motivating individual action has been challenged in ethnographic writing, and its limitations have been recognized (Farmer 1992, 2003; Lockhart 2008). And while rural women are by no means a homogeneous group and occupy various social positions in their communities, a poor rural woman's desire to improve her life and the life of her family is a force that should not be underestimated. Under-Five Clinics, by nature, target the mothers of young children, but they are not the only activity in which women are involved. Though various social forces, both local and global, often disadvantage them, rural women pursue various forms of self-improvement according to their age, interests and social position, and not just in matters of health.

One example of this is participation in the women's self-help groups (*zithandizeni*). Self-help groups offer women opportunities to gain social support, learn trades and expand their social networks by participating in microlending schemes or small businesses shared with other women. Unlike the Under-Five Clinics, self-help groups do not necessarily target the mothers of young children but are open to women with various shared interests. Although many of these groups are initiated by NGOs, whether local, national or international, participation in such groups has become common in rural

Malawi. Grace, a widow in her 50s and a leader of a rural women's group in the central region of the country, explained:

We have a group of women, and we teach each other different things. The women coming here go back to their villages and teach other women, and that's how we reach hundreds of women with information on health and work. AIDS changed everything, and women and children are hurting the most. In the group we help each other.

Moreover, women describe their participation in such groups as part of their role as providers in a time of poverty and disease. As Grace further explained:

People don't appreciate women's work. It's not that a man can't be a good provider, but still the woman is in charge of raising children and feeding them, and if a mother is not doing the job, then the children will not be healthy in the body and the head. I fed fifteen children from my garden; that's why women need to help themselves, and that's what we try to do in the group.

Community-based organizations providing home-based care and services are also extremely common in rural communities. Organized as communal initiatives, or based on the work of NGOs, many of these activities have a financial component as they involve microfinance schemes either between members or with outside organizations. However, even community-based initiatives without financial components are sometimes supported by government grants. Many of these initiatives are founded independently with the hope that they may benefit from funding in the future. From providing after-school lunches to orphans living with poor or elderly relatives to caring for the chronically ill in the village, voluntary care activities are commonplace in rural communities. Mary, a woman who established a support group for people living with HIV/AIDS, which was later supported by an NGO, described her group:

This community-based organization started as a result of the HIV/AIDS impact that was afflicting the community. I became HIV-positive, I knew of my secret in 2002, but, because we lacked any support system in the community, I had a very difficult time accessing any assistance or maybe getting into an antiretroviral program. When I started recovering, getting better, I thought of coming together with some of my friends to start a support system so that we can support all the other people having this problem in the community.

Mary continued to describe the group's work:

So this club's primary objective is to look after those who are clinically ill and the bedridden, by providing support in the homes. But also by providing psychosocial support to children, especially orphans, because when children lose one of their parents it becomes very difficult for them. We started from basically four of us, me and my sister, two others who are also HIV-positive, and then we talked to some other women. Then the group kept on growing, until we were about 40 women, and since we had no money to do anything, we started contributing our own money.

Almost all the community activists act on a volunteer basis. Although some are lucky to receive financial support for their work, most community-based care organizations are self-funded and operate independently from the government or NGOs.

Back to the Clinic: The Planned and Unplanned Consequences of Participation

By examining the participation of different stakeholders in Under-Five Clinics in the broader context of rural communities, a complex set of considerations is uncovered. The Under-Five Clinics are but one field of activity in which overlapping social roles, power relations and personal interests are played out. Participation in Under-Five Clinics is no longer a unique set of health-related activities but is one component in a plethora of care and welfare activities in which women, health workers and community elders are invested as part of their security-seeking strategies.

Women's efforts to be "good providers" and to "help themselves," as Grace described it, cannot be separated from both the roles and responsibilities women undertake in rural communities, and their need to navigate a universe in which their interactions with health providers and elders are infused with structured inequalities. Nevertheless, women's participation in Under-Five Clinics, much like participation in self-help groups or community-based care programs, might be clarified by addressing the perceptions of the opportunities presented by Under-Five Clinics as they are experienced by the women and their communities. First, for the women, the clinics present an opportunity to secure some health care services for their young children. Second, the clinics are an opportunity for women to broaden their social networks. And, third, on occasion, the clinics provide the women with much-needed material assistance such as cooking oil, beans and maize meal. Thus, participation in clinic activities has more than one goal,

or, in the words of one woman: "I come here to be a good mother and to learn, so I will know more."

For health care professionals, the clinics provide the opportunity not only to secure employment, which is not trivial in rural areas, but also to achieve social prestige. Within the context of community health work, HSAs are subjected to many of the limitations recognized by anthropologists as affecting the lives of community health workers. Community health workers are often underpaid and undertrained, constrained by the lack of employment opportunities and marginalized within the health care system, which treats them as cheap or even free labour (Closser and Jooma 2013; Maes 2012; Maes et al. 2014; Maes and Kalofonos 2013).

The HSAs are a part of the social stratum that Swidler and Watkins (2009) called the "aspiring elites"—young, secondary school-educated villagers trying to use their education as a stepping stone upward from life as a subsistence farmer to that of a formal employee. Nevertheless, as Swidler and Watkins point out, despite the promise of bright futures they hold, their professional status is insecure. Indeed, jobs are scarce, and many find themselves in a precarious social position in which, "by village standards, they are educated elite; by the standards of the elites who work for NGOs in the capital, they are not sufficiently educated" (Swidler and Watkins 2009:1188). Moreover, even within the Malawian health care systems, HSAs occupy extremely vulnerable positions as undertrained, underpaid and overworked employees (Nyirenda and Flikke 2012). With underpaid or volunteer work as their only alternative vocation, clinic staff are adamant about ensuring that the clinics remain a vibrant part of rural life.

The precarious social position held by the "aspiring elite" is highlighted by David, an HSA, and his wife, Chifundo, a schoolteacher, and their professional narrative, in which they left their remote home village and moved to the trading centre in search of work. After David had finally secured a position as an HSA, they described an improvement in their lives relative to when they lived in the village. Interviewed just a few months before their wedding ceremony, both agreed that it would be much easier to go back to the village to hold their ceremony now that they are both professionals holding paying jobs. And so, while David the HSA might hold a position of relative power over the rural mothers in his clinic, his standing within his community as well as within the medical profession and the NGO world is not as secure.

The professional ambitions of the "aspiring elites" in the villages are apparent not only in the lives of employed professionals like David and Chifundo but also

in the lives of others who are involved with NGOs providing health and welfare services. These activists are members of the community who take the initiative to start or operate some sort of a project in the community. Community activists may be a group of women trying to establish a network of mothers to help each other with childcare, or a teacher seeking to initiate an after-school program for children. Almost all of the community activists encountered during fieldwork acted as volunteers, and although they may have at some point been affiliated with the government or NGOs, they were rarely formally employed or paid for their community work. Nevertheless, community activists were actively involved in their communities far beyond the scope of their projects and were often in search of new projects or initiatives.

Both health care professionals and village activists share the same social strategies in their efforts to assert their professional status and separate themselves from the less educated villagers. In their struggle to maintain their authority as the professional elite, their professional language and self-reference are part of their "boundary work" (Gieryn 1983), used to distinguish themselves on the basis of their specialized knowledge. This distinction is useful not only for enhancing their social status but also as a means of exercising their authority over other members of the community. In an environment of limited employment possibilities, low-paid government jobs, volunteer work and community activism provide opportunities to become associated with local and international organizations; access to occasional resources such as money for transportation, staff lunches and per diems; and hope that there will be an opportunity to one day join the organization as a full-time paid employee (Maes 2012; Maes and Kalofonos 2013; Swidler 2006; Swidler and Watkins 2009).

For the village elders acting as village coordinators, the clinics provide benefits for the children but are also a tool for them to assert their leadership. Furthermore, the involvement of elders and other community leaders with the clinic's work is aligned with other roles they play in their communities. An elder or a chief may be involved in related community activities, such as allocating support for destitute widows and orphans or recruiting members of the community to take part in home-based care initiatives. On some occasions, community leaders serve as mediators between outside health and welfare organizations and their communities (Rosenthal 2012). Community-care activities like these are a channel through which leaders can maintain and enhance their social standing. Thus, the leaders who play a role in responding to people's needs, initiating activities and regulating behav-

iours are able to assert their leadership and secure their position in their communities.

In conversations with one of the headmen in the southern region of the country, where the clinics discussed in this article were located, the headman was constantly evaluating his role in the dynamics of health and illness in his community. In a region suffering from a high prevalence of HIV and high infant morbidity and mortality rates, the headman stated that he could not remain uninvolved when it came to the health of his people. His involvement took two forms: first, active and direct response to the needs of members of the community and, second, actions that were initiated by others but that involved community leaders as sponsors and supporters. Under-Five Clinics provided leaders with an opportunity to do both. Village coordination is therefore a triple opportunity for a village elder to improve the health of the village's children, reinforce his leadership and attain a unique social standing and authority over other members of the community.

In his discussion of human security, Freedom C. Onuoha (2009) states that this concept is based on three principles: the sanctity of life, the universality of an individual's dignity and rights, and the imperative of maintaining the individual's safety in a hostile world. David and Chifundu, Grace, Mary and many others live in a world in which human security is not a theoretical concept and the struggle to achieve a state of "freedom from fear and freedom from want" (Kaldor et al. 2007:273) is a daily challenge. With all social actors invested in the clinics, each for his or her own reason, the Under-Five Clinics become more than a health service. The various interests of all concerned illustrate the role Under-Five Clinics play in the broader context of rural life, where an unstable environment, limited opportunities and constant threats to human security are the only constants.

Conclusion

In an environment where efforts to achieve sustainability are sometimes the cause of greater insecurity (Swidler and Watkins 2009), I posit that participation in activities such as the Under-Five Clinic should be seen as more than health-seeking activities or expressions of social capital, but also as part of a broader social strategy of security-seeking behaviour. The activities surrounding the Under-Five Clinics are part of broader networks of care and welfare activities in rural communities, which include self-improvement initiatives and caregiving organizations providing care for the chronically ill or otherwise more vulnerable members of these communities.

Thus, women, health care professionals and community elders volunteering in the clinic are all engaged in the same practices, using all available resources and forms of social capital to improve their sense of human security and to cope with the “worries of daily life” (United Nations Development Programme 1994:22), namely, extreme poverty, lack of adequate employment and limited access to health care services.

What Swidler and Watkins (2009) describe as a hunting and gathering strategy (Bird-David 1983, 1990, 1992) in the world of AIDS NGOs is evident in other areas as well, turning security-seeking behaviour into a common daily practice for many in the developing world. However, security-seeking in an unstable environment may be a rather wasteful practice when measured in terms of return for energy invested. Participants are subject to a “capricious, irrationalizing environment that reinforces a contingent, opportunistic orientation among recipients” (Swidler and Watkins 2009:1183) and are forced to use all measures possible to gain food and health security and access to other forms of social and material goods. These hunting and gathering strategies are not only evident in the patterns of participation in the Under-Five Clinic but are part of a broader context of strategies in health, welfare and care. Thus, participation in Under-Five Clinics, much like participation in home-based care groups or women’s self-help clubs, is among the strategies in which people use all available resources and social networks to enhance their sense of security.

Health care delivery, of which the health of children under five is one component, happens at the intersection where policy, patients and providers meet. But the context of health care delivery goes beyond health. Being a context-oriented discipline and building on interaction, while aware of broad social and cultural processes, ethnography is the perfect methodological tool to inquire about the agendas, intentions, stakes and background of that unique meeting point. While global health policies govern much of the health care delivery process, and Under-Five Clinics as a part of it, the lived realities that drive people to security-seeking behaviours are the actual context in which these global health policies are implemented. Understanding the circumstances of providing care in rural communities sheds light on the process of delivery in its bare-bones state.

While Under-Five Clinics are an important field of inquiry in and of themselves, participation in them is but a part of a broader network of social activities in which vulnerable social actors take part as they strive to explore and take advantage of new opportunities to

improve their sense of human security in an environment characterized by instability, extreme poverty, limited access to resources and constant threats to human security.

Security-seeking strategies should be further investigated to assess the magnitude of their role as well as the impact of new services, such as the universal rollout of antiretroviral therapy in the country. Accordingly, the importance of local contexts, and their impact on needs as well as available opportunities, should be at the heart of any investigation into security-seeking practices. Nevertheless, in an environment still characterized by instability, the initiation of new services, if not provided as part of an inclusive system of care, might paradoxically exacerbate the sense of human insecurity and encourage reliance on security-seeking activities.

Understanding poverty and ill health as assaults on the dignity of individuals (Tadjbakhsh and Chenoy 2007), and thus on human security, allows for the development of a broader framework to analyze not only health-related behaviours but other responses to assaults on human security resulting from various disasters. Broadening the scope of investigation beyond Malawi and its unique political history to explore security-seeking behaviours in other resource-limited regions of the world has the potential to help us understand the contextualized patterns in the efforts made by people to overcome assaults on their dignity. And while contexts may vary, the concept is relevant to the study of postwar societies as well as societies coping with extreme poverty, natural disasters and other serious threats to human security. From post-earthquake Haiti to south Sudan, understanding and mapping security-seeking behaviours and the roles different social actors assume in them is a powerful tool anthropologists can provide to other social scientists as well as policy-makers.

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